

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

Our File No. 920

RULE REVIEW CHECKLIST

DATE RULE RECEIVED 5-23
DATE FOR REVIEW 6-3
DATE DUE 6-13

Adopted w/a hearing ✓
Adopted w/o hearing
Temporary rule

Approved June 13 Disapproved Returned to Agency June 14

Resubmitted Due
Approved Disapproved Returned to Agency

Date filed w/Secretary of State June 14 Revisor approved 5/25/83 disapproved

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✓ Rule as Adopted

✓ Rule as Proposed

✓ Order Adopting 5.12.83 Date

✓ Notice of Intent to Solicit Outside Opinion SR. 5.18.81

✓ Order for rulemaking
1.6.83 date of Hearing

N/A Certificate of Board's Authorizing Resolution

✓ Notice of rulemaking
✓ Sufficiency

✓ Affidavit of Mailing Notice or rulemaking
12.1.82 At least 30 days prior to hearing/~~adoption~~
✓ Additional Mailing

✓ Mailing list Certificate

✓ Publication in State Register
12.6.82 At least 30/~~20~~ days prior to hearing/~~adoption~~

✓ Hearing Examiner's Report

✓ Chief Hearing Examiner's Report(s)
3.8.83 Approving H.E.'s Report
5.19.83 Approving agency action

✓ Agency's Findings of Fact

N/A LCRAR Report or agency Affidavit

N/A Certificate of Board's Resolution Adopting Rules

✓ Order Approving Incorporation by Reference

✓ Statement of Need and Reasonableness

N/A Petition for Adoption of a Rule

Record (includes transcript or tape, exhibits, comments received by agency, requests for a hearing, and other relevant materials)

✓ Certificate of Compliance w/Rulemaking Procedures

✓ Affidavit of Mailing Notice of Submission to Attorney General

Notice of Submission to the Attorney General
misstates address
Comments to the Attorney General

SF-00006-02

DEPARTMENT ATTORNEY GENERAL

STATE OF MINNESOTA

Office Memorandum

TO : Leonard Levine, Commissioner of Welfare DATE: June 13, 1983

Attn: DIANNE MASTERS
Special Assistant
Attorney General

FROM : TED A. MARTINEZ TAM
Special Assistant
Attorney General

PHONE: 296-4692

SUBJECT: In the Matter of the Proposed Adoption of Rules of the Department of Public Welfare establishing minimum standards for Mental Health Centers and Mental Health Clinics for Purposes of Insurance and Subscriber Contract Reimbursement 12 MCAR §§ 2.029 - 2.0298.

Enclosed herewith are the rules you have submitted for approval. These rules have been approved by this office and filed with the Secretary of State. Please note that they have not been filed with the State Register. This must be done promptly by your agency.

Upon receipt and before transmittal to your agency, however, it is important that you recheck these rules as to:

1. Affixation of stamps of the Attorney General and Secretary of State;

2. Coverage by these stamps of all rules submitted; and

3. Inclusion of all pages to the rules in the approved set.

If you have any questions in this regard, please contact me.

Encs.
TAM/ls
cc: Ms. Kathy Burek
Mr. Duane Harves

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AG copy

Department of Public Welfare

Adopted Rules Governing Mental Health Center and Mental Health Clinic Standards

Rules as Adopted

12 MCAR S 2.029 Mental health center and mental health clinic standards. HE 10

Rules 12 MCAR SS 2.0291-2.0298 establish standards for approval of mental health centers and mental health clinics for purposes of insurance and subscriber contract HE 10 reimbursement under Minnesota Statutes, section 62A.152.

12 MCAR S 2.0291 Definitions.

A. Scope. As used in 12 MCAR SS 2.0291-2.0298, the following terms have the meanings given them.

B. Application. "Application" means the formal statement by a center to the commissioner, on the forms created for this purpose, requesting recognition as meeting the requirements of Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298.

C. Approval. "Approval" means the determination by the commissioner that the applicant center has met the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS ~~2.029~~ 2.0291 FOF F 2 -2.0298, and is therefore eligible to claim reimbursement for outpatient clinical services under the terms of Minnesota Statutes, section 62A.152. Approval of a center under 12 MCAR SS 2.0291-2.0298 does not mean approval of a multidisciplinary FOF F 2 staff person of such center to claim reimbursement from Medical Assistance or other third party payors when practicing privately. Approval of a center under 12 MCAR SS 2.0291-2.0298 does not mean approval of such center to claim reimbursement from Medical Assistance.

D. Case review. "Case review" means a consultation process thoroughly examining a client's condition and treatment. It includes review of the client's reason for seeking treatment,

diagnosis and assessment, and the individual treatment plan; review of the appropriateness, duration, and outcome of treatment provided; and treatment recommendations.

E. Center. "Center" means a public or private health and human services facility which provides clinical services in the treatment of mental illness. It is an abbreviated term used in place of "mental health center" or "mental health clinic" throughout the rule.

F. Client. "Client" means a person accepted by the center to receive clinical services in the diagnosis and treatment of mental illness.

G. Clinical services. "Clinical services" means services provided to a client to diagnose, describe, predict, and explain that client's status relative to a disabling condition or problem, and where necessary, to treat the client to reduce impairment due to that condition. Clinical services also HE 12 include individual treatment planning, case review, record keeping required for treatment, peer review, and supervision.

H. Commissioner. "Commissioner" means the Commissioner of the Minnesota Department of Public Welfare or a designated representative.

I. Competent. "Competent" means having sufficient knowledge of and proficiency in a specific mental illness assessment or treatment service, technique, method, or procedure, documented by experience, education, training, and certification, to be able to provide it to a client with little or no supervision.

J. Consultation. "Consultation" means the process of deliberating or conferring between multidisciplinary staff regarding a client and the client's treatment.

K. Deferral. "Deferral" means the determination by the commissioner that the applicant center does not meet the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298 and is not approved, but is granted a period of time to comply with these standards and receive a second review without reapplication.

L. Department. "Department" means the Minnesota Department

of Public Welfare.

M. Disapproval or withdrawal of approval. "Disapproval" or "withdrawal of approval" means a determination by the commissioner that the applicant center does not meet the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298.

N. Discipline. "Discipline" means a branch of professional knowledge or skill acquired through a specific course of study and training and usually documented by a specific educational degree or certification of proficiency. Examples of the mental health disciplines include but are not limited to psychiatry, ~~clinical~~ psychology, clinical social work, and psychiatric nursing.

O. Documentation. "Documentation" means the automatically or manually produced and maintained evidence that can be read by person or machine, and that will attest to the compliance with requirements of Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298.

P. Individual treatment plan. "Individual treatment plan" means a written plan of intervention and treatment developed on the basis of assessment results for a specific client, and updated as necessary. The plan specifies the goals and objectives in measurable terms, states the treatment strategy, and identifies responsibilities of multidisciplinary staff.

Q. Mental health practitioner. "Mental health practitioner" means a staff person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

1. by having a bachelor's degree in one of the behavioral sciences or a related ~~field~~ fields from an accredited college or university and 2,000 hours of supervised ~~clinical~~ experience in the delivery of clinical services in the treatment of mental illness;

2. by having 6,000 hours of supervised ~~clinical~~ experience in the delivery of clinical services in the treatment of mental illness;

3. by being a graduate student in ~~a mental health discipline~~ one of the behavioral sciences or related fields formally assigned to the center for clinical training by an accredited college or university; or

4. by having a master's or other graduate degree in a ~~mental health discipline~~ one of the behavioral sciences or related fields from an accredited college or university.

Documentation of compliance with 12 MCAR S 2.0294 D.2. is required for designation of work as supervised ~~clinical~~ experience in the delivery of clinical services. Documentation of the accreditation of a college or university shall be a listing in "Accredited Institutions of Post-Secondary Education Programs, Candidates" for the year the degree was issued. The master's degree in behavioral sciences or related fields shall include a minimum of 28 semester hours of graduate course credit in mental health theory and supervised clinical training, as documented by an official transcript.

R. Mental health professional. "Mental health professional" means a staff person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

1. in psychiatric nursing: a registered nurse with either a master's degree in ~~a mental health discipline~~ one of the behavioral sciences or related fields from an accredited college or university, or its equivalent, who is licensed under Minnesota Statutes, sections 148.171 to 148.285, with at least 4,000 hours of post master's supervised ~~clinical~~ experience in the delivery of clinical services in the treatment of mental illness~~.~~;

2. in clinical social work: a person with either a master's degree in ~~clinical~~ social work from an accredited college or university, or its equivalent, with at least 4,000 hours of post master's supervised ~~clinical~~ experience in the delivery of clinical services in the treatment of mental illness;

3. in ~~clinical~~ psychology: a psychologist licensed under Minnesota Statutes, sections 148.88 to 148.98, who has stated to

the Board of Psychology competencies in the diagnosis and treatment of mental illness; HE 16

4. in psychiatry: a physician licensed under Minnesota Statutes, chapter 147 and certified by the American Board of ~~Psychology~~ Psychiatry and Neurology or eligible for board certification in psychiatry; and

5. in allied fields: a person with either a master's degree from an accredited college or university in one of the behavioral sciences or related fields, or its equivalent, ~~whose official transcript documents that the degree or its equivalent includes a minimum of 28 semester hours of graduate course credit in mental health theory and supervised clinical training,~~ with at least 4,000 hours of post master's supervised ~~clinical~~ experience in the delivery of clinical services in the treatment of mental illness~~, or a physician licensed under Minnesota Statutes, chapter 147~~. HE 16

Documentation of compliance with 12 MCAR S 2.0294 D.2. is required for designation of work as supervised ~~clinical~~ experience in the delivery of clinical services. Documentation of the accreditation of a college or university shall be a listing in Accredited Institutions of Post-secondary Education, Programs, Candidates for the year the degree was issued. The master's degree in social work, behavioral sciences or related fields or its equivalent shall include a minimum of 28 semester hours of graduate course credit in mental health theory and supervised clinical training as documented by an official transcript. HE 14

S. Mental illness. "Mental illness" means a condition which results in an inability to interpret the environment realistically and in impaired functioning in primary aspects of daily living such as personal relations, living arrangements, work, and recreation, and which is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), Ninth Revision (1980), code range 290.0-302.99 or 306.0-316, or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III),

Third Edition (1980), Axes I, II or III. These publications are available from the state law library.

T. Multidisciplinary staff. "Multidisciplinary staff" means the mental health professionals and mental health practitioners employed by or under contract to the center to provide outpatient clinical services in the treatment of mental illness.

U. Serious violations of policies and procedures. "Serious violations of policies and procedures" means a violation which threatens the health, safety, or rights of clients or center staff; the repeated nonadherence to center policies and procedures; and the nonadherence to center policies and procedures which result in noncompliance with Minnesota Statutes, section 245.69, subdivision 2 and 12 MCAR SS 2.0291-2.0298. HE 22, 32

V. Treatment strategy. "Treatment strategy" means the particular form of service delivery or intervention which specifically addresses the client's characteristics and mental illness, and describes the process for achievement of individual treatment plan goals.

12 MCAR S 2.0292 Mental health center; mental health clinic.

A. Organizational structure.

1. The center or the facility of which it is a unit shall be legally constituted as a partnership, corporation, or government agency. The center shall be either the entire facility or a clearly identified unit within the facility which is administratively and clinically separate from the rest of the facility. All business shall be conducted ~~at that~~ in the name of the center or facility, except Medical Assistance billing by individually-enrolled providers when the center is not enrolled. HE 18

2. The center shall document that the prevention, diagnosis, and treatment of mental illness are the main purposes of the center. If the center is a unit within a facility, the rest of the facility shall not provide clinical services in the outpatient treatment of mental illness. The facility may provide services other than clinical services in the treatment of mental illness, including medical services, chemical

dependency services, social services, training, and education. The provision of these additional services is not reviewed in granting approval to the center under 12 MCAR SS 2.0291-2.0298.

3. The center shall have a governing body. The governing body shall provide written documentation of its source of authority. The governing body shall be legally responsible for the implementation of the standards set forth in Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298 through the establishment of written policy and procedures.

4. The center shall have an organizational chart or statement which specifies the relationships among the governing body, any administrative and support staff, mental health professional staff, and mental health practitioner staff; their respective areas of responsibility; the lines of authority involved; the formal liaison between administrative and clinical staff; and the relationship of the center to the rest of the facility and any additional services provided.

B. Secondary locations.

1. The center shall notify the commissioner of all center locations. If there is more than one center location, the center shall designate one as the main office and all secondary locations as satellite offices. The main office as a unit and the center as a whole shall be in compliance with 12 MCAR S 2.0295. The main office shall function as the center records and documentation storage area and house most administrative functions for the center. Each satellite office shall:

a. be included as a part of the legally constituted entity;

b. adhere to the same clinical and administrative policies and procedures as the main office;

c. operate under the authority of the center's governing body;

d. store all center records and the client records of terminated clients at the main office;

e. ensure that a mental health professional is ~~on-site~~

at the satellite office and competent to supervise and intervene in the clinical services provided ~~at that site~~ there, whenever the satellite office is open; } F&F 2

f. ensure that its multidisciplinary staff have access to and interact with main center staff for consultation, supervision, and peer review; and

g. ensure that clients have access to all clinical services provided in the treatment of mental illness and the multidisciplinary staff of the center.

2. If the commissioner determines that a secondary location is not in compliance with 1., it is not a satellite office. Outpatient clinical services in the treatment of mental illness delivered by the center or facility of which it is a unit shall cease at that location, or the application shall be disapproved.

12 MCAR S 2.0293 Minimum treatment standards.

A. Multidisciplinary approach. The center shall document that services are provided in a multidisciplinary manner. That documentation shall include evidence that staff interact in providing clinical services, that the services provided to a client involve all needed disciplines represented on the center staff and that staff participate in case review and consultation procedures as described in F.

B. Intake and case assignment.

1. The center shall establish an intake or admission procedure which outlines the intake process, including the determination of the appropriateness of accepting a person as a client by reviewing the client's condition and need for treatment, the clinical services offered by the center, and other available resources.

2. The center shall document that case assignment for assessment, diagnosis, and treatment is made to a multidisciplinary staff person who is competent in the service, in the recommended treatment strategy and in treating the individual client characteristics. Responsibility for each case shall remain with a mental health professional.

C. Assessment and diagnostic process. The center shall establish an assessment and diagnostic process that determines the client's condition and need for clinical services. The assessment of each client shall include clinical consideration of the client's general physical, medical, developmental, family, social, psychiatric, and psychological history and current condition. The diagnostic statement shall include the diagnosis based on the codes in the International Classification of Diseases or the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders and refer to the pertinent assessment data. The diagnosis shall be by or under the supervision of and signed by a psychiatrist or licensed consulting psychologist, or by and signed by a licensed psychologist.

D. Treatment planning. The individual treatment plan, based upon a diagnostic assessment of mental illness, shall be jointly developed by the client and the mental health professional. This planning procedure shall ensure that the client has been informed in the following areas: assessment of the client condition; treatment alternatives; possible outcomes and side effects of treatment; treatment recommendations; approximate length, cost, and hoped-for outcome of treatment; the client's rights and responsibilities in implementation of the individual treatment plan; staff rights and responsibilities in the treatment process; the Government Data Practices Act~~,-Minnesota Statutes,-sections-15.1611-to-15.1699~~; and procedures for reporting grievances and alleged violation of client rights. If the client is considering chemotherapy, hospitalization, or other medical treatment, the appropriate medical staff person shall inform the client of the treatment alternatives, the effects of the medical procedures, and possible side effects. Clinical services shall be appropriate to the condition, age, sex, socioeconomic, and ethnic background of the client, and provided in the least restrictive manner. Clinical services shall be provided according to the individual treatment plan and existing professional codes of ethics.

E. Client record. The center shall maintain a client record for each client. The record must document the assessment process, the development and updating of the treatment plan, the treatment provided and observed client behaviors and response to treatment, and serve as data for the review and evaluation of the treatment provided to a client. The record shall include:

1. a statement of the client's reason for seeking treatment;

2. a record of the assessment process and assessment data;

3. the initial diagnosis based upon the assessment data;

4. the individual treatment plan;

5. a record of all medication prescribed or administered by multidisciplinary staff;

6. documentation of services received by the client, including consultation and progress notes;

7. when necessary, the client's authorization to release private information, and client information obtained from outside sources;

8. at the closing of the case, a statement of the reason for termination, current client condition, and the treatment outcome; and

9. correspondence and other necessary information.

F. Consultation; case review. The center shall establish standards for case review and encourage the ongoing consultation among multidisciplinary staff. The multidisciplinary staff shall attend staff meetings at least twice monthly for a minimum of four hours per month, or a minimum of two hours per month if the multidisciplinary staff person provides clinical services in the treatment of mental illness less than 15 hours per week. The purpose of these meetings shall be case review and consultation. Written minutes of the meeting shall be maintained at the center for at least three years after the meeting.

G. Referrals. If the necessary treatment or the treatment desired by the client is not available at the center, the center shall facilitate appropriate referrals. The multidisciplinary

staff person shall discuss with the client the reason for the referral, potential treatment resources, and what the process will involve. The staff person shall assist in the process to ensure continuity of the planned treatment.

H. Emergency service. The center shall ensure that clinical services to treat mental illness are available to clients on an emergency basis.

I. Access to hospital. The center shall document that it has access to hospital admission for psychiatric inpatient care, and shall provide that access when needed by a client. This requirement for access does not require direct hospital admission privileges on the part of qualified multidisciplinary staff.

12 MCAR S 2.0294 Minimum quality assurance standards.

A. Policies and procedures. The center shall develop written policies and procedures and shall document the implementation of these policies and procedures for each treatment standard and each quality assurance standard in B.-G. and 12 MCAR S 2.0293. The policies shall be approved by the governing body. The procedures shall indicate what actions or accomplishments are to be performed, who is responsible for each action, and any documentation or required forms. Multidisciplinary staff shall have access to a copy of the policies and procedures at all times.

B. Peer review. The center shall have a multidisciplinary peer review system to assess the manner in which multidisciplinary staff provide clinical services in the treatment of mental illness. Peer review shall include the examination of clinical services to determine if the treatment provided was effective, necessary, and sufficient and of client records to determine if the recorded information is necessary and sufficient. The system shall ensure review of a randomly selected sample of five percent or six cases, whichever is less, of the annual caseload of each mental health professional by other ~~multidisciplinary~~ mental health professional staff. Peer review findings shall be discussed with staff involved in the

HE 21

case and followed up by any necessary corrective action. Peer review records shall be maintained at the center.

C. Internal utilization review. The center shall have a system of internal utilization review to examine the quality and efficiency of resource usage and clinical service delivery. The center shall develop and carry out a review procedure consistent with its size and organization which includes collection or review of information, analysis or interpretation of information, and application of findings to center operations. The review procedure shall minimally include, within any three year period of time, review of the appropriateness of intake, the provision of certain patterns of services, and the duration of treatment. Criteria may be established for treatment length and the provision of services for certain client conditions. Utilization review records shall be maintained, with an annual report to the governing body for applicability of findings to center operations.

D. Staff supervision.

1. The center shall have a clinical evaluation and supervision procedure which identifies each multidisciplinary staff person's areas of competence and documents that each multidisciplinary staff person receives the guidance and support needed to provide clinical services for the treatment of mental illness in the areas they are permitted to practice.

2. A mental health professional shall be responsible for the supervision of the mental health practitioner, including approval of the individual treatment plan and bimonthly case review of every client receiving clinical services from the practitioner. This supervision shall include a minimum of one hour of face-to-face, client-specific supervisory contact for each 40 hours of clinical services in the treatment of mental illness provided by the practitioner.

E. Continuing education. The center shall require that each multidisciplinary staff person attend a minimum of 36 clock hours every two years of academic or practical course work and training. This education shall augment job-related knowledge,

understanding, and skills to update or enhance staff competencies in the delivery of clinical services to treat mental illness.

F. Violations of standards.

1. The center shall have procedures for the reporting and investigating of alleged unethical, illegal, or grossly negligent acts, and of the serious violation of written policies and procedures. ~~Serious violations of policies and procedures are: a violation which threatens the health, safety, or rights of clients or center staff; the repeated nonadherence to policies and procedures; and the nonadherence to policies and procedures which result in noncompliance with Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298.~~ The center shall document that the reported behaviors have been reviewed and that responsible disciplinary or corrective action has been taken if the behavior was substantiated. The procedures shall address both client and staff reporting of complaints or grievances regarding center procedures, staff, and services. Clients and staff shall be informed they may file the complaint with the department if it was not resolved to mutual satisfaction. HE 22

2. The center shall have procedures for the reporting of suspected abuse or neglect of clients, in accordance with Minnesota Statutes, sections 241.62, subdivision 5, 626.556, and 626.557.

G. Data classification. Client information compiled by the center, including client records and minutes of case review and consultation meetings, shall be protected as private data on ~~individuals within the welfare system~~ under the Minnesota Government Data Practices Act. HE 23

12 MCAR S 2.0295 Minimum staffing standards.

A. Required staff.

1. The multidisciplinary staff of a center shall consist of at least four mental health professionals. At least two of the mental health professionals shall each be employed or under contract for a minimum of 35 hours a week by the center. Those

two professionals shall be of different disciplines and shall be either a clinical social worker, psychiatric nurse, psychologist, or a psychiatrist. ~~At least two mental health professionals shall be on site when the center is open.~~ HE 24

2. The mental health professional staff shall include a psychiatrist and a licensed consulting psychologist.

3. The mental health professional staff shall include either a clinical social worker or a psychiatric nurse.

4. The mental health professional employed or under contract to the center to meet a requirement of 2. or 3. shall be ~~on site~~ at the main office of the center and providing clinical services in the treatment of mental illness at least eight hours every two weeks. The center shall employ or contract with the professionals required in 2. ~~or~~ so that these professionals together comprise ten percent of the full-time equivalent multidisciplinary staff time spent in clinical services to ensure and document their ongoing presence and availability in the provision of clinical services. The center shall employ or contract with the professionals required in 3. so that each professional comprises five percent of the full-time equivalent multidisciplinary staff time spent in clinical services, or 35 hours, whichever is less, to ensure and document their ongoing presence and availability in the provision of clinical services. HE 24

B. Additional staff; staffing balance. Additional mental health professional staff may be employed by or under contract to the center provided that no single mental health discipline or combination of allied fields shall comprise more than 60 percent of the full-time equivalent mental health professional staff. This provision does not apply to a center with fewer than six full-time equivalent mental health professional staff. Mental health practitioners may also be employed by or under contract to a center to provide clinical services for the treatment of mental illness in their documented area of competence. Mental health practitioners shall not comprise more than 25 percent of the full-time equivalent multidisciplinary

staff. In determination of full-time equivalence, only time spent in clinical services for the treatment of mental illness shall be considered.

C. Multidisciplinary staff records. The center shall maintain records sufficient to document that the center has determined and verified the clinical service qualifications of each multidisciplinary staff person, and sufficient to document each multidisciplinary staff person's terms of employment.

D. Credentialed occupations. The center shall adhere to the qualifications and standards specified by rule for any human service occupation credentialed under Minnesota Statutes, section 214.13 and employed by or under contract to the center.

12 MCAR S 2.0296 Application procedures; review; decision.

A. Application.

1. A facility seeking approval as a center for insurance reimbursement of its outpatient clinical services in treatment of mental illness must make formal application to the commissioner for such approval. The application form for this purpose may be obtained from the Mental Illness Program Division of the department. The application form shall require only information which is required by statute or rule, and ~~may~~ shall require the applicant center to explain and provide documentation of compliance with the minimum standards in Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298. HE 26

2. Each application shall be accompanied by payment of the nonrefundable application fee. The fee shall be established and adjusted in accordance with Minnesota Statutes, section 16A.128 to cover the costs to the department in implementing Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298.

3. The application is considered complete on the date the application fee and all information required in the application form are received by the department.

4. The center shall designate in the application a mental health professional as the coordinator for issues surrounding

compliance with 12 MCAR SS 2.0291-2.0298.

~~5.--A-center-whose-application-is-disapproved-or-whose approval-is-withdrawn-may-not-reapply-for-90-days-following notification-of-disapproval-or-the-withdrawal-of-approval.--A center whose-approval-is-withdrawn-under-12-MCAR-S-2.0297-D.2. or-due-to-noncompliance-with-12-MCAR-S-2.0294-F.1.-may-not reapply-for-two-years-following-notification-of-disapproval.~~ HE 26

B. Review of applicant centers.

1. The formal review shall begin after the completed application has been received, and shall include an examination of the written application and a visit to the center. The applicant center shall be offered a choice of site visit dates, with at least one date falling within 60 days of the date on which the department receives the complete application. The site visit shall include interviews with multidisciplinary staff and examination of a random sample of ease client records, consultation minutes, quality assurance reports, and multidisciplinary staff records.

2. If implementation of a procedure is too recent to be reliably documented, a written statement of the planned implementation shall be accepted as documentation on the initial application. The evidence of licensure or accreditation through another regulating body shall be accepted as documentation of a specific procedure when the required minimum standard of that body is the same or higher than a specific provision of 12 MCAR SS 2.0291-2.0298.

~~3.--The-applicant-center-shall-allow-the-commissioner-to inspect-the-center-at-any-time-during-the-approval-and-deferral periods,-whether-or-not-the-visit-had-been-announced-in advance.--A-visit-shall-occur-only-during-normal-working-hours of-the-center-and-shall-not-disrupt-the-normal-functioning-of the-center.~~ HE 28

C. Decision on application.

1. Upon completion of the site visit, a report shall be written. The report shall include a statement of findings, a recommendation to approve, defer, or disapprove the application,

and the reasons for the recommendation.

2. The applicant center shall be sent written notice of approval, deferral, or disapproval within 30 days of the completion of the site visit. If the decision is a deferral or a disapproval, the notice shall indicate the specific areas of noncompliance.

3. An application shall be disapproved or deferred if it is the initial application of a center, when the applicant center is not in compliance with Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298.

4. If an application is deferred, the length of deferral shall not exceed 180 days. If the areas of noncompliance stated in the deferral notice are not satisfactorily corrected by the end of the deferral period, the application shall be disapproved. The applicant center shall allow the commissioner to inspect the center at any time during the deferral period, whether or not the site visit has been announced in advance. A site visit shall occur only during normal working hours of the center and shall not disrupt the normal functioning of the center. At any time during the deferral period, the applicant center may submit documentation indicating correction of noncompliance. The application shall then be approved or disapproved. At any time during the deferral period, the applicant center may submit a written request to the commissioner to change the application status to disapproval. The request shall be complied with within 14 days of receiving this written request. The applicant center is not an approved center for purposes of Minnesota Statutes, section 62A.152 during a deferral period. HE28

5. The effective date of a decision is the date the commissioner signs a letter notifying the applicant center of that decision.

D. Appeals. If an application is disapproved or approval is withdrawn, a contested case hearing and judicial review as provided in Minnesota Statutes, sections ~~15.0418 to 15.0425~~ 14.48 to 14.70, may be requested by the center within 30 days of HE29

the commissioner's decision.

12 MCAR S 2.0297 Post-approval requirements.

A. Duration of approval. Initial approval of an application is valid for 12 months from the effective date, subsequent approvals for 24 months, except when approval is withdrawn according to the criteria in D.

B. Reapplication. The center shall contact the department for reapplication forms, and submit the completed application at least 90 days prior to the expected expiration date. If an approved center has met the conditions of Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298, including reapplication when required, its status as an approved center shall remain in effect pending department processing of the reapplication.

C. Restrictions. The approval is issued only for the center named in the application and is not transferable or assignable to another center. The approval is issued only for the center location named in the application and is not transferable or assignable to another location. If the commissioner is notified in writing at least 30 days in advance of a change in center location and can determine that compliance with all provisions of Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298 are maintained, the commissioner shall continue the approval of the center at the new location.

D. Noncompliance.

1. Changes in center organization, staffing, treatment, or quality assurance procedures that affect the ability of the center to comply with the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298 shall be reported in writing by the center to the commissioner within 15 days of occurrence. Review of the change shall be conducted by the commissioner. A center with changes resulting in noncompliance in minimum standards shall receive written notice and may have up to 180 days to correct the areas of noncompliance before losing approval status. Interim procedures to resolve the noncompliance on a temporary basis

.0298

shall be developed and submitted in writing to the commissioner for approval within 30 days of the commissioner's determination of the noncompliance. Nonreporting within 15 days of occurrence of a change that results in noncompliance, failure to develop an approved interim procedure within 30 days of the determination of the noncompliance, or nonresolution of the noncompliance within 180 days shall result in the immediate withdrawal of approval status.

2. Serious violation of policies or procedures, professional association or board sanctioning, or loss of licensure for unethical practices, or the conviction of violating a state or federal statute shall be reported in writing by the center to the commissioner within ten days of the substantiation of such behavior. Review of this report and the action taken by the center shall be conducted by the commissioner. Approval shall be withdrawn immediately unless the commissioner determines that: the center acted with all proper haste and thoroughness in investigating the behavior, the center acted with all proper haste and thoroughness in taking appropriate disciplinary and corrective action, and that no member of the governing body was a party to the behavior. Failure to report such behavior within ten days of its substantiation shall result in immediate withdrawal of approval.

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see HE 32, CHE 3/8

E. Compliance reports. The center may be required to submit written information to the department during the approval period to document that the center has maintained compliance with the rule and center procedures. The center shall allow the commissioner to inspect the center at any time during the approval period, whether or not the site visit has been announced in advance. A site visit shall occur only during normal working hours of the center and shall not disrupt the normal functioning of the center.

HE 28

12 MCAR S 2.0298 Variances.

A. When allowed. The standards and procedures established by 12 MCAR SS 2.0291-2.0297 may be varied by the commissioner. Standards and procedures established by statute shall not be

varied.

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B. ~~Application~~ Request procedure. A request for a variance must be submitted in writing to the commissioner, accompanying or following the submission of a completed application for approval under Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298. The request shall state:

1. the standard or procedure to be varied;

2. the specific reasons why the standard or procedure cannot be or should not be complied with; and

3. the equivalent standard or procedure the center will establish to achieve the intent of the standard or procedure to be varied.

C. Decision procedure. Upon receiving the variance request, the commissioner shall consult with a panel of experts in the mental health disciplines regarding the request. Criteria for granting a variance shall be the commissioner's determination that B.1.-3. are met. Hardship shall not be a sufficient reason to grant a variance. No variance shall be granted that would threaten the health, safety, or rights of clients. Variances granted by the commissioner shall specify in writing the alternative standards or procedures to be implemented and any specific conditions or limitations imposed on the variance by the commissioner. Variances denied by the commissioner shall specify in writing the reason for the denial.

D. Notification. The commissioner shall send the center a written notice granting or not granting the variance within 90 days of receiving the written variance request. This notice shall not be construed as approval or disapproval of the center under Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298.

Repealer. The following provisions of 12 MCAR S 2.028 are repealed: the second sentence of the third paragraph of (a); the first sentence of (s); and (t). HE 9

Relettering. Reletter 12 MCAR S 2.028 (u) as (t).

APPROVED AS TO LEGALITY

June 13 19 83

HUBERT H. HUMPHREY, III
ATTORNEY GENERAL

BY Ted A. Mathews
SPECIAL ASSISTANT ATTORNEY GENERAL

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
JUN 14 1983
Joan Anderson Growe
Secretary of State

9:25 AM

OFFICE OF THE REVISOR OF STATUTES

Proposed Rule

RD135

Agency: Department of Public Welfare

Division: Mental Illness Program Division

Agency Contact: Trudy Dunham

Rule Numbers: 12 MCAR SS 2.029; 2.0291; 2.0292; 2.0293; 2.0294; 2.0295; 2.0296; 2.0297; 2.0298

Title: Proposed Rules Establishing Minimum Standards for Mental Health Centers for Purposes of Insurance Reimbursement

Type of Rules: Permanent

Incorporations by Reference:

Rule Number:	Material Incorporated:
12 MCAR S 2.0291 S.	Diagnostic and Statistical Manual of Mental Disorders, Third Edition.
12 MCAR S 2.0291 S.	International Classification of Diseases, Ninth Revised Edition.

Duplication of Statutory Language:
None

This approval is conditional upon deposit by the agency of two copies of each of the incorporated manuals noted on this certificate with the state law library before the effective date of these rules.

Steven C. Cross
Revisor of Statutes

Theresa M. Lauterbach
Assistant Deputy Revisor
Phone: 296-0956
Date: November 2, 1982

Rules as Proposed (all new material)

12 MCAR S 2.029 Mental health center standards. Rules 12 MCAR SS 2.0291-2.0298 establish standards for approval of mental health centers and mental health clinics for purposes of insurance reimbursement under Minnesota Statutes, section 62A.152.

12 MCAR S 2.0291 Definitions.

A. Scope. As used in 12 MCAR SS 2.0291-2.0298, the following terms have the meanings given them.

B. Application. "Application" means the formal statement by a center to the commissioner, on the forms created for this purpose, requesting recognition as meeting the requirements of Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298.

C. Approval. "Approval" means the determination by the commissioner that the applicant center has met the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.029-2.0298, and is therefore eligible to claim reimbursement for outpatient clinical services under the terms of Minnesota Statutes, section 62A.152. Approval of a center under 12 MCAR SS 2.0291-2.0298 does not mean approval of a staff person of such center to claim reimbursement from Medical Assistance or other third party payors when practicing privately. Approval of a center under 12 MCAR SS 2.0291-2.0298 does not mean approval of such center to claim reimbursement from Medical Assistance.

D. Case review. "Case review" means a consultation process thoroughly examining a client's condition and treatment. It includes review of the client's reason for seeking treatment, diagnosis and assessment, and the individual treatment plan; review of the appropriateness, duration, and outcome of treatment provided; and treatment recommendations.

E. Center. "Center" means a public or private health and human services facility which provides clinical services in the treatment of mental illness. It is an abbreviated term used in

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place of "mental health center" or "mental health clinic" throughout the rule.

F. Client. "Client" means a person accepted by the center to receive clinical services in the diagnosis and treatment of mental illness.

G. Clinical services. "Clinical services" means services provided to a client to diagnose, describe, predict, and explain that client's status relative to a disabling condition or problem, and where necessary, to treat the client to reduce impairment due to that condition. Clinical services include individual treatment planning, case review, record keeping required for treatment, peer review, and supervision.

H. Commissioner. "Commissioner" means the Commissioner of the Minnesota Department of Public Welfare or a designated representative.

I. Competent. "Competent" means having sufficient knowledge of and proficiency in a specific mental illness assessment or treatment service, technique, method, or procedure, documented by experience, education, training, and certification, to be able to provide it to a client with little or no supervision.

J. Consultation. "Consultation" means the process of deliberating or conferring between multidisciplinary staff regarding a client and the client's treatment.

K. Deferral. "Deferral" means the determination by the commissioner that the applicant center does not meet the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298 and is not approved, but is granted a period of time to comply with these standards and receive a second review without reapplication.

L. Department. "Department" means the Minnesota Department of Public Welfare.

M. Disapproval. "Disapproval" means a determination by the commissioner that the applicant center does not meet the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298.

N. Discipline. "Discipline" means a branch of professional

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knowledge or skill acquired through a specific course of study and training and usually documented by a specific educational degree or certification of proficiency. Examples of the mental health disciplines are psychiatry, clinical psychology, clinical social work, and psychiatric nursing.

O. Documentation. "Documentation" means the automatically or manually produced and maintained evidence that can be read by person or machine, and that will attest to the compliance with requirements of Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298.

P. Individual treatment plan. "Individual treatment plan" means a written plan of intervention and treatment developed on the basis of assessment results for a specific client, and updated as necessary. The plan specifies the goals and objectives in measurable terms, states the treatment strategy, and identifies responsibilities of multidisciplinary staff.

Q. Mental health practitioner. "Mental health practitioner" means a staff person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

1. by having a bachelor's degree in one of the behavioral sciences or a related field, from an accredited college or university and 2,000 hours of supervised clinical experience in the treatment of mental illness;

2. by having 6,000 hours of supervised clinical experience in the treatment of mental illness;

3. by being a graduate student in a mental health discipline formally assigned to the center for clinical training by an accredited college or university; or

4. by having a master's or other graduate degree in a mental health discipline from an accredited college or university.

Documentation of compliance with 12 MCAR S 2.0294 D.2. is required for designation of work as supervised clinical experience.

R. Mental health professional. "Mental health professional"

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means a staff person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

1. in psychiatric nursing: a registered nurse with either a master's degree in a mental health discipline from an accredited college or university, or its equivalent, who is licensed under Minnesota Statutes, sections 148.171 to 148.285, with at least 4,000 hours of post master's supervised clinical experience in the treatment of mental illness.

2. in clinical social work: a person with either a master's degree in clinical social work from an accredited college or university, or its equivalent, with at least 4,000 hours of post master's supervised clinical experience in the treatment of mental illness;

3. in clinical psychology: a psychologist licensed under Minnesota Statutes, sections 148.88 to 148.98;

4. in psychiatry: a physician licensed under Minnesota Statutes, chapter 147 and certified by the Board of Psychology or eligible for board certification in psychiatry; and

5. in allied fields: a person with either a master's degree from an accredited college or university in one of the behavioral sciences or related fields, or its equivalent, whose official transcript documents that the degree or its equivalent includes a minimum of 28 semester hours of graduate course credit in mental health theory and supervised clinical training, with at least 4,000 hours of post master's supervised clinical experience in the treatment of mental illness; or a physician licensed under Minnesota Statutes, chapter 147.

Documentation of compliance with 12 MCAR S 2.0294 D.2. is required for designation of work as supervised clinical experience.

S. Mental illness. "Mental illness" means a condition which results in an inability to interpret the environment realistically and in impaired functioning in primary aspects of daily living such as personal relations, living arrangements, work, and recreation, and which is listed in the clinical manual

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of the International Classification of Diseases (ICD-9-CM), Ninth Revision (1980), code range 290.0-302.99 or 306.0-316, or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III), Third Edition (1980), Axes I, II or III. These publications are available from the state law library.

T. Multidisciplinary staff. "Multidisciplinary staff" means the mental health professionals and mental health practitioners employed by or under contract to the center to provide outpatient clinical services in the treatment of mental illness.

U. Treatment strategy. "Treatment strategy" means the particular form of service delivery or intervention which specifically addresses the client's characteristics and mental illness, and describes the process for achievement of individual treatment plan goals.

12 MCAR S 2.0292 Mental health center; mental health clinic.

A. Organizational structure.

1. The center or the facility of which it is a unit shall be legally constituted as a partnership, corporation, or government agency. The center shall be either the entire facility or a clearly identified unit within the facility which is administratively and clinically separate from the rest of the facility. All business shall be conducted at that center or facility, except Medical Assistance billing by individually-enrolled providers when the center is not enrolled.

2. The center shall document that the prevention, diagnosis, and treatment of mental illness are the main purposes of the center. If the center is a unit within a facility, the rest of the facility shall not provide clinical services in the outpatient treatment of mental illness. The facility may provide services other than clinical services in the treatment of mental illness, including medical services, chemical dependency services, social services, training, and education. The provision of these additional services is not reviewed in granting approval to the center under 12 MCAR SS 2.0291-2.0298.

3. The center shall have a governing body. The governing

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body shall provide written documentation of its source of authority. The governing body shall be legally responsible for the implementation of the standards set forth in Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298 through the establishment of written policy and procedures.

4. The center shall have an organizational chart or statement which specifies the relationships among the governing body, any administrative and support staff, mental health professional staff, and mental health practitioner staff; their respective areas of responsibility; the lines of authority involved; the formal liaison between administrative and clinical staff; and the relationship of the center to the rest of the facility and any additional services provided.

B. Secondary locations.

1. The center shall notify the commissioner of all center locations. If there is more than one center location, the center shall designate one as the main office and all secondary locations as satellite offices. The main office as a unit and the center as a whole shall be in compliance with 12 MCAR S 2.0295. The main office shall function as the center records and documentation storage area and house most administrative functions for the center. Each satellite office shall:

a. be included as a part of the legally constituted entity;

b. adhere to the same clinical and administrative policies and procedures as the main office;

c. operate under the authority of the center's governing body;

d. store all center records and the client records of terminated clients at the main office;

e. ensure that a mental health professional is on-site and competent to supervise and intervene in the clinical services provided at that site, whenever the satellite office is open;

f. ensure that its multidisciplinary staff have access

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to and interact with main center staff for consultation, supervision, and peer review; and

g. ensure that clients have access to all clinical services provided in the treatment of mental illness and the multidisciplinary staff of the center.

2. If the commissioner determines that a secondary location is not in compliance with 1., it is not a satellite office. Outpatient clinical services in the treatment of mental illness delivered by the center or facility of which it is a unit shall cease at that location, or the application shall be disapproved.

12 MCAR S 2.0293 Minimum treatment standards.

A. Multidisciplinary approach. The center shall document that services are provided in a multidisciplinary manner. That documentation shall include evidence that staff interact in providing clinical services, that the services provided to a client involve all needed disciplines represented on the center staff and that staff participate in case review and consultation procedures as described in F.

B. Intake and case assignment.

1. The center shall establish an intake or admission procedure which outlines the intake process, including the determination of the appropriateness of accepting a person as a client by reviewing the client's condition and need for treatment, the clinical services offered by the center, and other available resources.

2. The center shall document that case assignment for assessment, diagnosis, and treatment is made to a multidisciplinary staff person who is competent in the service, in the recommended treatment strategy and in treating the individual client characteristics. Responsibility for each case shall remain with a mental health professional.

C. Assessment and diagnostic process. The center shall establish an assessment and diagnostic process that determines the client's condition and need for clinical services. The assessment of each client shall include clinical consideration

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of the client's general physical, medical, developmental, family, social, psychiatric, and psychological history and current condition. The diagnostic statement shall include the diagnosis based on the codes in the International Classification of Diseases or the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders and refer to the pertinent assessment data. The diagnosis shall be by or under the supervision of and signed by a psychiatrist or licensed consulting psychologist, or by and signed by a licensed psychologist.

D. Treatment planning. The individual treatment plan, based upon a diagnostic assessment of mental illness, shall be jointly developed by the client and the mental health professional. This planning procedure shall ensure that the client has been informed in the following areas: assessment of the client condition; treatment alternatives; possible outcomes and side effects of treatment; treatment recommendations; approximate length, cost, and hoped- for outcome of treatment; the client's rights and responsibilities in implementation of the individual treatment plan; staff rights and responsibilities in the treatment process; the Government Data Practices Act, Minnesota Statutes, sections 15.1611 to 15.1699; and procedures for reporting grievances and alleged violation of client rights. If the client is considering chemotherapy, hospitalization, or other medical treatment, the appropriate medical staff person shall inform the client of the treatment alternatives, the effects of the medical procedures, and possible side effects. Clinical services shall be appropriate to the condition, age, sex, socioeconomic, and ethnic background of the client, and provided in the least restrictive manner. Clinical services shall be provided according to the individual treatment plan and existing professional codes of ethics.

E. Client record. The center shall maintain a client record for each client. The record must document the assessment process, the development and updating of the treatment plan, the treatment provided and observed client behaviors and response to

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treatment, and serve as data for the review and evaluation of the treatment provided to a client. The record shall include:

1. a statement of the client's reason for seeking treatment;

2. a record of the assessment process and assessment data;

3. the initial diagnosis based upon the assessment data;

4. the individual treatment plan;

5. a record of all medication prescribed or administered by multidisciplinary staff;

6. documentation of services received by the client, including consultation and progress notes;

7. when necessary, the client's authorization to release private information, and client information obtained from outside sources;

8. at the closing of the case, a statement of the reason for termination, current client condition, and the treatment outcome; and

9. correspondence and other necessary information.

F. Consultation; case review. The center shall establish standards for case review and encourage the ongoing consultation among multidisciplinary staff. The multidisciplinary staff shall attend staff meetings at least twice monthly for a minimum of four hours per month, or a minimum of two hours per month if the staff person provides clinical services in the treatment of mental illness less than 15 hours per week. The purpose of these meetings shall be case review and consultation. Written minutes of the meeting shall be maintained at the center for at least three years after the meeting.

G. Referrals. If the necessary treatment or the treatment desired by the client is not available at the center, the center shall facilitate appropriate referrals. The multidisciplinary staff person shall discuss with the client the reason for the referral, potential treatment resources, and what the process will involve. The staff person shall assist in the process to ensure continuity of the planned treatment.

H. Emergency service. The center shall ensure that clinical

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services to treat mental illness are available to clients on an emergency basis.

I. Access to hospital. The center shall document that it has access to hospital admission for psychiatric inpatient care, and shall provide that access when needed by a client. This requirement for access does not require direct hospital admission privileges on the part of qualified multidisciplinary staff.

12 MCAR S 2.0294 Minimum quality assurance standards.

A. Policies and procedures. The center shall develop written policies and procedures and shall document the implementation of these policies and procedures for each treatment standard and each quality assurance standard in B.-G. and 12 MCAR S 2.0293. The policies shall be approved by the governing body. The procedures shall indicate what actions or accomplishments are to be performed, who is responsible for each action, and any documentation or required forms. Multidisciplinary staff shall have access to a copy of the policies and procedures at all times.

B. Peer review. The center shall have a multidisciplinary peer review system to assess the manner in which multidisciplinary staff provide clinical services in the treatment of mental illness. Peer review shall include the examination of clinical services to determine if the treatment provided was effective, necessary, and sufficient and of client records to determine if the recorded information is necessary and sufficient. The system shall ensure review of a randomly selected sample of five percent or six cases, whichever is less, of the annual caseload of each mental health professional by other multidisciplinary staff. Peer review findings shall be discussed with staff involved in the case and followed up by any necessary corrective action. Peer review records shall be maintained at the center.

C. Internal utilization review. The center shall have a system of internal utilization review to examine the quality and efficiency of resource usage and clinical service delivery. The

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center shall develop and carry out a review procedure consistent with its size and organization which includes collection or review of information, analysis or interpretation of information, and application of findings to center operations. The review procedure shall minimally include, within any three year period of time, review of the appropriateness of intake, the provision of certain patterns of services, and the duration of treatment. Criteria may be established for treatment length and the provision of services for certain client conditions. Utilization review records shall be maintained, with an annual report to the governing body for applicability of findings to center operations.

D. Staff supervision.

1. The center shall have a clinical evaluation and supervision procedure which identifies each multidisciplinary staff person's areas of competence and documents that each multidisciplinary staff person receives the guidance and support needed to provide clinical services for the treatment of mental illness in the areas they are permitted to practice.

2. A mental health professional shall be responsible for the supervision of the mental health practitioner, including approval of the individual treatment plan and bimonthly case review of every client receiving clinical services from the practitioner. This supervision shall include a minimum of one hour of face-to-face, client-specific supervisory contact for each 40 hours of clinical services in the treatment of mental illness provided by the practitioner.

E. Continuing education. The center shall require that each multidisciplinary staff person attend a minimum of 36 clock hours every two years of academic or practical course work and training. This education shall augment job-related knowledge, understanding, and skills to update or enhance staff competencies in the delivery of clinical services to treat mental illness.

F. Violations of standards.

1. The center shall have procedures for the reporting and

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investigating of alleged unethical, illegal, or grossly negligent acts, and of the serious violation of written policies and procedures. Serious violations of policies and procedures are: a violation which threatens the health, safety, or rights of clients or center staff; the repeated nonadherence to policies and procedures; and the nonadherence to policies and procedures which result in noncompliance with Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298. The center shall document that the reported behaviors have been reviewed and that responsible disciplinary or corrective action has been taken if the behavior was substantiated. The procedures shall address both client and staff reporting of complaints or grievances regarding center procedures, staff, and services. Clients and staff shall be informed they may file the complaint with the department if it was not resolved to mutual satisfaction.

2. The center shall have procedures for the reporting of suspected abuse or neglect of clients, in accordance with Minnesota Statutes, sections 241.62, subdivision 5, 626.556, and 626.557.

G. Data classification. Client information compiled by the center, including client records and minutes of case review and consultation meetings, shall be protected as private data on individuals within the welfare system under the Minnesota Government Data Practices Act.

12 MCAR S 2.0295 Minimum staffing standards.

A. Required staff.

1. The multidisciplinary staff of a center shall consist of at least four mental health professionals. At least two of the mental health professionals shall each be employed or under contract for a minimum of 35 hours a week by the center. Those two professionals shall be of different disciplines and shall be either a clinical social worker, psychiatric nurse, psychologist, or a psychiatrist. At least two mental health professionals shall be on-site when the center is open.

2. The mental health professional staff shall include a

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psychiatrist and a licensed consulting psychologist.

3. The mental health professional staff shall include either a clinical social worker or a psychiatric nurse.

4. The mental health professional employed or under contract to the center to meet a requirement of 2. or 3. shall be on-site and providing clinical services in the treatment of mental illness at least eight hours every two weeks. The center shall employ or contract with the professionals required in 2. or 3. so that each professional comprises five percent of the full-time equivalent multidisciplinary staff time spent in clinical services, or 35 hours, whichever is less, to ensure and document their ongoing presence and availability in the provision of clinical services.

B. Additional staff; staffing balance. Additional mental health professional staff may be employed by or under contract to the center provided that no single mental health discipline or combination of allied fields shall comprise more than 60 percent of the full-time equivalent mental health professional staff. This provision does not apply to a center with fewer than six full-time equivalent mental health professional staff. Mental health practitioners may also be employed by or under contract to a center to provide clinical services for the treatment of mental illness in their documented area of competence. Mental health practitioners shall not comprise more than 25 percent of the full-time equivalent multidisciplinary staff. In determination of full-time equivalence, only time spent in clinical services for the treatment of mental illness shall be considered.

C. Multidisciplinary staff records. The center shall maintain records sufficient to document that the center has determined and verified the clinical service qualifications of each multidisciplinary staff person, and sufficient to document each multidisciplinary staff person's terms of employment.

D. Credentialed occupations. The center shall adhere to the qualifications and standards specified by rule for any human service occupation credentialed under Minnesota Statutes,

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section 214.13 and employed by or under contract to the center.

12 MCAR S 2.0296 Application procedures; review; decision.

A. Application.

1. A facility seeking approval as a center for insurance reimbursement of its outpatient clinical services in treatment of mental illness must make formal application to the commissioner for such approval. The application form for this purpose may be obtained from the Mental Illness Program Division of the department. The application form shall require only information which is required by statute or rule, and may require the applicant center to explain and provide documentation of compliance with the minimum standards in Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298.

2. Each application shall be accompanied by payment of the nonrefundable application fee. The fee shall be established and adjusted in accordance with Minnesota Statutes, section 16A.128 to cover the costs to the department in implementing Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298.

3. The application is considered complete on the date the application fee and all information required in the application form are received by the department.

4. The center shall designate in the application a mental health professional as the coordinator for issues surrounding compliance with 12 MCAR SS 2.0291-2.0298.

5. A center whose application is disapproved or whose approval is withdrawn may not reapply for 90 days following notification of disapproval or the withdrawal of approval. A center whose approval is withdrawn under 12 MCAR S 2.0297 D.2. or due to noncompliance with 12 MCAR S 2.0294 F.1. may not reapply for two years following notification of disapproval.

B. Review of applicant centers.

1. The formal review shall begin after the completed application has been received, and shall include an examination of the written application and a visit to the center. The

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applicant center shall be offered a choice of site visit dates, with at least one date falling within 60 days of the date on which the department receives the complete application. The visit shall include interviews with multidisciplinary staff and examination of a random sample of case records, consultation minutes, quality assurance reports, and multidisciplinary staff records.

2. If implementation of a procedure is too recent to be reliably documented, a written statement of the planned implementation shall be accepted as documentation on the initial application. The evidence of licensure or accreditation through another regulating body shall be accepted as documentation of a specific procedure when the required minimum standard of that body is the same or higher than a specific provision of 12 MCAR SS 2.0291-2.0298.

3. The applicant center shall allow the commissioner to inspect the center at any time during the approval and deferral periods, whether or not the visit had been announced in advance. A visit shall occur only during normal working hours of the center and shall not disrupt the normal functioning of the center.

C. Decision on application.

1. Upon completion of the site visit, a report shall be written. The report shall include a statement of findings, a recommendation to approve, defer, or disapprove the application, and the reasons for the recommendation.

2. The applicant center shall be sent written notice of approval, deferral, or disapproval within 30 days of the completion of the site visit. If the decision is a deferral or a disapproval, the notice shall indicate the specific areas of noncompliance.

3. An application shall be disapproved or deferred if it is the initial application of a center, when the applicant center is not in compliance with Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298.

4. If an application is deferred, the length of deferral

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shall not exceed 180 days. If the areas of noncompliance stated in the deferral notice are not satisfactorily corrected by the end of the deferral period, the application shall be disapproved. At any time during the deferral period, the applicant center may submit documentation indicating correction of noncompliance. The application shall then be approved or disapproved. At any time during the deferral period, the applicant center may submit a written request to the commissioner to change the application status to disapproval. The request shall be complied with within 14 days of receiving this written request. The applicant center is not an approved center for purposes of Minnesota Statutes, section 62A.152 during a deferral period.

5. The effective date of a decision is the date the commissioner signs a letter notifying the applicant center of that decision.

D. Appeals. If an application is disapproved or approval is withdrawn, a contested case hearing and judicial review as provided in Minnesota Statutes, sections 15.0418 to 15.0425 may be requested by the center within 30 days of the commissioner's decision.

12 MCAR S 2.0297 Post-approval requirements.

A. Duration of approval. Initial approval of an application is valid for 12 months from the effective date, subsequent approvals for 24 months, except when approval is withdrawn according to the criteria in D.

B. Reapplication. The center shall contact the department for reapplication forms, and submit the completed application at least 90 days prior to the expected expiration date. If an approved center has met the conditions of Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298, including reapplication when required, its status as an approved center shall remain in effect pending department processing of the reapplication.

C. Restrictions. The approval is issued only for the center named in the application and is not transferable or assignable

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to another center. The approval is issued only for the center location named in the application and is not transferable or assignable to another location. If the commissioner is notified in writing at least 30 days in advance of a change in center location and can determine that compliance with all provisions of Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298 are maintained, the commissioner shall continue the approval of the center at the new location.

D. Noncompliance.

1. Changes in center organization, staffing, treatment, or quality assurance procedures that affect the ability of the center to comply with the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298 shall be reported in writing by the center to the commissioner within 15 days of occurrence. Review of the change shall be conducted by the commissioner. A center with changes resulting in noncompliance in minimum standards shall receive written notice and may have up to 180 days to correct the areas of noncompliance before losing approval status. Interim procedures to resolve the noncompliance on a temporary basis shall be developed and submitted in writing to the commissioner for approval within 30 days of the commissioner's determination of the noncompliance. Nonreporting within 15 days of occurrence of a change that results in noncompliance, failure to develop an approved interim procedure within 30 days of the determination of the noncompliance, or nonresolution of the noncompliance within 180 days shall result in the immediate withdrawal of approval status.

2. Serious violation of policies or procedures, professional association or board sanctioning, or loss of licensure for unethical practices, or the conviction of violating a state or federal statute shall be reported in writing by the center to the commissioner within ten days of the substantiation of such behavior. Review of this report and the action taken by the center shall be conducted by the commissioner. Approval shall be withdrawn immediately unless

APPROVED BY THE REVISOR OF STATUTES OFFICE BY:

the commissioner determines that: the center acted with all proper haste and thoroughness in investigating the behavior, the center acted with all proper haste and thoroughness in taking appropriate disciplinary and corrective action, and that no member of the governing body was a party to the behavior. Failure to report such behavior within ten days of its substantiation shall result in immediate withdrawal of approval.

E. Compliance reports. The center may be required to submit written information to the department during the approval period to document that the center has maintained compliance with the rule and center procedures.

12 MCAR S 2.0298 Variances.

A. When allowed. The standards and procedures established by 12 MCAR SS 2.0291-2.0297 may be varied by the commissioner. Standards and procedures established by statute shall not be varied.

B. Application. A request for a variance must be submitted in writing to the commissioner, accompanying or following the submission of a completed application for approval under Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298. The request shall state:

1. the standard or procedure to be varied;

2. the specific reasons why the standard or procedure cannot be or should not be complied with; and

3. the equivalent standard or procedure the center will establish to achieve the intent of the standard or procedure to be varied.

C. Decision procedure. Upon receiving the variance request, the commissioner shall consult with a panel of experts in the mental health disciplines regarding the request. Criteria for granting a variance shall be the commissioner's determination that B.1.-3. are met. Hardship shall not be a sufficient reason to grant a variance. No variance shall be granted that would threaten the health, safety, or rights of clients. Variances granted by the commissioner shall specify in writing the alternative standards or procedures to be implemented and any

PREPARED IN THE OFFICE OF STATUTES CODE BY:

specific conditions or limitations imposed on the variance by the commissioner. Variances denied by the commissioner shall specify in writing the reason for the denial.

D. Notification. The commissioner shall send the center a written notice granting or not granting the variance within 90 days of receiving the written variance request. This notice shall not be construed as approval or disapproval of the center under Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR SS 2.0291-2.0298.

APPROVED IN THE REVISOR OF STATUTES OFFICE BY:

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

In the Matter of the
Proposed Adoption of Rules
of the Department of Public
Welfare establishing minimum
standards for Mental Health Centers
and Mental Health Clinics for
Purposes of Insurance and Subscriber
Contract Reimbursement 12 MCAR
§§ 2.029 - 2.0298

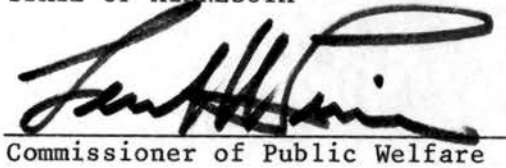
ORDER ADOPTING
RULES 2.029 - 2.0298

The above-entitled matter came on for hearing before Hearing Examiner Richard C. Luis, on the sixth day of January, 1983, at 9:00 a.m., in the Auditorium, Building 15, Minnesota Veteran's Home, 5100 Minnehaha Avenue, Minneapolis, Minnesota, and reconvened on the seventh day of January 1983, at the same time and in the same location after proper notice required by Minnesota Statutes section 15.0412 was served upon all persons, associations, and other interested groups registered with the State Department of Public Welfare for that purpose.

After affording interested persons an opportunity to present written and oral data, statements, and arguments, hearing all of the testimony, considering all of the evidence adduced and upon the records, files, and proceedings herein and applicable statutory standards or criteria, and confirming the need for and reasonableness of the above captioned rules,

NOW, THEREFORE, IT IS ORDERED that these rules identified as 12 MCAR §§ 2.029 - 2.0298, Minimum Standards for Mental Health Centers and Mental Health Clinics for Purposes of Insurance Coverage and repealing the following parts of 12 MCAR Section 2.028, the second sentence of the third paragraph of (a); the first sentence of (s); and (t), are adopted this twelfth day of May, 1983, pursuant to authority vested in me by Minnesota Statutes section 62A.152 and 245.69, Subdivision 2.

STATE OF MINNESOTA



Commissioner of Public Welfare

FW-01

DPW Exhibit No. G
File No.
Date 1/6/83

Department of Public Welfare
Mental Health Bureau

Notice of Intent to Solicit Outside Opinion Concerning Approval of Mental Health Centers and Clinics for Insurance Reimbursement

Notice is hereby given that the Minnesota Department of Public Welfare is considering Permanent Rule 29, governing standards for approval of mental health centers and clinics for insurance reimbursement.

This rule, authorized by Minn. Stat. § 245.69 (amended, 1980), governs the conditions under which the commissioner will approve mental health centers and clinics for insurance reimbursement pursuant to Minn. Stat. § 62A.152.

The proposed rule will set forth the minimum requirements to qualify for approval such as staffing, treatment standards, and quality assurance measures.

All interested or affected persons or groups are requested to participate. Statements of information and comment may be made orally or in writing. Written statements of information and comment may be made to:

Trudy Dunham
Mental Illness Program Division
Fourth Floor, Centennial Building
St. Paul, MN 55155

Oral statements of information and comment will be received during regular business hours over the telephone at 612/296-4503.

All statements of information and comment must be received by June 23, 1981. Any written material received by the Department shall become part of the hearing record.

Department of Public Welfare
Income Maintenance Bureau

Public Notice Regarding Changes in Minnesota's Medical Assistance Program

Notice is hereby given to all providers and recipients of Minnesota Medical Assistance, and to the public, of changes to be made in the statewide methods and levels of reimbursement for Medical Assistance services. These changes are set forth in House File 1446 and Senate File 1391, passed by the respective houses of the Minnesota State Legislature during the 1981 session. The provisions set forth in this notice are subject to change. The effective date of the changes will be July 20, 1981. If any standard in the final version is *more restrictive* than set forth in this notice, a separate notice will be published later, reflecting the changes. Also, recipients of Medical Assistance will receive individual notice of any cut-backs in service and should assume that coverage continues until receiving such notice.

This notice presents a summary of the changes. The full text of the final enactment will constitute the official version of any changes.

Applicable sections of House File 1446 and Senate File 1391 may be reviewed at your county welfare or social services department.

Written comments on the changes and suggestions for implementation may be sent to:

Health Care Program Policy Section
P.O. Box 43170
St. Paul, Minnesota 55164

Comments and suggestions received from the public may be reviewed during normal business hours at:

Health Care Program Policy Section
First Floor, Space Center
444 Lafayette Road
St. Paul, Minnesota

These changes are being published pursuant to federal regulations which govern administration of the Medical Assistance Program, 42 C.F.R. § 447.205 (1980).

DRW Exhibit No. B
File No.
Date 1/6/83

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of Rules of the State Department of Public Welfare Governing Mental Health Center Standards (12 MCAR §§ 2.0290 - 2.0298)

ORDER FOR HEARING

IT IS ORDERED this 12th day of November, 1982, that a public hearing on the proposed rules captioned above be held in the Minnesota Veterans Home Auditorium Building 15, Minnehaha Avenue, Minneapolis, on the 6th day of January, 1983, commencing at 9:00 a.m., and continuing until all representatives of associations or other interested groups or persons have had an opportunity to be heard.

IT IS FURTHER ORDERED that notice of said hearing be given to all persons who have registered their names with the Department of Public Welfare for that purpose and be published in the State Register.

STATE OF MINNESOTA

Commissioner of Public Welfare

DEPARTMENT OF PUBLIC WELFARE

DPW Exhibit No. A
File No.
Date 1/6/83

IN THE MATTER OF THE PROPOSED
ADOPTION OF RULES OF THE STATE
DEPARTMENT OF PUBLIC WELFARE
GOVERNING MENTAL HEALTH CENTER
STANDARDS (12 MCAR §§2.0290 - 2.0298)

NOTICE OF HEARING

A public hearing concerning the above-entitled matter will be held in the Minnesota Veterans Home Auditorium (Building 15), 5100 Minnehaha Avenue, Minneapolis, Minnesota 55417 on January 6, 1983 commencing at 9:00 a.m. and continuing until all interested persons have an opportunity to be heard. 5b The proposed rules may be modified as a result of the hearing process. Therefore, if you are affected in any manner by the proposed rules, you are urged to participate in the rule hearing process.

Following the agency's presentation at the hearing, all interested or affected persons will have an opportunity to ask questions and make comments. 2 Statements may be made orally and written material may be submitted. 5a In addition, whether or not an appearance is made at the hearing, written statements or material may be submitted to Richard C. Luis, Office of Administrative Hearings, 400 Summit Bank Building, 310 South Fourth Avenue, Minneapolis, Minnesota 55415, 612/341-7610 either before the hearing or within five working days after the public hearing ends. 7a The hearing examiner may, at the hearing, order that the record be kept open for a longer period not to exceed 20 calendar days. 7b The rule hearing procedure is governed by Minn. Stat. §§15.0411-15.0417 and 15.052, and by 9 MCAR §§2.101 - 2.112 (Minnesota Code of Agency Rules). 11a If you have any questions about the procedure, call or write the hearing examiner. 11b

Notice is hereby given that 25 days prior to the hearing, a Statement of Need and Reasonableness will be available for review at the agency and at the Office of Administrative Hearings. This Statement of Need and Reasonableness will include a summary of all the evidence and argument which the agency anticipates presenting at the hearing justifying both the need for and the reasonableness of the proposed rule or rules. Copies of the Statement of Need and Reasonableness may be obtained from the Office of Administrative Hearings at a minimal charge. 9

Proposed rules 12 MCAR §§2.0290 - 2.0298 cover the following areas:

Rules 12 MCAR §§2.0290 - 2.0298 establish organization, treatment, quality assurance and staffing standards for approval of mental health clinics and mental health centers for purposes of insurance reimbursement pursuant to Minn. Stat. 62A.152. Minn. Stat. 62A.152 mandates minimum level of benefits for outpatient treatment of mental or nervous disorders under certain conditions. Approval is not required for the existence of a mental health center. 3a

12 MCAR §2.0291 defines the following terms as used in these rules: application, approval, case review, center, client, clinical services, commissioner, competent, consultation, deferral, department, disapproval, discipline documentation, individual treatment plan, mental health professional, mental illness, multidisciplinary staff, and treatment strategy.

12 MCAR §2.0292 lists the requirements for the center's organizational structure, and a satellite office.

12 MCAR §2.0293 sets out the minimum treatment standards, including procedures for intake, case assignment, assessment and diagnosis, treatment planning, consultation meetings, referral, emergency services and hospital access. Minimum requirements for the client record are also specified.

12 MCAR §2.0294 sets out the minimum quality assurance standards, including written policies and procedures for treatment and quality assurance processes, and standard for peer review, internal utilization review, supervision, continuing education, data privacy and handling of complaints and adverse incidents.

12 MCAR §2.0295 sets out minimum standards for required staff and additional staff, requirements for staff records, and relationship to staff credentialed under Minn. Stat. 214.13.

12 MCAR §2.0296 explains the application and review process, including how to obtain an application, how the fee is established, what the review entails, timeline for application and review, possible review decisions, and cites the appeals process.

12 MCAR §2.0297 explains the post-approval requirements: duration of approval, reapplication process, restrictions on approval, procedures required when the center becomes in noncompliance, and compliance reports.

12 MCAR §2.0298 sets out the variance process, how to apply and how the decision is made.

The agency's authority to adopt the proposed rule is contained in Minn. Stat. §245.69, Subd. 2.

The Department estimates that county or local costs will be $51,900, $74,800 and $44,900 for FY 1983 - FY 1985. These costs are assumed to be a portion of Rule 28 (12 MCAR §2.028) center costs. The costs include biennial applicant fees and annual ongoing charge or training to ensure that compliance is maintained by the center.

Copies of the proposed rule are now available and at least one free copy may be obtained by writing to Trudy Dunham, Mental Illness Program Division, Mental Health Bureau, Department of Public Welfare, Fourth Floor, Centennial Office Building, St. Paul, Minnesota 55155, telephone 612/296-4503. Additional copies will be available at the hearing. If you have any questions on the content of the rule, please call Trudy Dunham.

Notice: Any person may request notification of the date on which the hearing examiner's report will be available, after which date the agency may not take any final action on the rules for a period of five working days. Any person may request notification of the date on which the hearing record has been submitted or resubmitted to the Attorney General by the agency. If you desire to be so notified, you may so indicate at the hearing. After the hearing, you may request notification by sending a written request to the hearing examiner, in the case of the hearing examiner's report, or to the agency, in the case of the agency's submission or resubmission to the Attorney General.

Minn. Stat. ch. 10A requires each lobbyist to register with the State Ethical Practices Board within five days after he or she commences lobbying. A lobbyist is defined in Minn. Stat. §10A.01, Subd. 11, 1979 supp., as any individual:

(a) Engaged for pay or other consideration, or authorized by another individual or association to spend money, who spends more than five hours in any month or more than $250, not including his own travel expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials; or

(b) Who spends more than $250, not including his own traveling expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials.

The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 41 State Office Building, St. Paul, Minnesota 55155, telephone (612) 296-5615.

Dated: 11-19-82

Arthur E. Noot
Commissioner of Public Welfare

K8-41

DW Exhibit No. C
File No.
Date 1/6/83

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of Rules of the State Department of Public Welfare Governing Mental Health Center Standards (12 MCAR § S2.0290 - 2.0298)

AFFIDAVIT OF MAILING

Wendy Johnson, being first duly sworn, deposes and says:

That on the 1st day of December, 1982, at the City of St. Paul, County of Ramsey, State of Minnesota, she served the attached Notice of Hearing by depositing in the State of Minnesota Central Mail System for first class mailing a copy thereof, properly enveloped, with postage prepaid, on all persons and associations who have requested that their names be placed on file with the Department of Public Welfare for the purpose of receiving notice of the proposed adoption of rules by this Department.

Wendy Johnson

Subscribed and sworn to before me

this 2 day of December, 1982.

Margaret Holt

MARGARET HOLT
NOTARY PUBLIC-MINNESOTA
RAMSEY COUNTY
My Comm. Expires Sept. 22, 1984

BPW Exhibit No. D
File No.
Date 1/6/83

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of Rules of the State Department of Public Welfare Governing Mental Health Center Standards (12 MCAR §§ 2.0290 - 2.0298)

AFFIDAVIT OF ADDITIONAL MAILING

Wendy Johnson, being first duly sworn, deposes and says:

That on the 1st day of December, 1982, at the City of St. Paul, County of Ramsey, State of Minnesota, in addition to serving the attached Notice of Hearing to all persons and associations who have requested that their names be placed on file for the purpose of receiving notice of the proposed adoption of rules by this Department, she also served the attached Notice by depositing in the State of Minnesota Central Mail System for first class mailing, a copy thereof, properly enveloped, with postage prepaid to the following agencies:

Mental Health Centers and Clinics
Individual Mental Health Professionals
Professional Mental Health Associations
Governmental Agencies and Boards

Wendy Johnson

Subscribed and sworn to before me

this 2 day of December, 1982.

Margaret Holt

MARGARET HOLT
NOTARY PUBLIC-MINNESOTA
RAMSEY COUNTY
My Comm. Expires Sept. 22, 1984

DRW Exhibit No. E
File No.
Date 1/6/83

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of Rules of the State Department of Public Welfare Governing Mental Health Center Standards (12 MCAR § §2.0290 - 2.0298)

CERTIFICATE

I hereby certify that the list of persons, associations, and other interested groups who have requested, pursuant to Minn. Stat. §15.0412, subd. 4, that their names be placed on file with and maintained by the Department of Public Welfare for the purpose of receiving notice of the proposed adoption of rules by this Department is accurate and complete as of 4:00, P.M., this 1st day of December, 1982.

Wendy Johnson

Exhibit No. 4
File No.
Date 1/6/83

The proposed changes to the rules would update the maximum total household income levels that qualify for "Inability to Pay" status under the Cold Weather Rule.

Persons interested in this rule shall have 30 days to submit comments on the proposed amendment. The proposed amendment may be modified if the modifications are supported by the data and views submitted to the agency and do not result in a substantial change in the proposed language.

Unless seven or more persons submit written requests for a public hearing on the proposed amendment within the 30-day comment period, a public hearing will not be held. In the event a public hearing is required, the agency will proceed according to the provisions of Minn. Stat. § 15.0412, subds. 4-4f.

Persons who wish to submit comments or a written request for a public hearing should submit such comments or requests to:

Mr. Randall D. Young, Executive Secretary
Minnesota Public Utilities Commission
780 American Center Building
160 East Kellogg Boulevard
St. Paul, Minnesota 55101

Authority for the amending of this rule is contained in Minn. Stat. § 216A.05, subd. 1 and § 216B. Additionally, a statement of need and reasonableness that describes the need for the reasonableness of the proposed amendment and identifies the data and information relied upon to support the proposed amendment has been prepared and is available from Mr. Christopher K. Sandberg upon request. Mr. Sandberg may be reached at the above address or by telephone at (612) 296-2357.

Upon adoption of the amendment without a public hearing, the proposed amendment to the rule, this notice, and the statement of need and reasonableness, all written comments received, and the final rule as amended will be delivered to the Attorney General for review as to form and legality, including the issue of substantial change. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the final rules as proposed for adoption, should submit a written statement of such request to Mr. Sandberg.

A copy of the proposed amendment to the Cold Weather Rule is attached to this notice.

Copies of this notice and the proposed amendment to the rule are available and may be obtained from Mr. Sandberg.

November 17, 1982

Randall D. Young
Executive Secretary

Rule as Proposed

4 MCAR § 3.0299 Disconnection of service during periods of cold weather.

A.-E. [Unchanged.]

F. Commission determination of inability to pay.

1. All appeals of declarations of inability to pay shall be determined on an informal basis by the commission within 30 days after receipt of the utility's written appeal.

2. The commission shall determine the residential customer's inability to pay based upon the following:

a. a finding that the residential customer is in compliance with 4 MCAR § 3.0299 D.1.; and

b. a finding of "lower budget," as defined in the Bureau of Labor Statistics Guidelines, which are ~~those applicable on the effective date of this rule~~ contained in the United States Department of Labor News (82-139) dated April 16, 1982, "Autumn 1981 Urban Family Budgets and Comparative Indexes for Selected Urban Areas" for the Minneapolis-St. Paul, Minnesota area.

3.-4. [Unchanged].

G.-I. [Unchanged.]

Department of Public Welfare

Proposed Rules Governing Mental Health Center Standards (12 MCAR §§ 2.0290-2.0298)

Notice of Hearing

A public hearing concerning the above-entitled matter will be held in the Minnesota Veterans Home Auditorium (Building 15), 5100 Minnehaha Avenue, Minneapolis, Minnesota 55417 on January 6, 1983 commencing at 9:00 a.m. and continuing until

all interested persons have an opportunity to be heard. The proposed rules may be modified as a result of the hearing process. Therefore, if you are affected in any manner by the proposed rules, you are urged to participate in the rule hearing process.

Following the agency's presentation at the hearing, all interested or affected persons will have an opportunity to ask questions and make comments. Statements may be made orally and written material may be submitted. In addition, whether or not an appearance is made at the hearing, written statements or material may be submitted to Richard C. Luis, Office of Administrative Hearings, 400 Summit Bank Building, 310 South Fourth Avenue, Minneapolis, Minnesota 55415, 612/341-7610 either before the hearing or within five working days after the public hearing ends. The hearing examiner may, at the hearing, order that the record be kept open for a longer period not to exceed 20 calendar days. The rule hearing procedure is governed by Minn. Stat. §§ 15.0411-15.0417 and 15.052, and by 9 MCAR §§ 2.101-2.112 (Minnesota Code of Agency Rules). If you have any questions about the procedure, call or write the hearing examiner.

Notice is hereby given that 25 days prior to the hearing, a statement of need and reasonableness will be available for review at the agency and at the Office of Administrative Hearings. This statement of need and reasonableness will include a summary of all the evidence and argument which the agency anticipates presenting at the hearing justifying both the need for and the reasonableness of the proposed rule or rules. Copies of the statement of need and reasonableness may be obtained from the Office of Administrative Hearings at a minimal charge.

Proposed rules 12 MCAR §§ 2.0290-2.0298 cover the following areas:

Rules 12 MCAR §§ 2.0290-2.0298 establish organization, treatment, quality assurance and staffing standards for approval of mental health clinics and mental health centers for purposes of insurance reimbursement pursuant to Minn. Stat. § 62A.152. Minn. Stat. § 62A.152 mandates minimum level of benefits for outpatient treatment of mental or nervous disorders under certain conditions. Approval is not required for the existence of a mental health center.

Rule 12 MCAR § 2.0291 defines the following terms as used in these rules: application, approval, case review, center, client, clinical services, commissioner, competent, consultation, deferral, department, disapproval, discipline documentation, individual treatment plan, mental health professional, mental illness, multidisciplinary staff, and treatment strategy.

Rule 12 MCAR § 2.0292 lists the requirements for the center's organizational structure, and a satellite office.

Rule 12 MCAR § 2.0293 sets out the minimum treatment standards, including procedures for intake, case assignment, assessment and diagnosis, treatment planning, consultation meetings, referral, emergency services and hospital access. Minimum requirements for the client record are also specified.

Rule 12 MCAR § 2.0294 sets out the minimum quality assurance standards, including written policies and procedures for treatment and quality assurance processes, and standard for peer review, internal utilization review, supervision, continuing education, data privacy and handling of complaints and adverse incidents.

Rule 12 MCAR § 2.0295 sets out minimum standards for required staff and additional staff, requirements for staff records, and relationship to staff credentialed under Minn. Stat. § 214.13.

Rule 12 MCAR § 2.0296 explains the application and review process, including how to obtain an application, how the fee is established, what the review entails, timeline for application and review, possible review decisions, and cites the appeals process.

Rule 12 MCAR § 2.0297 explains the post-approval requirements: duration of approval, reapplication process, restrictions on approval, procedures required when the center becomes in noncompliance, and compliance reports.

Rule 12 MCAR § 2.0298 sets out the variance process, how to apply and how the decision is made.

The agency's authority to adopt the proposed rule is contained in Minn. Stat. § 245.69, subd. 2.

The department estimates that county or local costs will be $51,900, $74,800 and $44,900 for FY 1983-FY 1985. These costs are assumed to be a portion of Rule 28 (12 MCAR § 2.028) center costs. The costs include biennial applicant fees and annual ongoing charge or training to ensure that compliance is maintained by the center.

Copies of the proposed rule are now available and at least one free copy may be obtained by writing to Trudy Dunham, Mental Illness Program Division, Mental Health Bureau, Department of Public Welfare, Fourth Floor, Centennial Office Building, St. Paul, Minnesota 55155, telephone (612) 296-4503. Additional copies will be available at the hearing. If you have any questions on the content of the rule, please call Trudy Dunham.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

Notice: Any person may request notification of the date on which the hearing examiner's report will be available, after which date the agency may not take any final action on the rules for a period of five working days. Any person may request notification of the date on which the hearing record has been submitted or resubmitted to the Attorney General by the agency. If you desire to be so notified, you may so indicate at the hearing. After the hearing, you may request notification by sending a written request to the hearing examiner, in the case of the hearing examiner's report, or to the agency, in the case of the agency's submission or resubmission to the Attorney General.

Minn. Stat. ch. 10A requires each lobbyist to register with the State Ethical Practices Board within five days after he or she commences lobbying. A lobbyist is defined in Minn. Stat. § 10A.01, Subd. 11, 1979 supp., as any individual:

(a) Engaged for pay or other consideration, or authorized by another individual or association to spend money, who spends more than five hours in any month or more than $250, not including his own travel expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials; or

(b) Who spends more than $250, not including his own traveling expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials.

The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 41 State Office Building, St. Paul, Minnesota 55155, telephone (612) 296-5615.

November 19, 1982

Arthur E. Noot
Commissioner of Public Welfare

Rules as Proposed (all new material)

12 MCAR § 2.029 Mental health center standards. Rules 12 MCAR §§ 2.0291-2.0298 establish standards for approval of mental health centers and mental health clinics for purposes of insurance reimbursement under Minnesota Statutes, section 62A.152.

12 MCAR § 2.0291 Definitions.

A. Scope. As used in 12 MCAR §§ 2.0291-2.0298, the following terms have the meanings given them.

B. Application. "Application" means the formal statement by a center to the commissioner, on the forms created for this purpose, requesting recognition as meeting the requirements of Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR §§ 2.0291-2.0298.

C. Approval. "Approval" means the determination by the commissioner that the applicant center has met the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR §§ 2.029-2.0298, and is therefore eligible to claim reimbursement for outpatient clinical services under the terms of Minnesota Statutes, section 62A.152. Approval of a center under 12 MCAR §§ 2.0291-2.0298 does not mean approval of a staff person of such center to claim reimbursement from Medical Assistance or other third party payors when practicing privately. Approval of a center under 12 MCAR §§ 2.0291-2.0298 does not mean approval of such center to claim reimbursement from Medical Assistance.

D. Case review. "Case review" means a consultation process thoroughly examining a client's condition and treatment. It includes review of the client's reason for seeking treatment, diagnosis and assessment, and the individual treatment plan; review of the appropriateness, duration, and outcome of treatment provided; and treatment recommendations.

E. Center. "Center" means a public or private health and human services facility which provides clinical services in the treatment of mental illness. It is an abbreviated term used in place of "mental health center" or "mental health clinic" throughout the rule.

F. Client. "Client" means a person accepted by the center to receive clinical services in the diagnosis and treatment of mental illness.

G. Clinical services. "Clinical services" means services provided to a client to diagnose, describe, predict, and explain that client's status relative to a disabling condition or problem, and where necessary, to treat the client to reduce impairment due to that condition. Clinical services include individual treatment planning, case review, record keeping required for treatment, peer review, and supervision.

H. Commissioner. "Commissioner" means the Commissioner of the Minnesota Department of Public Welfare or a designated representative.

I. Competent. "Competent" means having sufficient knowledge of and proficiency in a specific mental illness assessment or treatment service, technique, method, or procedure, documented by experience, education, training, and certification, to be able to provide it to a client with little or no supervision.

J. Consultation. "Consultation" means the process of deliberating or conferring between multidisciplinary staff regarding a client and the client's treatment.

K. Deferral. "Deferral" means the determination by the commissioner that the applicant center does not meet the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR §§ 2.0291-2.0298 and is not approved, but is granted a period of time to comply with these standards and receive a second review without reapplication.

L. Department. "Department" means the Minnesota Department of Public Welfare.

M. Disapproval. "Disapproval" means a determination by the commissioner that the applicant center does not meet the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR §§ 2.0291-2.0298.

N. Discipline. "Discipline" means a branch of professional knowledge or skill acquired through a specific course of study and training and usually documented by a specific educational degree or certification of proficiency. Examples of the mental health disciplines are psychiatry, clinical psychology, clinical social work, and psychiatric nursing.

O. Documentation. "Documentation" means the automatically or manually produced and maintained evidence that can be read by person or machine, and that will attest to the compliance with requirements of Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR §§ 2.0291-2.0298.

P. Individual treatment plan. "Individual treatment plan" means a written plan of intervention and treatment developed on the basis of assessment results for a specific client, and updated as necessary. The plan specifies the goals and objectives in measurable terms, states the treatment strategy, and identifies responsibilities of multidisciplinary staff.

Q. Mental health practitioner. "Mental health practitioner" means a staff person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

1. by having a bachelor's degree in one of the behavioral sciences or a related field, from an accredited college or university and 2,000 hours of supervised clinical experience in the treatment of mental illness;

2. by having 6,000 hours of supervised clinical experience in the treatment of mental illness;

3. by being a graduate student in a mental health discipline formally assigned to the center for clinical training by an accredited college or university; or

4. by having a master's or other graduate degree in a mental health discipline from an accredited college or university.

Documentation of compliance with 12 MCAR § 2.0294 D.2. is required for designation of work as supervised clinical experience.

R. Mental health professional. "Mental health professional" means a staff person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

1. in psychiatric nursing: a registered nurse with either a master's degree in a mental health discipline from an accredited college or university, or its equivalent, who is licensed under Minnesota Statutes, sections 148.171 to 148.285, with at least 4,000 hours of post master's supervised clinical experience in the treatment of mental illness.

2. in clinical social work: a person with either a master's degree in clinical social work from an accredited college or university, or its equivalent, with at least 4,000 hours of post master's supervised clinical experience in the treatment of mental illness;

3. in clinical psychology: a psychologist licensed under Minnesota Statutes, sections 148.88 to 148.98;

4. in psychiatry: a physician licensed under Minnesota Statutes, chapter 147 and certified by the Board of Psychology or eligible for board certification in psychiatry; and

5. in allied fields: a person with either a master's degree from an accredited college or university in one of the behavioral sciences or related fields, or its equivalent, whose official transcript documents that the degree or its equivalent includes a minimum of 28 semester hours of graduate course credit in mental health theory and supervised clinical training, with at least 4,000 hours of post master's supervised clinical experience in the treatment of mental illness; or a physician licensed under Minnesota Statutes, chapter 147.

Documentation of compliance with 12 MCAR § 2.0294 D.2. is required for designation of work as supervised clinical experience.

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S. Mental illness. "Mental illness" means a condition which results in an inability to interpret the environment realistically and in impaired functioning in primary aspects of daily living such as personal relations, living arrangements, work, and recreation, and which is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), Ninth Revision (1980), code range 290.0-302.99 or 306.0-316, or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III), Third Edition (1980), Axes I, II or III. These publications are available from the state law library.

T. Multidisciplinary staff. "Multidisciplinary staff" means the mental health professionals and mental health practitioners employed by or under contract to the center to provide outpatient clinical services in the treatment of mental illness.

U. Treatment strategy. "Treatment strategy" means the particular form of service delivery or intervention which specifically addresses the client's characteristics and mental illness, and describes the process for achievement of individual treatment plan goals.

12 MCAR § 2.0292 Mental health center; mental health clinic.

A. Organizational structure.

1. The center or the facility of which it is a unit shall be legally constituted as a partnership, corporation, or government agency. The center shall be either the entire facility or a clearly identified unit within the facility which is administratively and clinically separate from the rest of the facility. All business shall be conducted at that center or facility, except Medical Assistance billing by individually-enrolled providers when the center is not enrolled.

2. The center shall document that the prevention, diagnosis, and treatment of mental illness are the main purposes of the center. If the center is a unit within a facility, the rest of the facility shall not provide clinical services in the outpatient treatment of mental illness. The facility may provide services other than clinical services in the treatment of mental illness, including medical services, chemical dependency services, social services, training, and education. The provision of these additional services is not reviewed in granting approval to the center under 12 MCAR §§ 2.0291-2.0298.

3. The center shall have a governing body. The governing body shall provide written documentation of its source of authority. The governing body shall be legally responsible for the implementation of the standards set forth in Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR §§ 2.0291-2.0298 through the establishment of written policy and procedures.

4. The center shall have an organizational chart or statement which specifies the relationships among the governing body, any administrative and support staff, mental health professional staff, and mental health practitioner staff; their respective areas of responsibility; the lines of authority involved; the formal liaison between administrative and clinical staff; and the relationship of the center to the rest of the facility and any additional services provided.

B. Secondary locations.

1. The center shall notify the commissioner of all center locations. If there is more than one center location, the center shall designate one as the main office and all secondary locations as satellite offices. The main office as a unit and the center as a whole shall be in compliance with 12 MCAR § 2.0295. The main office shall function as the center records and documentation storage area and house most administrative functions for the center. Each satellite office shall:

a. be included as a part of the legally constituted entity;

b. adhere to the same clinical and administrative policies and procedures as the main office;

c. operate under the authority of the center's governing body;

d. store all center records and the client records of terminated clients at the main office;

e. ensure that a mental health professional is on-site and competent to supervise and intervene in the clinical services provided at that site, whenever the satellite office is open;

f. ensure that its multidisciplinary staff have access to and interact with main center staff for consultation, supervision, and peer review; and

g. ensure that clients have access to all clinical services provided in the treatment of mental illness and the multidisciplinary staff of the center.

2. If the commissioner determines that a secondary location is not in compliance with 1., it is not a satellite office. Outpatient clinical services in the treatment of mental illness delivered by the center or facility of which it is a unit shall cease at that location, or the application shall be disapproved.

12 MCAR § 2.0293 Minimum treatment standards.

A. Multidisciplinary approach. The center shall document that services are provided in a multidisciplinary manner. That

documentation shall include evidence that staff interact in providing clinical services, that the services provided to a client involve all needed disciplines represented on the center staff and that staff participate in case review and consultation procedures as described in F.

B. Intake and case assignment.

1. The center shall establish an intake or admission procedure which outlines the intake process, including the determination of the appropriateness of accepting a person as a client by reviewing the client's condition and need for treatment, the clinical services offered by the center, and other available resources.

2. The center shall document that case assignment for assessment, diagnosis, and treatment is made to a multidisciplinary staff person who is competent in the service, in the recommended treatment strategy and in treating the individual client characteristics. Responsibility for each case shall remain with a mental health professional.

C. Assessment and diagnostic process. The center shall establish an assessment and diagnostic process that determines the client's condition and need for clinical services. The assessment of each client shall include clinical consideration of the client's general physical, medical, developmental, family, social, psychiatric, and psychological history and current condition. The diagnostic statement shall include the diagnosis based on the codes in the International Classification of Diseases or the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders and refer to the pertinent assessment data. The diagnosis shall be by or under the supervision of and signed by a psychiatrist or licensed consulting psychologist, or by and signed by a licensed psychologist.

D. Treatment planning. The individual treatment plan, based upon a diagnostic assessment of mental illness, shall be jointly developed by the client and the mental health professional. This planning procedure shall ensure that the client has been informed in the following areas: assessment of the client condition; treatment alternatives; possible outcomes and side effects of treatment; treatment recommendations; approximate length, cost, and hoped-for outcome of treatment; the client's rights and responsibilities in implementation of the individual treatment plan; staff rights and responsibilities in the treatment process; the Government Data Practices Act, Minnesota Statutes, sections 15.1611 to 15.1699; and procedures for reporting grievances and alleged violation of client rights. If the client is considering chemotherapy, hospitalization, or other medical treatment, the appropriate medical staff person shall inform the client of the treatment alternatives, the effects of the medical procedures, and possible side effects. Clinical services shall be appropriate to the condition, age, sex, socioeconomic, and ethnic background of the client, and provided in the least restrictive manner. Clinical services shall be provided according to the individual treatment plan and existing professional codes of ethics.

E. Client record. The center shall maintain a client record for each client. The record must document the assessment process, the development and updating of the treatment plan, the treatment provided and observed client behaviors and response to treatment, and serve as data for the review and evaluation of the treatment provided to a client. The record shall include:

1. a statement of the client's reason for seeking treatment;

2. a record of the assessment process and assessment data;

3. the initial diagnosis based upon the assessment data;

4. the individual treatment plan;

5. a record of all medication prescribed or administered by multidisciplinary staff;

6. documentation of services received by the client, including consultation and progress notes;

7. when necessary, the client's authorization to release private information, and client information obtained from outside sources;

8. at the closing of the case, a statement of the reason for termination, current client condition, and the treatment outcome; and

9. correspondence and other necessary information.

F. Consultation; case review. The center shall establish standards for case review and encourage the ongoing consultation among multidisciplinary staff. The multidisciplinary staff shall attend staff meetings at least twice monthly for a minimum of

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four hours per month, or a minimum of two hours per month if the staff person provides clinical services in the treatment of mental illness less than 15 hours per week. The purpose of these meetings shall be case review and consultation. Written minutes of the meeting shall be maintained at the center for at least three years after the meeting.

G. Referrals. If the necessary treatment or the treatment desired by the client is not available at the center, the center shall facilitate appropriate referrals. The multidisciplinary staff person shall discuss with the client the reason for the referral, potential treatment resources, and what the process will involve. The staff person shall assist in the process to ensure continuity of the planned treatment.

H. Emergency service. The center shall ensure that clinical services to treat mental illness are available to clients on an emergency basis.

I. Access to hospital. The center shall document that it has access to hospital admission for psychiatric inpatient care, and shall provide that access when needed by a client. This requirement for access does not require direct hospital admission privileges on the part of qualified multidisciplinary staff.

12 MCAR § 2.0294 Minimum quality assurance standards.

A. Policies and procedures. The center shall develop written policies and procedures and shall document the implementation of these policies and procedures for each treatment standard and each quality assurance standard in B.-G. and 12 MCAR § 2.0293. The policies shall be approved by the governing body. The procedures shall indicate what actions or accomplishments are to be performed, who is responsible for each action, and any documentation or required forms. Multidisciplinary staff shall have access to a copy of the policies and procedures at all times.

B. Peer review. The center shall have a multidisciplinary peer review system to assess the manner in which multidisciplinary staff provide clinical services in the treatment of mental illness. Peer review shall include the examination of clinical services to determine if the treatment provided was effective, necessary, and sufficient and of client records to determine if the recorded information is necessary and sufficient. The system shall ensure review of a randomly selected sample of five percent or six cases, whichever is less, of the annual caseload of each mental health professional by other multidisciplinary staff. Peer review findings shall be discussed with staff involved in the case and followed up by any necessary corrective action. Peer review records shall be maintained at the center.

C. Internal utilization review. The center shall have a system of internal utilization review to examine the quality and efficiency of resource usage and clinical service delivery. The center shall develop and carry out a review procedure consistent with its size and organization which includes collection or review of information, analysis or interpretation of information, and application of findings to center operations. The review procedure shall minimally include, within any three year period of time, review of the appropriateness of intake, the provision of certain patterns of services, and the duration of treatment. Criteria may be established for treatment length and the provision of services for certain client conditions. Utilization review records shall be maintained, with an annual report to the governing body for applicability of findings to center operations.

D. Staff supervision.

1. The center shall have a clinical evaluation and supervision procedure which identifies each multidisciplinary staff person's areas of competence and documents that each multidisciplinary staff person receives the guidance and support needed to provide clinical services for the treatment of mental illness in the areas they are permitted to practice.

2. A mental health professional shall be responsible for the supervision of the mental health practitioner, including approval of the individual treatment plan and bimonthly case review of every client receiving clinical services from the practitioner. This supervision shall include a minimum of one hour of face-to-face, client-specific supervisory contact for each 40 hours of clinical services in the treatment of mental illness provided by the practitioner.

E. Continuing education. The center shall require that each multidisciplinary staff person attend a minimum of 36 clock hours every two years of academic or practical course work and training. This education shall augment job-related knowledge, understanding, and skills to update or enhance staff competencies in the delivery of clinical services to treat mental illness.

F. Violations of standards.

1. The center shall have procedures for the reporting and investigating of alleged unethical, illegal, or grossly negligent acts, and of the serious violation of written policies and procedures. Serious violations of policies and procedures are: a violation which threatens the health, safety, or rights of clients or center staff; the repeated nonadherence to policies and procedures; and the nonadherence to policies and procedures which result in noncompliance with Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR §§ 2.0291-2.0298. The center shall document that the reported behaviors have been reviewed and that responsible disciplinary or corrective action has been taken if the behavior was substantiated. The procedures shall address both client and staff reporting of complaints or grievances regarding center procedures, staff, and services. Clients and staff shall be informed they may file the complaint with the department if it was not resolved to mutual satisfaction.

2. The center shall have procedures for the reporting of suspected abuse or neglect of clients, in accordance with Minnesota Statutes, sections 241.62, subdivision 5, 626.556, and 626.557.

G. Data classification. Client information compiled by the center, including client records and minutes of case review and consultation meetings, shall be protected as private data on individuals within the welfare system under the Minnesota Government Data Practices Act.

12 MCAR § 2.0295 Minimum staffing standards.

A. Required staff.

1. The multidisciplinary staff of a center shall consist of at least four mental health professionals. At least two of the mental health professionals shall each be employed or under contract for a minimum of 35 hours a week by the center. Those two professionals shall be of different disciplines and shall be either a clinical social worker, psychiatric nurse, psychologist, or a psychiatrist. At least two mental health professionals shall be on-site when the center is open.

2. The mental health professional staff shall include a psychiatrist and a licensed consulting psychologist.

3. The mental health professional staff shall include either a clinical social worker or a psychiatric nurse.

4. The mental health professional employed or under contract to the center to meet a requirement of 2. or 3. shall be on-site and providing clinical services in the treatment of mental illness at least eight hours every two weeks. The center shall employ or contract with the professionals required in 2. or 3. so that each professional comprises five percent of the full-time equivalent multidisciplinary staff time spent in clinical services, or 35 hours, whichever is less, to ensure and document their ongoing presence and availability in the provision of clinical services.

B. Additional staff; staffing balance. Additional mental health professional staff may be employed by or under contract to the center provided that no single mental health discipline or combination of allied fields shall comprise more than 60 percent of the full-time equivalent mental health professional staff. This provision does not apply to a center with fewer than six full-time equivalent mental health professional staff. This provision does not apply to a center with fewer than six full-time equivalent mental health professional staff. Mental health practitioners may also be employed by or under contract to a center to provide clinical services for the treatment of mental illness in their documented area of competence. Mental health practitioners shall not comprise more than 25 percent of the full-time equivalent multidisciplinary staff. In determination of full-time equivalence, only time spent in clinical services for the treatment of mental illness shall be considered.

C. Multidisciplinary staff records. The center shall maintain records sufficient to document that the center has determined and verified the clinical service qualifications of each multidisciplinary staff person, and sufficient to document each multidisciplinary staff person's terms of employment.

D. Credentialed occupations. The center shall adhere to the qualifications and standards specified by rule for any human service occupation credentialed under Minnesota Statutes, section 214.13 and employed by or under contract to the center.

12 MCAR § 2.0296 Application procedures; review; decision.

A. Application.

1. A facility seeking approval as a center for insurance reimbursement of its outpatient clinical services in treatment of mental illness must make formal application to the commissioner for such approval. The application form for this purpose may be obtained from the Mental Illness Program Division of the department. The application form shall require only information which is required by statute or rule, and may require the applicant center to explain and provide documentation of compliance with the minimum standards in Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR §§ 2.0291-2.0298.

2. Each application shall be accompanied by payment of the nonrefundable application fee. The fee shall be established and adjusted in accordance with Minnesota Statutes, section 16A.128 to cover the costs to the department in implementing Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR §§ 2.0291-2.0298.

3. The application is considered complete on the date the application fee and all information required in the application form are received by the department.

4. The center shall designate in the application a mental health professional as the coordinator for issues surrounding compliance with 12 MCAR §§ 2.0291-2.0298.

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5. A center whose application is disapproved or whose approval is withdrawn may not reapply for 90 days following notification of disapproval or the withdrawal of approval. A center whose approval is withdrawn under 12 MCAR § 2.0297 D.2. or due to noncompliance with 12 MCAR § 2.0294 F.1. may not reapply for two years following notification of disapproval.

B. Review of applicant centers.

1. The formal review shall begin after the completed application has been received, and shall include an examination of the written application and a visit to the center. The applicant center shall be offered a choice of site visit dates, with at least one date falling within 60 days of the date on which the department receives the complete application. The visit shall include interviews with multidisciplinary staff and examination of a random sample of case records, consultation minutes, quality assurance reports, and multidisciplinary staff records.

2. If implementation of a procedure is too recent to be reliably documented, a written statement of the planned implementation shall be accepted as documentation on the initial application. The evidence of licensure or accreditation through another regulating body shall be accepted as documentation of a specific procedure when the required minimum standard of that body is the same or higher than a specific provision of 12 MCAR §§ 2.0291-2.0298.

3. The applicant center shall allow the commissioner to inspect the center at any time during the approval and deferral periods, whether or not the visit had been announced in advance. A visit shall occur only during normal working hours of the center and shall not disrupt the normal functioning of the center.

C. Decision on application.

1. Upon completion of the site visit, a report shall be written. The report shall include a statement of findings, a recommendation to approve, defer, or disapprove the application, and the reasons for the recommendation.

2. The applicant center shall be sent written notice of approval, deferral, or disapproval within 30 days of the completion of the site visit. If the decision is a deferral or a disapproval, the notice shall indicate the specific areas of noncompliance.

3. An application shall be disapproved or deferred if it is the initial application of a center, when the applicant center is not in compliance with Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR §§ 2.0291-2.0298.

4. If an application is deferred, the length of deferral shall not exceed 180 days. If the areas of noncompliance stated in the deferral notice are not satisfactorily corrected by the end of the deferral period, the application shall be disapproved. At any time during the deferral period, the applicant center may submit documentation indicating correction of noncompliance. The application shall then be approved or disapproved. At any time during the deferral period, the applicant center may submit a written request to the commissioner to change the application status to disapproval. The request shall be complied with within 14 days of receiving this written request. The applicant center is not an approved center for purposes of Minnesota Statutes, section 62A.152 during a deferral period.

5. The effective date of a decision is the date the commissioner signs a letter notifying the applicant center of that decision.

D. Appeals. If an application is disapproved or approval is withdrawn, a contested case hearing and judicial review as provided in Minnesota Statutes, sections 15.0418 to 15.0425 may be requested by the center within 30 days of the commissioner's decision.

12 MCAR § 2.0297 Post-approval requirements.

A. Duration of approval. Initial approval of an application is valid for 12 months from the effective date, subsequent approvals for 24 months, except when approval is withdrawn according to the criteria in D.

B. Reapplication. The center shall contact the department for reapplication forms, and submit the completed application at least 90 days prior to the expected expiration date. If an approved center has met the conditions of Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR §§ 2.0291-2.0298, including reapplication when required, its status as an approved center shall remain in effect pending department processing of the reapplication.

C. Restrictions. The approval is issued only for the center named in the application and is not transferable or assignable to another center. The approval is issued only for the center location named in the application and is not transferable or assignable to another location. If the commissioner is notified in writing at least 30 days in advance of a change in center location and can determine that compliance with all provisions of Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR §§ 2.0291-2.0298 are maintained, the commissioner shall continue the approval of the center at the new location.

D. Noncompliance.

1. Changes in center organization, staffing, treatment, or quality assurance procedures that affect the ability of the center to comply with the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR §§ 2.0291-2.0298 shall be reported in writing by the center to the commissioner within 15 days of occurrence. Review of the

change shall be conducted by the commissioner. A center with changes resulting in noncompliance in minimum standards shall receive written notice and may have up to 180 days to correct the areas of noncompliance before losing approval status. Interim procedures to resolve the noncompliance on a temporary basis shall be developed and submitted in writing to the commissioner for approval within 30 days of the commissioner's determination of the noncompliance. Nonreporting within 15 days of occurrence of a change that results in noncompliance, failure to develop an approved interim procedure within 30 days of the determination of the noncompliance, or nonresolution of the noncompliance within 180 days shall result in the immediate withdrawal of approval status.

2. Serious violation of policies or procedures, professional association or board sanctioning, or loss of licensure for unethical practices, or the conviction of violating a state or federal statute shall be reported in writing by the center to the commissioner within ten days of the substantiation of such behavior. Review of this report and the action taken by the center shall be conducted by the commissioner. Approval shall be withdrawn immediately unless the commissioner determines that: the center acted with all proper haste and thoroughness in investigating the behavior, the center acted with all proper haste and thoroughness in taking appropriate disciplinary and corrective action, and that no member of the governing body was a party to the behavior. Failure to report such behavior within ten days of its substantiation shall result in immediate withdrawal of approval.

E. Compliance reports. The center may be required to submit written information to the department during the approval period to document that the center has maintained compliance with the rule and center procedures.

12 MCAR § 2.0298 Variances.

A. When allowed. The standards and procedures established by 12 MCAR §§ 2.0291-2.0297 may be varied by the commissioner. Standards and procedures established by statute shall not be varied.

B. Application. A request for a variance must be submitted in writing to the commissioner, accompanying or following the submission of a completed application for approval under Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR §§ 2.0291-2.0298. The request shall state:

1. the standard or procedure to be varied;

2. the specific reasons why the standard or procedure cannot be or should not be complied with; and

3. the equivalent standard or procedure the center will establish to achieve the intent of the standard or procedure to be varied.

C. Decision procedure. Upon receiving the variance request, the commissioner shall consult with a panel of experts in the mental health disciplines regarding the request. Criteria for granting a variance shall be the commissioner's determination that B.1.-3. are met. Hardship shall not be a sufficient reason to grant a variance. No variance shall be granted that would threaten the health, safety, or rights of clients. Variances granted by the commissioner shall specify in writing the alternative standards or procedures to be implemented and any specific conditions or limitations imposed on the variance by the commissioner. Variances denied by the commissioner shall specify in writing the reason for the denial.

D. Notification. The commissioner shall send the center a written notice granting or not granting the variance within 90 days of receiving the written variance request. This notice shall not be construed as approval or disapproval of the center under Minnesota Statutes, section 245.69, subdivision 2, and 12 MCAR §§ 2.0291-2.0298.

Department of Revenue
Petroleum Tax Division

Proposed Rules Governing Special Fuel Requirements (13 MCAR § 1.4006)

Notice of Intent to Adopt a Rule without a Public Hearing

Notice is hereby given that the Department of Revenue proposes to adopt the above-entitled rule without a public hearing. The commissioner has determined that the proposed adoption of this rule will be noncontroversial in nature and has elected to follow the procedures set forth in Minnesota Statutes § 15.0412, subdivision 4h (1981).

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DPW-83-018-RL

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of Rules of the Department of Public Welfare Establishing Minimum Standards for Mental Health Centers and Mental Health Clinics for Purposes of Insurance Coverage, 12 MCAR §§ 2.029-2.0298.

ORDER OF THE CHIEF HEARING EXAMINER

WHEREAS, a hearing was held on January 6 and 7, 1983, before Richard C. Luis, a Hearing Examiner of the State Office of Administrative Hearings, on the above-entitled matter in compliance with the rule-making provisions of Minn. Stat. Ch. 14 (1982); and

WHEREAS, the Report of Hearing Examiner made pursuant to Minn. Stat. § 14.50, was issued to the Department of Public Welfare and;

WHEREAS, the Department of Public Welfare has now determined to adopt rules; and

WHEREAS, the Department of Public Welfare has submitted said rules to the Chief Hearing Examiner for review pursuant to Minn. Stat. §§ 14.16, 14.51, and 9 MCAR § 2.111; and

WHEREAS, the Chief Hearing Examiner finds that the final proposed rules are not substantially different from those proposed at the public hearing and that the Department of Public Welfare has cured the defects in the rule as required.

NOW, THEREFORE, upon receipt of this Order, the Department of Public Welfare has the responsibility of submitting the complete hearing record and the rules as adopted by the Department of Public Welfare to the Attorney General and to publish in the State Register if approved by the Attorney General.

Dated: May 19th, 1983.

DUANE R. HARVES
Chief Hearing Examiner

STATE OF MINNESOTA)
(ss.
COUNTY OF HENNEPIN)

DPW-83-018-RL (Rules)
12 MCAR §§ 2.029-2.0298

Donna L. Day being first duly sworn, deposes and says that at the City of Minneapolis, county and state aforementioned, on the 9th day of March, 1983, she served the attached REPORT OF THE HEARING EXAMINER AND REPORT OF THE CHIEF HEARING EXAMINER, OAH Docket No. DPW-83-018-RL. by depositing in the United States mail at said city of Minneapolis, a true and correct copy thereof, properly enveloped, with first class postage prepaid, and addressed to the individuals named on the attached mailing list.

Donna L. Day

Subscribed and sworn to before me
this 9th day of March, 1983.

Susan C. Wojcik

SUSAN C. WOJCIK
NOTARY PUBLIC - MINNESOTA
RAMSEY COUNTY
My Comm. Expires Apr. 26, 1986

DPW-83-018-RL (Rules)
12 MCAR §§ 2.029-2.0298

Commissioner Leonard Levine
Department of Public Welfare
4th Floor, Centennial Building
658 Cedar Street
St. Paul, MN 55155

Ms. Diane Masters
Special Assistant Attorney General
515 Transportation Building
St. Paul, MN 55155

Ms. Ruth Mickelsen
Special Assistant Attorney General
515 Transportation Building
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DPW-83-018-DH

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of Rules of the Department of Public Welfare Establishing Minimum Standards for Mental Health Centers and Mental Health Clinics for Purposes of Insurance Coverage, 12 MCAR SS 2.029-2.0298.

REPORT OF THE
CHIEF HEARING EXAMINER

The above-entitled matter came on for review by the Chief Hearing Examiner pursuant to the provisions of Minn. Stat. § 14.15, subds. 3 and 4 (1982) which provide in part:

> If the [hearing examiner's] report contains a finding that the proposed rule is substantially different from that which was proposed at the public hearing, or that the agency has not met the requirements of sections 14.13 to 14.18 it shall be submitted to the chief hearing examiner for approval. If the chief hearing examiner approves the finding of the hearing examiner, he shall advise the agency of actions which will correct the defects, and the agency shall not adopt the rule until the chief hearing examiner determines that the defects have been corrected. If the chief hearing examiner determines that the need for and reasonableness of the rule has not been established pursuant to section 14.14, subdivision 2, and if the agency does not elect to follow the suggested actions of the hearing examiner to correct that defect, then the agency shall submit the proposed rule to the legislative commission to review administrative rules for the commission's advice and comment. The agency shall not proceed to adopt the rule until it has received and considered the advice of the commission; provided, that the agency is not required to delay adoption longer than 30 days after the commission's receipt of the agency's submission.

Based upon a review of the record in this proceeding, the Chief Hearing Examiner hereby approves the Report of the Hearing Examiner as follows:

At Finding of Fact No. 32, the hearing examiner has indicated that the agency has failed to establish the need for and reasonableness of its proposal and that it would constitute a substantial change in the rules. I am of the opinion that the agency has made an error in its January 27, 1983 submission to the hearing examiner. At page 32 of that submission the agency proposes to "Delete the sentence definition of . . ." There is no sentence in proposed rule 12 MCAR § 2.0297 D.2 which defines "serious violations of policies and procedures."

The definition of the phrase in question was originally contained in proposed rule 12 MCAR § 2.0294 F.1. However, the agency deleted the definition from that section and proposed to add it to the definition section of the rules as 12 MCAR § 2.0291 U, which change was found to be necessary and reasonable by the examiner at Finding No. 22.

If the agency's proposal in its January 27 submission is read literally, the remainder of the rule would not make sense. The first sentence requires a report. The remainder of the rule discusses what happens once the report is made. Thus, the section would be ineffectual without the first sentence. As

such, the rule would lack specificity which is a substantive requirement imposed on the agency by law. Therefore, if the agency really intends to delete the first sentence of this section, the entire section must be deleted. Deletion of 12 MCAR § 2.0297 D.2., would not constitute a substantial change in the rules as proposed. The deletion of this section would not impose any new burdens on those regulated by the rule. Rather, it would relieve them of a responsibility. The deletion would not change the basic thrust of the rules as a whole.

Assuming that I am correct in suggesting that the agency was in error in proposing to delete the first sentence in the rule, the agency may adopt the rule as indicated by the hearing examiner in the last paragraph of Finding No. 32. If it intended to delete the first sentence, it may do so but must then delete the remainder of the section. The other alternative would be to reconvene the rule hearing as if initiating a new hearing, in the event the agency really intended to delete the first sentence.

So adopted p. 19

If the agency chooses to take the action recommended by the Hearing Examiner, it shall, prior to submitting the rules to the Attorney General for review, submit to the Chief Hearing Examiner a copy of the rules as initially published in the State Register, a copy of the rules as proposed for final adoption in the form required by the State Register for final publication, and a copy of the agency's Findings of Fact and Order Adopting Rules. The Chief Hearing Examiner will then make a determination as to whether the defects have been corrected and whether the modifications in the rules are substantial changes.

Should the agency make changes in the rules other than those recommended by the Hearing Examiner, it shall also, prior to submitting the rule to the Attorney General, submit the complete record to the Chief Hearing Examiner for a review in regard to substantial changes.

Dated: March 8, 1983.

Duane R. Harves

DUANE R. HARVES
Chief Hearing Examiner

DPW-83-018-RL

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of Rules of the Department of Public Welfare Establishing Minimum Standards for Mental Health Centers and Mental Health Clinics for Purposes of Insurance Coverage, 12 MCAR §§ 2.029-2.0298.

REPORT OF THE HEARING EXAMINER

Pursuant to an Order for Hearing Issued November 12, 1982 by Arthur E. Noot, then Commissioner of Public Welfare, the above-entitled matter came on for hearing before State Hearing Examiner Richard C. Luis at 9:00 a.m. on Thursday, January 6, 1983 in the Auditorium, Building 15, of the Minnesota Veterans Home, 5100 Minnehaha Avenue, Minneapolis, Minnesota. At the close of the proceedings on January 6, 1983, due to the inclement weather on that day, and the resultant inability of many interested parties to attend the January 6 hearing, the Hearing Examiner ordered a recess of the hearing until the following day. This matter reconvened on Friday, January 7, 1983, at the same time and in the same location as the previous day's proceedings, for the hearing of additional testimony.

This Report is part of a rulemaking proceeding conducted pursuant to Minn. Stat. §§ 14.01 to 14.70 (the Minnesota Administrative Procedure Act) to determine whether the Department of Public Welfare (hereinafter the "Department" or "DPW") has authority to adopt proposed 12 MCAR §§ 2.029-2.0298, which would establish minimum standards for outpatient mental health centers and outpatient mental health clinics for the purpose of Minn. Stat. § 62A.152, subd. 2, which law mandates the provision of insurance coverage to such centers and clinics as are approved by the Commissioner of Public Welfare (hereinafter "Commissioner").

Diane Masters and Ruth Mickelsen, Special Assistant Attorneys General, 515 Transportation Building, St. Paul, Minnesota 55155, appeared as counsel for the Department. Members of the Agency panel included: Trudy Dunham, Mental Health Program Adviser, Mental Health Bureau; Ronald Young, M.D., Medical Director and former Assistant Commissioner, Mental Health Bureau; and Terry Sarazin, Director, Mental Illness Programs, Mental Health Bureau. The Department personnel were assisted in their presentation by the following persons: Bill Conley, Director of Public Affairs, Minnesota Mental Health Association; Margo Dickinson, Research Assistant, Blue Cross and Blue Shield of Minnesota; Dr. Loring McAllister, Assistant Professor of Psychology, University of Minnesota; Dr. Bill Duffy, Executive Director, Center for Behavior Therapy; Dr. Robert Barron, a licensed consulting psychologist in private practice; and Harvey Bartz, Vice President, Family Services of Greater St. Paul.

Forty-nine persons signed the hearing register. Thirteen members of the public spoke at the hearing. The Department submitted 16 exhibits at the hearing, and the public submitted 62.

The Commissioner of Public Welfare must wait at least five working days before taking any final action on the rules; during that period, this Report must be made available to all interested persons upon request.

Pursuant to the provisions of Minn. Stat. § 14.15, subd. 3 (1982), this Report has been submitted to the Chief Hearing Examiner for his approval. If the Chief Hearing Examiner approves the findings of this Report, he will advise the Commissioner of actions which will correct the defects and the Commissioner may not adopt the rule until the Chief Hearing Examiner determines that the defects have been corrected. However, in those instances where the Chief Hearing Examiner identifies defects which relate to the issues of need or reasonableness, the Commissioner may either adopt the Hearing Examiner's recommendations to cure the defects or, in the alternative, if the Commissioner does not elect to adopt the recommendations, he may submit the proposed rule to the Legislative Commission to Review Administrative Rules for the Commission's advice and comment. Provisions relating to this submission to the Commission may be found in Minn. Stat. § 14.15, subd. 4 (1982).

If the Commissioner elects to adopt the recommendations of the Hearing Examiner and makes no other changes and the Chief Hearing Examiner determines that the defects have been corrected, then the Commissioner shall submit the rule to the Attorney General for review of form and legality. If the Commissioner makes changes in the rule other than those recommended by the Hearing Examiner, then he shall submit the rule, with the complete record, to the Chief Hearing Examiner for a review of the changes before adopting it and submitting it to the Attorney General. Procedures relating to this subsequent review by the Chief Hearing Examiner are set forth in Minn. Stat. § 14.16 (1982).

When the Commissioner submits the rule to the Attorney General, he shall give notice on the day of submission to all persons who requested that they be informed of the submission to the Attorney General.

Based upon all the testimony, exhibits and written comments, the Hearing Examiner makes the following:

FINDINGS OF FACT

Procedural Requirements

1. On May 5, 1980, October 27, 1980, November 24, 1980, and May 18, 1981, Notices of Intent to Solicit Outside Opinion concerning the approval of Mental Health Centers and Clinics for Insurance Reimbursement were published at 4 State Register 1744, 5 State Register 680, 5 State Register 856, and 5 State Register 1845, respectively.

2. On November 15, 1982, the Department of Public Welfare filed the following documents with the Chief Hearing Examiner:

(a) A copy of the proposed rules.
(b) The Order for Hearing.
(c) The Notice of Hearing proposed to be issued.
(d) A Statement of the number of persons expected to attend the hearing and estimated length of the Agency's presentation.
(e) A Statement of Expenditures estimated to be required under the proposed rules for local public bodies for the next two fiscal years following adoption of the proposed rules.

3. On December 1, 1982, the Department mailed the Notice of Hearing to all persons and associations who had registered their names with the Department for the purpose of receiving such notice, and to certain other individuals and associations, which included:

(a) Mental Health Centers and Clinics.
(b) Individual Mental Health Professionals.

(c) Professional Mental Health Associations.
(d) Governmental Agencies and Boards.

4. On December 6, 1982, a Notice of Hearing and a copy of the proposed rules were published at 7 State Register 890.

5. On December 10, 1982, the Department filed the following documents with the Hearing Examiner:

(a) The Notice of Hearing as mailed.
(b) The Agency's certification that its mailing list was accurate and complete.
(c) The Affidavit of Mailing the Notice to all persons on the Agency's list.
(d) The Statement of Need and Reasonableness.
(e) The names of Department personnel who would represent the Agency at the hearing together with the names of any other witnesses solicited by the Agency to appear on its behalf.
(f) A copy of the State Register containing the proposed rules.
(g) An Affidavit of Additional Notice.
(h) All materials received following publication of Notices of Intent to Solicit Outside Opinion published at 4 State Register 1744, 5 State Register 680, 5 State Register 856, and 5 State Register 1845 on May 5, 1980, October 27, 1980, November 24, 1980, and May 18, 1981, respectively.

These documents were available for inspection at the Office of Administrative Hearings from the date of filing to the date of the hearing.

6. The record remained open through January 27, 1982, for the receipt of written comments and statements, the period having been extended by order of the Hearing Examiner to 20 calendar days following the hearing. Pursuant to Minn. Stat. § 14.15, subd. 2 (1982), the Chief Hearing Examiner granted an extension of the deadline for filing this Report beyond the 30-day statutory limit, to March 7, 1983.

Statutory Authority.

7. The specific statutory authority to adopt the proposed rules is contained in Minn. Stat. §§ 62A.152 and 245.69, subd. 2 (1982). Those statutes read:

62A.152. Benefits for ambulatory mental health services

Subdivision 1. Scope. The provisions of this section apply (a) to all group policies or subscriber contracts which provide benefits for at least 100 certificate holders who are residents of this state or groups of which more than 90 percent are residents of this state and are issued, delivered, or renewed by accident and health insurance companies regulated under this chapter, or by nonprofit health service plan corporations regulated under chapter 62C and (b), unless waived by the commissioner to the extent applicable to holders who are both nonresidents and employed outside this state, to all group policies or subscriber contracts which are issued, delivered, or renewed within this state by accident and health insurance companies regulated under this chapter, or by nonprofit health service plan corporations regulated under chapter 62C.

Subd. 2. Minimum benefits. All group policies and all group subscriber contracts providing benefits for mental or nervous disorder treatments in a hospital shall also provide coverage, to at least the extent of 80 percent of the first $750 of the cost of the usual and customary charges incurred over a 12-month period, for mental or nervous disorder consultation, diagnosis and treatment services delivered while the insured person is not a bed patient in a hospital, if the services are furnished by (1) a licensed or accredited hospital, (2) a community mental health center or mental health clinic approved or licensed by the commissioner of public welfare or other authorized state agency,

or (3) a licensed consulting psychologist licensed under the provisions of sections 148.87 to 148.98, or a psychiatrist licensed under chapter 147.

* * *

245.69. Additional duties of the commissioner

Subd. 2. The commissioner of public welfare has the authority to approve or disapprove public and private mental health centers and public and private mental health clinics for the purposes of section 62A.152, subdivision 2. For the purposes of this subdivision the commissioner shall promulgate both temporary and permanent rules in accordance with sections 14.01 to 14.70. The rules shall require each applicant to pay a fee to cover costs of processing applications and determining compliance with the rules and this subdivision. The commissioner may contract with any state agency, individual, corporation or association to which he shall delegate all but final approval and disapproval authority to determine compliance or noncompliance.

(a) Each approved mental health center and each approved mental health clinic shall have a multidisciplinary team of professional staff persons as required by rule. A mental health center or mental health clinic may provide the staffing required by rule by means of written contracts with professional persons or with other health care providers. Any personnel qualifications developed by rule shall be consistent with any personnel standards developed pursuant to chapter 214.

(b) Each approved mental health clinic and each approved mental health center shall establish a written treatment plan for each outpatient for whom services are reimbursable through insurance or public assistance. The treatment plan shall be developed in accordance with the rules and shall include a patient history, treatment goals, a statement of diagnosis and a treatment strategy. The clinic or center shall provide access to hospital admission as a bed patient as needed by any outpatient. The clinic or center shall ensure ongoing consultation among and availbility of all members of the multidisciplinary team.

(c) As part of the required consultation, members of the multidisciplinary team shall meet at least twice monthly to conduct case reviews, peer consultations, treatment plan development and in-depth case discussion. Written minutes of these meetings shall be kept at the clinic or center for three years.

(d) Each approved centaer or clinic shall establish mechanisms for quality assurance and submit documentation concerning the mechanisms to the commissioner as required by rule, including:

(1) Continuing education of each professional staff person;

(2) An ongoing internal utilization and peer review plan and procedures;

(3) Mechanisms of staff supervision; and

(4) Procedures for review by the commissioner or his delegate.

(e) The commissioner shall disapprove an applicant, or withdraw approval of a clinic or center, which the commissioner finds does not comply with the requirements of the rules or this subdivision. A clinic or center which is disapproved or whose disapproval is withdrawn is entitled to a contested case hearing and judicial review pursuant to sections 14.01 to 14.70.

(f) Data on individuals collected by approved clinics and centers, including written minutes of team meetings, is private data on individuals within the welfare system as provided in chapter 13.

(g) Each center or clinic that is approved and in compliance with the commissioner's existing rule on July 1, 1980 is approved for purposes of section 62A.152, subdivision 2, until rules are promulgated to implement this section.

The Hearing Examiner finds that the Department has general statutory authority to adopt proposed 12 MCAR §§ 2.029-2.0298.

General Discussion of Proposed 12 MCAR §§ 2.029-2.0298.

8. For the sake of clarity, the Hearing Examiner points out that, in addition to the amendments to the proposed rule submitted by the Department at the public hearing, the Department filed with the Hearing Examiner a Memorandum on the last day of the comment period. In this Memorandum, the Department responds to questions and comments raised at the hearing and thereafter and proposes further amendments to proposed 12 MCAR §§ 2.029-2.0298. The Hearing Examiner hopes to alleviate any confusion which might result when amendments to the proposed rule and other issues are discussed in the remainder of the body of this Report. The Hearing Examiner has chosen not to discuss many questions raised by the public which, in his opinion, the Department adequately addressed in its Statement of Need and Reasonableness or adequately responded to in its Memorandum. Nor will this Report dwell upon each and every new proposal advanced by the Department prior to the close of the record. Any changes proposed by the Department not discussed herein are found by the Hearing Examiner to be either technical, clarifying or editorial in nature, or corrections of grammatical, spelling and clerical errors, and are found not to constitute a substantial change from the rule as originally published in the State Register. Each of these proposed changes are specifically found by the Hearing Examiner to be necessary and reasonable. A copy of the Department's 65-page Memorandum has been retained by the Hearing Examiner and is available upon request from the Office of Administrative Hearings for the customary copying fee. For organizational purposes, an effort has been made to discuss individual proposals in sequential order as they appear in the proposed new rules, wherever practicable. Any provisions of the rules as finally proposed which are not specifically discussed below are found to be necessary and reasonable, supported by an affirmative presentation of facts in the record.

Proposed Repeal of Portions of 12 MCAR § 2.028.

9. The first two pages of the Department's Memorandum details for the first time in these proceedings, a proposal to repeal the last sentence of section (a), the first paragraph of section (s), and all of section (t) of 12 MCAR §§ 2.028 (Community Mental Health Services). The rules thus proposed for repeal read:

(a). . . The definitions of centers and clinics constitutes the standards for the commissioner's "approval" of a program for purposes of Laws of Minnesota 1975, chapter 89, which requires certain group insurance policies and plans to provide benefits to nonhospitalized persons for mental health diagnosis, treatment and consultation services.

* * *

(s) Within 30 days of receipt of an application for "approval status" as a center or clinic, under Laws of Minnesota 1975, chapter 89, the commissioner shall approve or deny the request.

* * *

(t) An appeal of the commissioner's denial of grant application or "approval" status as community mental health center or community mental health clinic under Laws of Minnesota 1975, chapter 89, is available under the procedures set forth in the state Administrative Procedures Act, Minnesota Statutes, sections 15.01 et seq.

The Department argues that the proposed repeal constitutes a housekeeping matter only because the statutory authority behind "Rule 28" has been amended to the extent that this rule "no longer exists". It is further argued that the rule has not been enforced since 1979. Repeal is proposed in order to eliminate any confusion.

The Hearing Examiner finds the proposed repealer amendments to be necessary and reasonable because they are, in essence, only clerical and clarifying in nature. The record is clear that all centers and/or clinics potentially affected by the passage of the proposed rules have been operating under "Temporary Rule 29", and not the sections of 12 MCAR § 2.028 proposed for repeal, for the purposes of standards to meet if they want to qualify for insurance reimbursement, since May 4, 1981. Since all interested parties and all persons potentially affected by the passage of 12 MCAR §§ 2.029-2.0298 already know, or should know, that the portions of 12 MCAR § 2.028 proposed for repeal are no longer in use, it is found that this repeal will not constitute a substantial change within the meaning of Minn. Stat. § 14.15, subd. 3 (1982), and 9 MCAR §§ 2.110A. and 2.111 (1980 Ed.). Since the Department's Memorandum fails to specify how this proposal will be implemented, it is suggested that the rules, as adopted, close with a "Repealer", followed by a specification of which portions of 12 MCAR § 2.028 are actually being repealed.

So closed p.20

12 MCAR § 2.029 - Mental health center standards.

10. Two amendments are proposed for the scope and applicability section. The first, an amendment of the section's title, to read "Mental health center and mental health clinic standards.", is found necessary and reasonable and is further found not to constitute a substantial change because the proposed title accurately describes the contents of the proposed rules.

amended p.1

In addition, the Department proposes insertion of the phrase "and subscriber contract" between the words "insurance" and "reimbursement" in the body of the section. This change is found to be clarifying in nature, not substantial, and is further found to be necessary and reasonable because it provides consistency with the authorizing statute.

✓ inserted p.1

12 MCAR § 2.0291 - Definitions.

11. The Minnesota Medical Association has suggested that the word "client", defined at subsection .0291F., and used throughout the proposed rules, be replaced throughout by the word "patient". This suggestion was not accepted by the Department. Much of the criticism of the proposed rules centers around their alleged bias toward the "medical model" approach to the approval standards. The term "client", which is used in the statutes governing licensure of psychologists, reflects the Department's decision to use a word more attuned

to a "multidisciplinary", as opposed to a "medical" approach. Such a decision is within the Department's discretion, and the subsection is found to be necessary and reasonable.

12. At subsection G, the definition of clinical services, the Department has proposed insertion of the word "also" as the third word of the second sentence. The Hearing Examiner finds this amendment to be clarifying in nature, in that it helps to make clear that the two sentences of the subsection together define the term "clinical services". The proposed amendment is found to be necessary and reasonable and not a substantial change.

13. The Department proposes an amendment to the last sentence of subsection N., which would now read, in relevant part: "Examples of the mental health disciplines include but are not limited to. . . ." (new words underlined). The definition as finally proposed is found to be necessary and reasonable because it clarifies the Department's intent not to limit the mental health disciplines to the four that are listed. This approach is consistent with the authorizing legislation, which requires that the mental health treatment staff be "multidisciplinary". See Minn. Stat. § 245.69, subd. 2(a), and proposed 12 MCAR § 2.0291 R.5., which recognizes that mental health professionals can come from "allied fields", so long as they have the proper background in education and experience. It is further found that adoption of this amendment would not be a substantial change, and that the subsection as finally proposed does not violate any substantive provisions of law.

14. Subsections Q. and R. define "Mental health practitioner" and "Mental health professional". The Department has variously proposed, or declined to propose, amendments of its own or amendments suggested by several interested parties, with respect to these definitions.

Attorney Diane Heins, representing Minnesota Psychologists in Private Practice (MPPP), proposed at the hearing and in written correspondence that subsection Q.2., which provides that an individual can become a mental health practitioner without any post-secondary education, be withdrawn. This proposal was not accepted by the Department. The Department's reasoning is that a number of credentialed practitioners who have no formal training have been providing mental health services for several (or more) years, and these people would be excluded under the MPPP proposal. In subsections Q.1., Q.2., R.1., R.2. and R.5., and in the first sentences of the last paragraphs of both sections Q. and R., the word "clinical" before "experience" is proposed for deletion, and the words "in the delivery of client services" would be added to follow "experience". The Hearing Examiner finds this amendment to be necessary and reasonable and not a substantial change. Rather, it is necessary in order to provide consistency with subsection G. In addition, new final paragraphs are proposed for addition to subsections Q. and R. They would read:

> Documentation of the accreditation of a college or university shall be a listing in "Accredited Institutions of Postsecondary Education, Program Candidates" for the year the degree was issued.

The Hearing Examiner finds these additional final sentences to be clarifying amendments only, necessary and reasonable for the further definition of "accredited". Furthermore, the addition of these two sentences is found not to be a substantial change.

The Department proposes adoption of one of the suggestions of the Board of Psychology which would delete the phrase "a mental health discipline" and substitute in its place "one of the behavioral sciences" at subsections Q.3., Q.4. and R.1. This amendment is found to be necessary and reasonable, and not a substantial change, because it recognizes that some master's degrees combine theory and course work from more than one mental health "discipline". For further clarification, the Department also proposes in its Memorandum to add one more sentence to the proposed new last paragraphs of both sections Q. and R. specifying that the equivalent degree includes, minimally, 28 semester credits in mental health. The general thrust of this proposal is laudable because it provides further clarity. However, no specific language has been proposed. It is recommended that the Department adopt specific additional language addressing its stated intent. Such a rule, if adopted, is found to be necessary and reasonable and not a substantial change. The Hearing Examiner finds subsections .0291 Q. and R., as finally proposed, to be necessary and reasonable.

15. Mr. Dennis Montgomery, a mental health worker from Bemidji, Minnesota, spoke at the hearing and enriched the record with extensive documentation (Pub. Exs. 59-A through 59-X), supporting inclusion of mental health workers, or at least the recognition of their expertise as a qualifying factor for such inclusion, under the definition of mental health "professionals". The Department argues that this has been done by use of the phrase "or its equivalent" at subsections R.1., R.2., and R.5., which allow for agency latitude to consider experience and/or training outside the areas of traditional academia in determining professional qualifications for all classes of mental health "professionals", except psychiatrists and certain psychologists. The Hearing Examiner agrees with the Department's contention and finds the use of the phrase "or its equivalent" in the subsections mentioned above to be necessary and reasonable. Equivalency will be decided by the Department on a case-by-case basis, using the standards specified elsewhere in the subsections for comparison.

16. At subsection R.2., the Department proposes an amendment inserting the following language between "equivalent" and "with":

> "whose official transcript documents that the degree or its equivalent includes a minimum of 28 semester hours of graduate course credit in mental health theory and supervised clinical training,"

In addition, the second usage of the word "clinical" would be deleted from the definition. The rationale is that there is no master's degree in clinical social work, but that some reasonable standard is still necessary. Therefore, the Hearing Examiner finds these proposed amendments to subsection R.2. to be both necessary and reasonable. They are further found to constitute no substantial change because the thrust of the rule, a definition of minimum standards for a mental health professional practicing clinical social work, is still preserved.

At subsection R.3., the Department has proposed to adopt an MPPP suggestion that would further amend a subsection that was proposed for amendment by the Department at the outsent of the public hearing. As finally proposed, the subsection would read:

"3. In psychology: a psychologist licensed under Minnesota Statutes, sections 148.88 to 148.98, ~~with listed~~ who has stated to the Board of Psychology competencies in the diagnosis and treatment of mental illness."

so amended p. 5

As illustrated in the above quotation, the words "who has stated to the Board of Psychology" have replaced "with listed" in the originally-proposed amendment. The Hearing Examiner finds the subsection as finally amended to be necessary and reasonable. The amendment, as proposed, would not be substantial in nature, only a technical clarification.

In response to the suggestions of many psychiatrists who expressed their concern, and in response to questions raised by both the Hearing Examiner and Ms. Heins, the Department has now proposed to delete the phrase, "or a physician licensed under Minnesota Statutes, chapter 147" from the end of subsection R.5. This amendment is found to be necessary and reasonable and not a substantial change. The change is not substantial because the subsection's general thrust, an attempt to assure that an individual not be recognized as an "allied mental health professional" without appropriate training and/or experience, has been preserved. The amendment represents a compromise between persons and groups who wanted the phrase eliminated because they contend that the mere possession of a physician's license cannot qualify an individual as a professional in an allied mental health field, absent a specific demonstration of academic credit in mental health theory and supervised clinical training, and the stance taken by the Minnesota Medical Association, who wanted a licensed physician with one year (2,000 hours) of experience in mental health service delivery to qualify "in psychiatry" under subsection R.4. The Department's determination to require all licensed physicians to have the same minimum education and experience qualifications as any other allied mental health professional is necessary and reasonable because it has a rational basis - the imposition of uniform quality assurance standards upon persons allowed to perform mental health diagnoses in order for a center or clinic to receive approval for insurance coverage.

deleted p. 5

In addition, with respect to subsection R.5., it is found that the Department has demonstrated the need for and reasonableness of the subsection as originally proposed in the State Register. This finding is made in case the Department would ultimately propose to adopt the State Register draft, which automatically included all licensed physicians as mental health professionals. It is so found because the record demonstrates through an affirmative presentation of facts that one does not obtain a physician's license in Minnesota without some training in mental health, and the decision to elevate (or not to elevate) any licensed physician to the status of a mental health professional for the purposes of these rules is within the Department's discretion.

17. The Board of Psychology recommends deleting the phrase "or under contract to the" from subsection .0291 T. because, it is argued, allowing mental health centers and mental health clinics to contract with mental health professionals may lead to situations which constitute the unauthorized, unlicensed private practice of psychology. The Hearing Examiner finds that this concern is speculative, and that it is beyond his jurisdiction herein, beyond the scope of this Report, and beyond the jurisdiction of the Department of Public Welfare as well, to determine what is the unauthorized practice of the profession of

psychology. In addition, the subsection, as proposed, is found to be necessary and reasonable in order to allow the centers and clinics who will be applying for approval under the proposed rules, the flexibility needed to secure a staff large enough to meet the minimum staffing and quality assurance standards required elsewhere in the proposed rules. Furthermore, inclusion of the phrase "or under contract to the" provides consistency with the authorizing legislation. See Minn. Stat. § 245.69, subd. 2(a).

12 MCAR § 2.0292 - Mental health center; mental health clinic.

18. At the hearing, the Department proposed amending the last sentence of subsection .0292 A.1. by striking the words "at that" and substituting "as the" in their place. In its final submission, the Department proposed deleting "as" and placing the phrase "in the name of" after the word "conducted". The first amendment was necessary in order to clarify the fact that a center's business could be conducted in one of its satellite offices, not just in one location. It was not a substantial change, but clarifying only. However, the syntax of the first amendment implied that the center could be one or more individual practitioners. Since this was not the original intent of the Department, the second amendment was offered in the Department's Memorandum. The Hearing Examiner finds that subsection A.1., as finally proposed, is necessary and reasonable and does not constitute a substantial change.

OK p. 6

19. Subsection A.2. provides, in part: "If the center is a unit within a facility, the rest of the facility shall not provide clinical services in the outpatient treatment of mental illness.". The record contains strong objection to this provision from Byron Laher of the United Fund of Greater Minneapolis, and from David Southward of the Minneapolis Clinic. The Department's rationale is that approved centers and clinics must not be used as alternate offices for the private practice of individuals who can receive reimbursement for services performed by them in such private practice under Minn. Stat. § 62A.152, subd. 2, which allows reimbursement to individual licensed consulting psychologists and individual psychiatrists. The objectors argue that insurance carriers can be separately billed for such services and that systems have been set up by the carriers to guard against reimbursing individuals in situations where the proper recipient of the reimbursement would be the centers or clinics as separate entities. The Hearing Examiner finds the subsection to be necessary and reasonable because it represents a policy decision within the discretion of the Department to choose between two alternatives, each of which has a rational basis in the record.

12 MCAR § 2.0293 - Minimum treatment standards.

20. Subsection .0293 C., the required assessment and diagnostic process, is very possibly the most controversial portion of this entire rule package. The controversy is about the final sentence, which reads: "The diagnosis shall be by or under the supervision of and signed by a psychiatrist or licensed consulting psychologist, or by and signed by a licensed psychologist.". This provision makes psychiatrists, licensed consulting psychologists, and licensed psychologists ultimately responsible for all diagnositic decisions made by an approved center or clinic. Any diagnosis not performed by these three classes of mental health professionals must be under the supervision of a psychiatrist

no change p. 9

or a licensed consulting psychologist. Licensed psychologists who are not licensed consulting psychologists are allowed to make and sign diagnoses, but cannot supervise the diagnostic processes of another mental health professional. A basic decision made by the DPW in proposing this system was to grant diagnostic and supervisory authority to the two classes of mental health professionals who were designated by the Legislature for reimbursement as individuals under Minn. Stat. § 62A.152. Extension of the assignment of responsibility for diagnoses, but not supervisory authority, to licensed psychologists has a rational basis as well - as explained in the Statement of Need and Reasonableness, the licensing process for psychologists in Minnesota requires competence in the diagnosis of mental and nervous disorders. The proposal to withhold supervisory authority over diagnoses made by other professionals from all psychologists except those certified by the Board of Psychology as licensed consulting psychologists is based upon the fact that the licensure requirements for licensed consulting psychologists are much more stringent than those for licensed psychologists. Under Minn. Stat. § 148.91 (1982), a licensed consulting psychologist must have a doctorate degree with a major in psychology, plus a minimum of two full years, or their equivalent, of post-doctoral employment as a psychologist. An individual can qualify as a licensed psychologist by earning a master's degree in psychology, or its equivalent, followed by two years of employment as a psychologist. The Hearing Examiner finds subsection C. to be necessary and reasonable.

The greatest opposition to subsection C. came from social workers, their advocates, such as Dr. William Walker of the Nicollet Clinic and Attorney Philip Bush, and their supporters within the other mental health disciplines, who argued for a provision allowing qualified social work practitioners to make unsupervised diagnoses. The basic rationale of persons holding this view is: (1) many qualified social workers are being deprived of the status and dignity they deserve, especially since many of them are able to make mental illness diagnoses with greater accuracy and reliability than the persons designated to supervise them in that function; (2) the time required for supervision of diagnoses made by other mental health professionals will unreasonably reduce the amount of time psychiatrists and licensed consulting psychologists could otherwise spend on the direct delivery of mental health services; (3) the majority of outpatient clients of mental health centers or mental health clinics do not require medical intervention and are seen and properly diagnosed, in practice, by social workers; (4) clients will be deprived of freedom of choice; and (5) the unnecessary costs incurred by psychiatrists and licensed consulting psychologists for supervisory time, including the review of each client's file before signing for a diagnosis, will be prohibited. In response to these arguments, the Department, and its supporters on this issue, such as Blue Cross and Blue Shield of Minnesota, reply:

> (a) Although many social workers have advanced educations and years of practical experience, the profession is unregulated by the state licensure process, which means there is no uniform quality assurance mechanism for entrance into the profession;
>
> (b) Supervisory time is necessary so that the ultimate responsibility for diagnoses made by others rests with professions that the Legislature has deemed qualified for individual reimbursement;

(c) The freedom of a client to choose the type of mental health service (s)he wants is not restricted because the mental health professional staff must be multidisciplinary in its makeup in order for approval to be granted; and

(d) The costs incurred in supervisory and review time will be offset by more efficient case management, with less total direct service time needed for each client.

The arguments are compelling on either side of this debate. However, the policy decision by the Department to follow the "medical model" has a rational basis in facts placed on the record. In a situation such as this, the Department is not legally required to choose the "best" alternatives, only alternatives that could be chosen rationally, given the facts in the record. See, Sterling Secret Service, Inc. v. Michigan Department of State Police, 20 Mich.App. 502, 174 N.W.2d 298, 304 (1969), and Federal Security Administrator v. Quaker Oats Company, 318 U.S. 218, 233, 87 L.Ed. 724, 63 S.Ct. 589, 158 A.L.R. 832 (1943). Since a rational choice has been made, subsection .0293 C. has been approved.

12 MCAR § 2.0294 - Minimum quality assurance standards.

21. The peer review required by subsection .0294 B. has been proposed for amendment by the Department in its final submission. The proposal is to substitute "mental health professional" for "multidisciplinary" in the third complete sentence of the subsection. The Hearing Examiner finds this amendment to be clarifying in nature and not a substantial change, because other sections in the proposed rules would assure that the professional staffers represent a minimum of three mental health disciplines. The subsection as amended is further found to be needed and reasonable. so amended p.11

The fourth complete sentence of subsection C., the topic of which is "internal utilization review", reads: "Criteria may be established for treatment length and the provision of services for certain client conditions.". The use of the permissive "may" is proper in this context because criteria for treatment length or service provision, dependent on the condition of the client, cannot be established intelligently in advance of the center's acquiring actual experience in the treatment of clients. Even then, as the Department points out in the Statement of Need and Reasonableness and in its final submission, such criteria would only be generalizations that will not necessarily fit a specific case. Therefore, the Department decided to encourage, rather than mandate, the establishment of such criteria. The Hearing Examiner finds subsection C. to be necessary and reasonable as proposed.

22. Subsection .0294 F.1., regarding violations of standards, was originally drafted containing a definition within it of "serious violations of policies and procedures". The Department's amendments presented at the hearing proposed insertion of the word "center" before the word "policies" in each of the last two subclauses of the definition. In the Department's final submission before the closing of the record, this definition, the second sentence of subsection F.1., as earlier proposed, was proposed for removal to the Definitions section, to be now renumbered as new subsection .0291 U. The Hearing Examiner finds both proposals to be necessary and reasonable and not substantial changes because they constitute a clarification of the rule's meaning and provide further clarification by placing the definition of a term used throughout the rules in the "Definitions" section. so removed, p.6

23. At subsection G., the phrase "on individuals within the welfare system" is proposed for deletion from the rule as originally published. The Hearing Examiner finds this proposal to be necessary and reasonable because it simplifies the Department's intent - that approved centers and clinics must follow all applicable provisions of the Minnesota Government Data Practices Act. The proposed deletion is also found not to constitute a substantial change.

deleted p. 13

12 MCAR § 2.0295 - Minimum staffing standards.

24. Section .0295 has also caused a great deal of controversy, which will be detailed below. However, most of that controversy should be stilled by two amendments proposed by the Department in its final submission. First, the Department proposes deletion of the last sentence of subsection .0295 A.1., which required at least two mental health professionals to be on-site when the center was opened, and replacement of "on-site" with the phrase "at the main office of the center" in subsection A.4. Those amendments are an attempt to address the concerns raised by Robert Butler of the Sioux Trails Mental Health Center in New Ulm, Minnesota, with respect to the difficulty, especially in rural areas of the State, of simultaneously staffing satellite offices and the headquarters of an approved center or clinic for every hour they are open. The Hearing Examiner finds these amendments necessary and reasonable and not a substantial change, since the multidisciplinary concept is still retained by the minimum requirement of 35 hours per week in employment or under contract by at least two mental health professionals representing separate disciplines.

The second amendment involves the final sentence of subsection A.4., which originally read:

> "The center shall employ or contact with the professionals required in 2. or 3. (a psychiatrist, a licensed consulting psychologist, and either a clinical social worker or a psychiatric nurse) so that each professional comprises five percent of the full-time equivalent multidisciplinary staff time spent in clinical services, or 35 hours, whichever is less, to ensure and document their ongoing presence and availability in the provision of clinical services."

Much consternation was expressed over this requirement, most of it centered around the difficulty and expense in arranging for psychiatric services to cover five percent of the full-time multidisciplinary staff time spent in clinical services, or 35 hours, whichever is less. The chief opposition was led by Dr. Karl Ostrom of Wadena, Minnesota, representing small centers and clinics, especially those in isolated, rural locations, and by several persons from Hennepin County, chiefly Dr. Leo Hanvik from the Washburn Child Guidance Center, Bonnie Brysky of Community University Health Care Center, and Barbara Homce of the County's Mental Health Division. In response to this opposition, the Department proposes to:

> "Amend 2.0295 A. to delete five percent psychiatric time and five percent licensed consulting psychologist time, and insert ten percent combination psychiatric and licensed consulting psychologist clinical services time, retaining the minimum of eight hours every two weeks for both the licensed consulting psychologist and psychiatrist."

This compromise should resolve much of the controversy, including potential re-organizations of staffs, lay-offs, and unnecessary expenses on the part of mental health centers and mental health clinics if they were to be given approval. The general thrust of the proposed amendment is found to be necessary

and reasonable and not a substantial change because the multidisciplinary intent of the subsection is still preserved by the first sentence, which requires the provision of a minimum of eight ours every two weeks of clinical services in the treatment of mental illness by each required member of the mental health professional staff (a psychiatrist, a licensed consulting psychologist, and either a clinical social worker or a psychiatric nurse). In addition, it allows for much greater flexibility on the part of the centers and clinics than was found in the State Register draft. However, the Department has failed to submit specific language to implement its proposal. Because of this, the Hearing Examiner can only assume that the "35-hour" requirement is being deleted as well, and the above findings of need and reasonable and no substantial change were based, in part, on that presumption. The Department is reminded that it must draft its amendment in a manner consistent with this Finding or submit the rule as modified with the complete hearing record to the Chief Hearing Examiner prior to adopting the modified rule and submitting it to the Attorney General for review. See Minn. Stat. § 14.16 (1982).

If the Department withdraws the amendment to A.4., as proposed in its final submission, and decides to adopt the originally published subsection, that subsection is found to be necessary and reasonable because it preserves, however strictly, the multidisciplinary model.

25. Subsection .0295 B., which mandates that "no single mental health discipline or combination of allied fields shall comprise more than 60% of the full-time equivalent mental health professional staff" and that "mental health practi- tioners shall not comprise more than 25% of the full-time equivalent multidis- ciplinary staff" was also a source of controversy.

Considering first the 25% limit on the amount of clinical services treatment time that can be spent by mental health practitioners, the Hearing Examiner finds that provision to be needed and reasonable. The 25% figure represents a compromise between persons advocating no minimal academic requirements for clinical staff (such as Dennis Montgomery), and those who believe approval should be granted only to centers or clinics whose staffs possess the highest individual credentials in mental health education and certification (such as Blue Cross and Blue Shield of Minnesota). It is also a compromise between factions who stress the importance of cost effectiveness and those who promote the quality assurance potential of highly educated, licensed or certified staff. After considering all the competing interests, in order to assure that the work of practitioners would be supervised, while still allowing for mental health professionals to devote adequate time on direct services to the centers' or clinics' mentally ill clientele, the Department decided to mandate a specific limit on the amount of treatment practitioners would be allowed to give to the clients. This approach has a rational basis, and therefore, has been approved by the Hearing Examiner.

The 60% limit on full-time equivalent professional staffing by any one mental health discipline is also found to be necessary and reasonable. It is noted first that subsection B. contains an exception for centers with fewer than six full-time equivalent mental health professional staffers. The Department's rationale for this exception is that the goal of attaining a multidisciplinary staff for such small groups is reached by making those centers adhere

to subsection A.1. requirements for having two full-time staff from different disciplines (either a clinical social worker, a psychiatric nurse, a psychologist or a psychiatrist) and the subsection A.4. requirements of minimal representation from the three required disciplines (psychiatry, licensed consulting psychology, and either clinical social work or psychiatric nursing). The intent of subsection B. is to assure that the mental health professional staff of an approved center or clinic is truly multidisciplinary, as mandated by the authorizing statute. See, Minn. Stat. § 245.69, subd. 2 (1982). The imposition of a set percentage is necessary in order to assure preservation of the multidisciplinary approach and to provide certainty in the standard so that centers and clinics will know what is needed to qualify for approval. The 60% figure is reasonable because it permits a center to specialize in one discipline, while at the same time preventing such a strong domination by any one discipline that the center becomes a single-discipline clinic with only token involvement of staff trained in other disciplines.

12 MCAR § 2.0296 - Application procedures; review; decision.

26. The last section of subsection .0296 A.1., as published in the State Register, provided that applicant centers "may" be required to explain and provide documentation of compliance with the minimum standards mandated by statute and by the rest of the proposed rules. In response to testimony to the effect that such discretion was overly broad, in that it allowed for a potential inequality of treatment in the application process, the Department deleted "may" and substituted "shall" in its final submission prior to the close of the record. The Hearing Examiner finds that this change is not substantial, and further finds that the subsection, as finally amended, is necessary and reasonable.

27. Subsection A.5., as published in the State Register, read:

> "5. A center whose application is disapproved or whose approval is withdrawn may not reapply for 90 days following notification of disapproval or the withdrawal of approval. A center whose approval is withdrawn under 12 MCAR § 2.0297 D.2. or due to non-compliance with 12 MCAR § 2.0294 F.1. may not reapply for two years following notification of disapproval."

After consideration of comments made at the hearing to the effect that the authorizing legislation did not give the Department the authority to punish further or impose discipline on the mental health centers or mental health clinics it was to approve or disapprove under the rules, the Department withdrew subsection .0296 A.5.

28. Subsection .0296 B.3., as published in the State Register, reads:

> "3. The applicant center shall allow the commissioner to inspect the center at any time during the approval and deferral periods, whether or not the visit had been announced in advance. A visit shall occur only during normal working hours of the center and shall not disrupt the normal functioning of the center."

In its final submission, the Department proposed the following clarifying and editorial changes regarding this language, all of which are found to be necessary and reasonable, and none of which is found to constitute a substantial change:

> (a) Insertion of the word "site" before "visit" on the two occasions that the word "visit" appears in the subsection;

(b) Deletion of subsection .0296 B.3. from its present location in the rules; p.17

(c) Insertion of the subsection's language, as amended, to a position between the second and third sentences of the originally-published subsection .0296 C.4., within which it would now constitute a new third sentence; and p.17

(d) insertion of the subsection's language as amended at (a) above, with deletion of the word "applicant" between "The" and "center", at the end of subsection .0297 E., in which it would now constitute a new last sentence. p.19

29. Subsection .0296 D. sets out an appeal process for disapproved applicants or for centers or clinics from whom approval has been withdrawn. The proposed language allows for a contested case hearing and judicial review as provided in the Minnesota Administrative Procedure Act, which it incorrectly cites as "Minnesota Statutes, sections 15.0418 to 15.0425". The Administrative Procedure Act was renumbered in 1982, such that the correct citation for contested case procedures and judicial review is now "Minnesota Statutes, sections 14.48 to 14.70". It is suggested that the Department adopt the new numbering system. Such a revision is found to be necessary and reasonable, and constitutes an editorial change only, not a substantial change. so adopted p.17

12 MCAR § 2.0297 - Post-approval requirements.

30. In order to clarify Departmental intent that "disapproval" and "withdrawal of approval" have the same meaning and effect as used throughout the rules, the Department proposed, in its final submission, to amend definitional subsection .0291 M. by placing the words "or 'withdrawal of approval'" after the word "'Disapproval'". The Hearing Examiner finds this change to be editorial and clarifying only and not a substantial change. Subsection .0291 M., as amended, is also found to be needed and reasonable.

31. The third sentence of subsection .0297 D.1. provides: "A center with changes resulting in noncompliance in minimum standards shall receive notice and may have up to 180 days to correct the areas of noncompliance before losing approval status.". The use of the permissive "may" in this sentence was questioned at the hearing because it allows the Commissioner of Public Welfare discretion in designating how long a clinic or center will have to come into compliance. The Hearing Examiner finds that the discretion allowed by this provision is necessary and reasonable in this context because it enables the Commissioner to use his judgment to decide if the full 180-day compliance period is unwarranted in situations of gross violations or repeated instances of non-compliance. The need for such latitude, resulting in more effective enforcement and adminstration, outweighs the potential for any abuse or harassment. It is further found that the subsection as proposed does not violate any substantive provisions of law.

32. With respect to subsection .0297 D.2., the Department offered an editorial amendment at the hearing, which amendment would delete the comma after the word "sanctioning". The Hearing Examiner finds this amendment to be necessary and reasonable, and editorial, not substantial in nature. deleted p.19

In its final submission prior to the close of the record, the Department proposed the following additional action with respect to this subsection:

"Delete the sentence definition of 'serious violations of policies and procedures' from 2.097 D.2. and insert verbatim as 12 MCAR § 2.0291 U.; renumber 2.0291 U. as 2.0291 V."

The sentence proposed for deletion is the first one in the subsection as originally published. It reads:

"2. Serious violation of policies or procedures, professional association or board sanctioning or loss of licensure for unethical practices, or the conviction of violating a state or federal statute, shall be reported in writing by the center to the commissioner within ten days of the substantiation of such behavior."

Initially, it is apparent that the sentence proposed for removal to the Definitions section is not a definition at all. Therefore, the Hearing Examiner finds that the need for and reasonableness of inserting this sentence as a definition, at subsection 2.0291 U., has not been demonstrated by an affirmative presentation of facts in the record. It is also noted that such a proposal is in conflict with the Department's proposal to insert the second sentence of subsection 2.0294 F.1. as the new definition of "serious violation of policies or procedures". See, Finding of Fact No. 22. The proposed amendment cannot be adopted at this time due to these defects. To cure these defects, the Department should leave subsection 2.0297 D.2., as amended at the hearing, intact and implement the changes proposed at Finding 22.

It is further found that the proposed deletion of the sentence in question constitutes a substantial change within the meaning of 9 MCAR § 2.111 because it results in a rule fundamentally different from that contained in the rules as originally published and because it makes a major substantive change not raised by the original publication in such a way as to invite reaction at the hearing. Therefore, the proposed amendment cannot be adopted at this time. It is so found because the thrust of the subsection is a requirement that the centers report certain situations to the Commissioner of Public Welfare. The first sentence states which situations or behavior require reporting, and deletion of that explication leaves the remainder of the subsection internally inconsistent and vague. These defects can be remedied by leaving the subsection (as amended at the hearing) intact and implementing the amendments proposed at Finding 22.

It was mentioned in the preceding paragraph that the surviving portions of subsection D.2., if the proposed amendment is adopted, would leave the subsection internally inconsistent and vague. As a result, it is further found that the amendment, as proposed, cannot be adopted in this proceeding because it violates substantive provisions of law. See, Minn. Stat. § 14.02, subd. 4 (1982), which defines "Rule", in part, as "every agency statement . . . adopted to implement or make specific the law enforced or administered by it. . . ." (Emphasis supplied). This defect can be corrected by adopting the subsection, as amended at the hearing, intact and implementing the amendments proposed at Finding of Fact 22.

33. The first sentence of proposed subsection .0297 E. reads: "The center may be required to submit written information to the department during the approval period to document that the center has maintained compliance with the rule and center procedures." The use of the discretionary word "may" herein is found to be necessary and reasonable because it is the Department's intent to

use this subsection as a monitoring mechanism. It is not the intent of the Department to require each approved center or clinic to file regular reports to the effect that it is following its procedures in accordance with these rules. Rather, this subsection is intended for implementation only in situations where there has been a history of difficulty with compliance, when there have been complaints about a center or clinic, or when a new procedure was in effect for too short a time at the time of a site visit to effectively monitor its implementation. In order to allow the Department the latitude to obtain necessary information, the use of the term "may" has been approved. The Department's need to know outweighs any potential for unequal harassment or abuse. It is further found that the subsection as proposed is not in violation of any substantive provisions of law.

12 MCAR § 2.0298 - Variances.

34. The proposed rule contains provisions for variance requests, a new feature not contained in any of the Department's preliminary drafts or in Temporary 12 MCAR § 2.029. It is found that the need for and reasonableness of this section has been adequately demonstrated by an affirmative showing of facts in the record, specifically at pages 38 and 39 of the Department's Statement of Need and Reasonableness.

One editorial change has been proposed in this section. The title of subsection B. is proposed for change from "Application" to "Request procedure". This change is found to be necessary and reasonable to avoid confusion with the "application" procedures that form the subject matter of § 2.0296. It is further found that the title change is editorial and clarifying in nature, and not a substantial change.

OK/p.20

Based upon the foregoing Findings of Fact, the Hearing Examiner makes the following:

CONCLUSIONS

1. That the Department of Public Welfare gave proper notice of the hearing in this matter.

2. That the Department has fulfilled the procedural requirements of Minn. Stat. § 14.14, subds. 1 and 2 (1982) and all other procedural requirements of law or rule.

3. That the Department has demonstrated its statutory authority to adopt the proposed rules and has fulfilled all other substantive requirements of law or rule within the meaning of Minn. Stat. §§ 14.05, subd. 1, 14.15, subd. 3 and 14.50 (i) and (ii) (1982), except as noted at Finding 32.

4. That the Department has documented the need for and reasonableness of its proposed rules with an affirmative presentation of facts in the record within the meaning of Minn. Stat. §§ 14.14, subd. 2 and 14.50 (iii) (1982), except as noted at Finding 32.

5. That the amendments and additions to the proposed rules which were suggested by the Department after publication of the proposed rules in the State Register do not result in rules which are substantially different from the proposed rules as published in the State Register within the meaning of Minn. Stat. § 14.15, subd. 3 (1982) and 9 MCAR §§ 2.110 A. and 2.111 (1980 Ed.), except as noted at Finding 32.

6. That the Hearing Examiner has suggested action to correct the defects cited in Conclusions 3, 4 and 5, as noted at Finding 32.

7. That due to Conclusions 3, 4, 5 and 6, this Report has been submitted to the Chief Hearing Examiner for his approval pursuant to Minn. Stat. § 14.15, subd. 3 (1982).

8. That any Findings which might properly be termed Conclusions and any Conclusions which might properly be termed Findings are hereby adopted as such.

9. That a finding or conclusion of need and reasonableness in regard to any particular rule subsection does not preclude and should not discourage the Department of Public Welfare from further modification of the proposed rules based upon an examination of the public comments, provided that no substantial change is made from the proposed rules as originally published, and provided that the rule finally adopted is based upon facts appearing in this rule hearing record.

Based upon the foregoing Conclusions, the Hearing Examiner makes the following:

RECOMMENDATION

It is hereby recommended that the proposed rules be adopted except where specifically otherwise noted above.

Dated this 4th day of March, 1983.

Richard C. Luis

RICHARD C. LUIS
Hearing Examiner

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed
Adoption of Rules of the Department
of Public Welfare Establishing
Minimum Standards for Mental Health
Centers and Mental Health Clinics
for Purposes of Insurance and
Subscriber Contract Reimbursement,
12 MCAR §§2.029-2.0298

FINDINGS OF FACT
AND CONCLUSIONS

The above-entitled matter came on for hearing before Hearing Examiner Richard C. Luis on the sixth day of January, 1983 at 9:00 a.m. in the Auditorium, Building 15, of the Minnesota Veteran's Home, 5100 Minnehaha Avenue, Minneapolis, Minnesota and reconvened on the seventh day of January at the same time and in the same location, after proper notice required by Minnesota Statutes §14.14, subdivision 1 was served upon all persons, associations, and other interested groups registered with the State Department of Public Welfare for that purpose.

After affording interested persons an opportunity to present written and oral data, statements and arguments, having heard all of the testimony, having considered all of the evidence adduced upon the records, files and proceeding herein, having considered the Hearing Examiner's report, I find the following:

1. The Findings of Fact of the Hearing Examiner are enumerated 1 through 34 in his report. The Commissioner accepts the Findings of Fact 1 through 7 relating to procedural requirements and statutory authority, and Findings 10, 11, 12, 13, 15, 17 through 23, 25, 26, 27, 28, 30, 31, 33 and 34 which are substantive to the rule. The Commissioner agrees that the changes are not substantial in nature and are needed and reasonable.

2. In Finding 8, the Hearing Examiner found that the changes proposed by the Department at the Hearing and in the Memorandum filed with the Hearing Examiner and not discussed within the Hearings Examiner's Report are either technical, clarifying or editorial in nature, or corrections of grammatical, spelling and clerical errors, are found not to constitute a substantial change from the rule as originally published, and are specifically found to be necessary and reasonable changes to the rules. The Commissioner accepts this finding, agrees that the changes are not a substantial change, and is necessary and reasonable, and amends the rules as proposed. The amendments are located in the proposed rules, Revisor of Statutes format, as follows:

Rule Section	Location	Memorandum Page
2.0291 C.	Page 1, line 18, 21	Proposed by DPW at Hearing
2.0291 N.	Page 3, line 4	Proposed by DPW at Hearing
2.0291 R.1.	Page 4, line 9	Proposed by DPW at Hearing
2.0291 R.3.	Page 4, line 15	Proposed by DPW at Hearing

2.0291 R.4.	Page 4, line 18	Proposed by DPW at Hearing
2.0292 B.1.e.	Page 6, lines 32, 34	Page 24
2.0293 D.	Page 8, lines 21-22	Proposed by DPW at Hearing
2.0293 F.	Page 9, line 24	Proposed by DPW at Hearing
2.0296 B.1.	Page 15, line 3	Page 24
	Page 15, line 5	Proposed by DPW at Hearing
2.0296 D.	Page 16, line 19	Proposed by DPW at Hearing

3. In Finding 9, the Hearing Examiner recommended that the rules as adopted close with a "repealer" which specifies the portions of 12 MCAR §2.028 being repealed. The Commissioner agrees this is not a substantial change and is necessary and reasonable, accepts the recommendation and amends these rules by adding after 12 MCAR § 2.0298:

Repealer. The following provisions of 12 MCAR § 2.028 are repealed: the second sentence of the third paragraph of (a); the first sentence of (s); and (t).

Relettering. Reletter 12 MCAR § 2.028 (u) as (t).

4. In Finding 14, the Hearing Examiner recommended that the Department adopt specific language addressing its stated intent to clarify the experience and education requirements and provide consistency in 12 MCAR §2.0291 Q. and R. The Commissioner agrees that the addition of this language is necessary and reasonable and not a substantial change. The Commissioner accepts the recommendation and amends 2.0291. Q. and R. to read as follows:

Q. Mental Health Practitioner. "Mental health practioner" means a staff person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

1. by having a bachelor's degree in one of the behavorial sciences or ~~a~~ related ~~field~~ fields, from an accredited college or university and 2,000 hours of supervised ~~clinical~~ experience in the delivery of clinical services in the treatment of mental illness;

2. by having 6,000 hours of supervised ~~clinical~~ experience in the delivery of clinical services in the treatment of mental illness;

3. by being a graduate student in ~~a mental health discipline~~ one of the behavioral sciences or related fields formally assigned to the center for clinical training by an accredited college or university; or

4. by having a master's or other graduate degree in ~~a mental health discipline~~ one of the behavioral sciences or related fields from an accredited college or university.

Documentation of compliance with 12 MCAR §2.0294 D.2. is required for designation of work as supervised ~~clinical~~ experience in the delivery of clinical services. Documentation of the accreditation of a college or university shall be a listing in

"Accredited Institutions of Postsecondary Education, Programs, Candidates" for the year the degree was issued. The master's degree in behavioral sciences or related fields shall include a minimum of 28 semester hours of graduate course credit in mental health theory and supervised clinical training, as documented by an official transcript.

R. Mental health professional. "Mental health professional" means a staff person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

1. in psychiatric nursing: a registered nurse with either a master's degree in ~~a mental health discipline~~ one of the behavioral sciences for related fields from an accredited college or university, or its equivalent, who is licensed under Minnesota Statutes, sections 148.171 to 148.285, with at least 4,000 hours of post-master's supervised ~~clinical~~ experience in the delivery of clinical services in the treatment of mental illness~~.~~;

2. in clinical social work: a person with either a master's degree in ~~clinical~~ social work from an accredited college or university, or its equivalent, with at least 4,000 hours of post-master's supervised ~~clinical~~ experience in the delivery of clinical services in the treatment of mental illness;

3. in ~~clinical~~ psychology: a psychologist licensed under Minnesota Statutes, sections 148.88 to 148.98 who has stated to the Board

of Psychology competencies in the diagnosis and treatment of mental illness;

4. in psychiatry: a physician licensed under Minnesota Statutes, chapter 147 and certified by the American Board of ~~Psychology~~ Psychiatry and Neurology or eligible for board certification in psychiatry; and

5. in allied fields: a person with either a master's degree from an accredited college or university in one of the behavioral sciences or related fields, or its equivalent, ~~whose official transcript documents that the degree or its equivalent includes a minimum of 28 semester hours of graduate course credit in mental health theory and supervised clinincal training~~, with at least 4,000 hours of post-master's supervised ~~clinincal~~ experience in the delivery of clinical services in the treatment of mental illness~~; or a physician licensed under Minnesota Statutes, chapter 147~~.

Documentation of compliance with 12 MCAR §2.0294 D.2. is required for designation of work as supervised ~~clinical~~ experience in the delivery of clinical services. Documentation of the accreditation of a college or university shall be a listing in "Accredited Institutions of Postsecondary Education, Programs, Candidates" for the year the degree was issued. The master's degree in social work, behavioral sciences or related fields or its equivalent shall include a minimum

of 28 semester hours of graduate course credit in mental health theory and supervised clinical training, as documented by an official transcript.

5. In Finding 16, the Hearing Examiner found insertion of 28 semester credits in mental health into 2.0291 R.2., clinical social work, necessary and reasonable. In Finding 14, the same thrust, without specific language proposed, was found necessary and reasonable as a final paragraph for sections Q. and R. After further consideration, the Commissioner finds inclusion of this language necessary only once within each rule section and amends the rules by not adding the 28 credits language to R.2., and adding the 28 credits language to the last paragraph of R. with clarification that this is pertinent to the clinical social work and behavioral sciences degrees. The Commissioner finds this language necessary and reasonable and not a substantial change. The specific proposed language for R. is found above in Finding 4.

6. In Finding 16, the Hearing Examiner found the proposed deletion of the physician as an allied mental health professional to be reasonable and not a substantial change. The Commissioner accepts this finding. The Commissioner agrees it is not a substantial change and is necessary and reasonable. The Commissioner amends 2.0291 R.5 to delete the phrase, "or physician licensed under Minnesota Statutes Chapter 147" to read as found above in Finding 4.

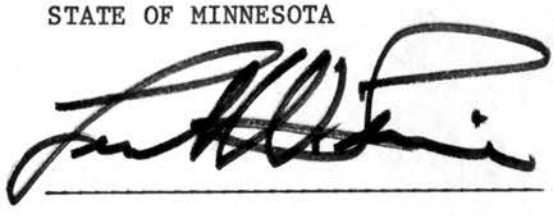
7. In Finding 24, the Hearing Examiner found the proposed amendments to 2.0295 necessary and reasonable and not a substantial change and requested the Commissioner adopt specific language. The Commissioner agrees with and accepts this finding, and amends 2.0295 A.4. to read as follows:

4. The mental health professional employed or under contract to the center to meet a requirement of 2. or 3. shall be ~~on-site~~ at the main office of the center and providing clinical services in the treatment of mental illness at least eight hours every two weeks. The center shall employ or contract with the professionals required in 2. so that these professionals together comprise ten percent of the full-time equivalent multidisciplinary staff time spent in clinical services to ensure and document their ongoing presence and availability in the provision of clinical services. The center shall employ or contract with the professionals required in ~~or~~ 3. so that each professional comprises five percent of the full-time equivalent multidisciplinary staff time spent in clinical services, or 35 hours, whichever is less, to ensure and document their ongoing presence and availability in the provision of clinical services.

8. In Finding 29, the Hearing Examiner recommended amending the statutory reference to the contested case hearing process from "sections 15.0418 to 15.0425" to its new codification, "sections 14.48 to 14.70." The Commissioner accepts this recommendation, agrees it is necessary and reasonable and not a substantial change and so amends 2.0296D.

9. In Finding 32, the Hearing Examiner found that the proposed amendment to 2.0297 D.2. was not supported. The Chief Hearing Examiner was correct in assuming the reference to D.2. was an error; the correct reference is 2.0294 F.1. The Commissioner accepts the Hearing Examiner's recommendations, does not amend section 2.0297 D.2. and amends sections 2.0294 F.1, 2.0291 U. and V. in accord with the Hearing Examiner's Finding 22 and the Commissioner's Finding 1.

STATE OF MINNESOTA



Leonard W. Levine
Commissioner of the Department of
Public Welfare

KD3/101

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

RECEIVED
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ADMINISTRATIVE HEARINGS

In the Matter of the Proposed
Adoption of Rules of the
Department of Public Welfare
Governing Mental Health Center
Standards (12 MCAR §§2.0290 - 2.0298)

STATEMENT OF NEED AND
REASONABLENESS

INTRODUCTION AND BACKGROUND

The proposed Rules 12 MCAR §§2.0290 - 2.0298 establish standards for mental health centers to be approved by the Department of Public Welfare. The approval entitles the center to seek the mandated reimbursement from health insurance companies and nonprofit health service plan corporations for certain outpatient service provided in treatment of a mental illness. Without approval, the reimbursement is only mandated when the service is provided by certain licensed individuals or a hospital. This introduction briefly reviews the history of third party reimbursement for mental health services, and reimbursement specific to Minnesota.

Health Insurance History

Insurance is a contractual agreement whereby one party guarantees a second party compensation against loss due to a specific contingency or peril for a fee. Basic to the theory of insurance are the concepts that the loss can be measured, the loss is predictable, and the loss is not under the control of the insured.

The concept of health insurance is relatively new. Until well into the twentieth century, health care was viewed as a service sought out at the consumer's discretion. The use and thus the costs of health care were seen as too much under the control of the consumer for health insurance to be profitable. During the depression of the 1930's, hospitals found that people needed health care services yet were not able to pay for the service. Health care was already viewed as the consumer's right, and hospitals were struggling under bad debts and cash flow problems. Non-profit hospitals began to form associations which charged potential consumers a small monthly fee in exchange for a guarantee of full hospital health care coverage when needed. These associations developed into the non-profit Blue Cross and Blue Shield plans. Thus, health insurance began for the economic advantage of the health provider.[1]

Only hospitalization was covered under these earliest plans. Hospitalization was primarily for surgery and acute infectious diseases, with the patient dying or recovering within a relatively brief time. Since only a physician could admit a patient to a hospital, the consumer appeared to have little control over the use of the service. Hospitalization met the criteria of an insurable service, and hospitalization insurance became seen as good business.

Few benefits for outpatient services existed until the commerical insurers began to compete for a corner of the health insurance market in the 1950's. Coverage was extended on an "all risk" basis with the new major medical policies, as medical services in general came to be regarded as an insurable risk.

In the early 1960's, the federal government took the first step toward a national health insurance plan with the introduction of Medicare and Medicaid, health care coverage for the elderly, the disabled and the poor. Increased attention was given to a complete national insurance plan during the 1970's. Health maintenance organizations (HMO's) came into being, with complete health care coverage when treatment was provided by a certain group of health professionals who also determined the need for the health services. As the 1980's begin, the model for health care and coverage is becoming increasingly cost conscious and competitive, with greater acceptance of advertising and consumer choice of insurer and benefits.

Mental Health Insurance

Coverage for mental illness was excluded from the origins of insurance for several reasons. Insurance developed in general hospitals; most general hospitals did not offer psychiatric services. During the 1920's - 1940's most treatment of mental illness was lifetime confinement in a state mental hospital. Traditionally, the government has assumed financial responsibility for the mentally ill. The first state hospital for "lunatics" was established in Pennsylvania in 1751. Other states followed this lead. Since lifetime confinement was the accepted treatment of this era, the state was accepting total responsibility for the mentally ill. Private insurers did not see their function as subsidizing public institutions. Coverage was generally only for "approved" hospitals, and included among the requirements for approval were surgical facilities; most psychiatric hospitals did not have surgical units. Private mental hospitals generally served the wealthy, who preferred to pay the costs and not draw attention to the mental illness in their family. With the social stigma of mental illness still very strong, there was little or no consumer demand for the coverage. Thus, exclusion of mental health services from health insurance does not appear to have been an intentional act, but a function of the delivery system. When hospitalization for mental illness became available in general hospitals (largely after World War II) many insured clients found their commercial policy covered their mental health care costs.[1]

With health insurance coverage extending to outpatient health services during the 1950's, the exclusions or limitations placed on psychiatric services became intentional. Psychoanalysis was the prevalent outpatient treatment of the 1950's, with from one to five sessions per week over a period of years. The treatment costs were disastrous for insurers. Insurers again became concerned over the "moral hazard"[1] of persons developing the conditions for which they were insured, the loss being under the control of the insured. Psychoanalysis had become a status symbol in certain social circles. Psychiatrists refused or were unable to clearly define the mental illness, state the prognosis, and explain how the treatment worked. Insurers responded by limiting reimbursement for outpatient treatment of mental illness. Co-payments of 50% of service cost was the common response.

Health care costs were already rapidly increasing for general medicine, requiring insurers to increase premiums. In order to keep premiums as low as possible, insurers began to cut coverage of services for which there was little demand. There was little demand for mental health insurance, and the insurers were wary of their high losses in this area. Coverage of mental illness treatment was limited or dropped as policies were renewed.

As the treatment of mental illness advanced, shorter hospitalization periods, verbal therapies, behavioral therapies and chemotherapy were found to be effective. The idea of discharge from a psychiatric facility came into being, followed slowly by the idea some mental illnesses could be cured or at least controlled in a community or outpatient setting. In 1960, the National Institute of Mental Health published guidelines for mental health insurance which emphasized the importance of coverage for ambulatory treatment.

Medicare had imposed certain limitations on mental illness coverage, but Medicaid provided the same coverage for mental illness as any other diagnosis with the exception of psychiatric hospital services for persons under 65. In 1965, the United Auto Workers Union demanded psychiatric benefits in their contract negotiations. In 1967, the Federal Employees Health Benefit Program changed its coverage to include psychiatric services on the same basis as other health services. FEHBP studied the utilization of mental health services and determined that mental illness hospitalization and outpatient services were insurable at a reasonable cost. The Community Mental Health Centers were developing during this same time period. Medicaid provided coverage for services offered by these centers, the advent of coverage for non-physician-provided, non-hospital services.[1] Insurers became less reticent to offer mental health coverage under the lead of the federal government. During the 1970's, psychologists were accepted as individual providers by the insurance companies. States began to pass legislation to require the availability of mental health insurance.

Third party payors have generally seen it to be their goal and responsibility to cover those medical services which can be clearly defined and monitored, and shown to be necessary and effective in treating specific disorders. Granted that physical health care has difficulty meeting these standards (consider the treatment for the common cold or a backache), their science of diagnosis and treatment is more advanced than that of mental health. Mental health professionals can be criticized for the inaccuracy or lack of agreement across provider in diagnosis.[2,3] Research shows conflicting findings for the "medical need" and effectiveness of services, with quite respectable rates of "spontaneous recovery" without treatment. Other findings show that the training of the provider (or lack thereof) is irrelevant to the outcome, and insurers wonder if they are being asked to cover the purchase of friendship.[4]

These findings can be criticized for methodology flaws, but as treatment departs from the medical model there is an increasing need to justify the need for, effectiveness of, and legitimacy of treatment as a health service. There is evidence that psychiatric coverage improves employee productivity, reduces absenteeism and cuts utilization of other physical health care.[5,6] Insurers, however, question whether they are being asked to cover treatment for mental illness or services to improve the happiness, human potential, or marriage of the client, at the client's option.

Because of these concerns and the history of expensive psychoanalysis, mental health insurance benefits, have generally been lacking or more limited than medical coverage, with extensive co-payments, deductibles, and limits on days or overall benefit level.

In response to the limits placed on mental health insurance, service providers began promoting legislation mandating mental health insurance benefits. Legal authority for such a mandate comes from the McCarron-Ferguson Act, 1945, giving states the authority to regulate insurance companies. Insurance companies generally have opposed such legislation, arguing that benefits should be left up to the free market, and that states are trying to shift their responsibility for the mentally ill to the private sector. Providers argue that the working people (equivalent to the insured generally) are not eligible for state programs for the indigent mentally ill, and that the stigma and lack of knowledge about mental illness prevents people from requesting or demanding this benefit.

During the past ten years, two types of legislatively mandated mental health insurance have been passed: mandated minimum benefits (which explicitly define the minimum benfits that an insurer must include in policies) and mandated availability of benefits (stipulates that insurers must offer mental health benefits to the subscribers). Twenty-one states have mandated benefits or availability legislation, with legislation pending in a number of other states. Generally, these mandates apply to group policies only, apply to both outpatient and inpatient coverage, and stipulate a minimum number of dollars (outpatient) or days (inpatient) coverage. Generally, coverage applies to physicians and organized settings (hospitals, JCAH accredited or state certified mental health centers). Psychologists licensed at a Ph.D. level are also frequently covered as individuals under Freedom of Choice laws. Other individuals are less likely covered as individuals, but may be covered if working in an organized setting and/or under the direct supervision of a physician or psychologist.[7]

Minnesota Outpatient Mental Health Insurance Coverage

Minnesota is one of ten states to mandate minimum mental health insurance benefits. The original provisions of Minn. Stat. 62A.152, enacted in 1975 were:

- for group policies and subscriber contracts providing inpatient MI benefits (excluded all individual policies, and those group policies not covering inpatient)
- written or issued by accident and health insurance companies and non-profit health service plan corporations in MN (excludes HMO's, self-insured companies, Medical Assistance and federal benefit programs)
- there is mandated coverage of outpatient mental or nervous disorder diagnosis, consultation and treatment services
- at a minimum level of 90% of the first $600 of the usual and customary charges per year
- when the service was provided by a hospital, licensed consulting psychologist, psychiatrist, or approved community mental health center or mental health clinic.

This legislation was promoted as a cost effective alternative to inpatient treatment, with the main push coming from community mental health centers. These centers were primarily funded by state and county tax dollars with Medical Assistance reimbursement but no insurance reimbursement.

The legislation was amended in 1981 to provide minimum coverage of 80% of the first $750, and extend to policies written outside of Minnesota when either 100 subscribers or 90% of the group covered were residents of Minnesota.

This legislation is supplemented by separate legislation mandating insurance coverage for chemical dependency treatment (Minn. Stat. 62A.149) and children's residential treatment for emotional disorders (Minn. Stat. 62A.151). Hospital inpatient coverage for mental illness treatment is not mandated in Minnesota.

The Department of Public Welfare was the only government agency with ties to mental health centers, so the centers receiving grant-in-aid through the Department were designated as "approved" in DPW Rule 12 MCAR §2.028 in April, 1976, for purposes of Minn. Stat. 62A.152. The term "clinic" was interpreted at that time to refer to nonprofit non-comprehensive centers receiving state funds through a contract with a comprehensive (community) mental health center. Thirty-five centers and clinics were approved under this rule.

Services provided by individuals or agencies not receiving government funds were reimbursed if the person providing the service was a licensed consulting psychologist or psychiatrist, in accordance with the legal mandate. Insurance companies frequently reimbursed services provided by other persons under the supervision of a licensed consulting psychologist or psychiatrist. There was no standard definition of supervision or meaning of the signature on claim forms. As mental health treatment became more popular or at least more prevalent, insurers became concerned that signatures were placed on claim forms with little or no actual supervision provided. Professional boards and associations wondered uneasily about the ethical and legal issues of accepting a fee and responsibility for a client you had not seen.

By 1977, there had been several inquiries from non-CMHC providers looking for center approval for insurance reimbursement status. By 1978 there was a group of insurers and private providers ready to assist the Department in writing standards for approval of these private centers based on the authority in Minn. Stat. 62A.152. In 1979, it was determined that this statute was insufficient legal authority for the Department to promulgate a rule with these standards. Legislation was introduced and passed in the 1980 session to provide this authority (Chapter 506, 1980; Minn. Stat. 245.69, Subd. 2).

A new committee was formed and staff hired to assist the Department in drafting the rule. Temporary Rule 29 was promulgated in April 1981. Fifty-one centers, including 34 of the 35 original community mental health centers were approved during its first six months. Special legislation extended the temporary rule through December, 1982. Currently, 75 centers are approved or expected to be approved under the temporary rule by December 31.

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12 MCAR §2.029

This section titles and states the purpose of the rules. Promulgation of these rules was mandated by Minn. Stat. 245.69, Subd. 2 to delineate the procedure and standards for approval. It is reasonable to assist the public in determining the relevance of and their interest in these rules.

12 MCAR §2.0291 Definitions

This section is designed to establish common usage of language, to clarify those words or phrases that may have several interpretations, or those that need exact definitions in order to be consistent with statutory language. Terms used in a manner consistent with current common usage and understanding in the mental health field are not defined unless the rule requires a specific procedure or standard for use of the term.

A. Scope. This section is necessary to clarify that definitions apply to this entire sequence of rules but only this sequence of rules.

B. Application. This definition is needed because Minn. Stat. 245.69, Subd. 2 refers to the processing of "application" but does not define application. The word is used throughout the rule, and is reasonable to clarify its use in the rule and statute.

C. Approval. This definition is needed because Minn. Stat. 245.69, Subd. 2 establishes that centers will be approved, but does not provide the meaning or procedure. Minn. Stat. 62A.152 included the option of approval or licensure of centers; the licensure option was rescinded in 1980 by Minn. Stat. 245.69, Subd. 2. Historically, approval has been used by the Department when there was some reason to review or recognize a program and the Department did not have the authority to license the program. Examples include programs located on federal property (Indian reservation, military base) and when a licensing rule did not exist (detox). Approval was generally seen as a courtesy review. Such review occurred at the program's request, usually to become eligible for funding or a grant. As approval and licensure were originally presented as options and as both provide for program review, it is reasonable to assume the procedures for these two would be similar, with an important difference. If a licensure procedure exists, a program must be licensed and maintain licensure to operate. Under an approval procedure, the approval grants some privilege or recognition, but approval is not required for a program to operate. The definition is necessary to clarify the privilege granted by approval: insurance reimbursement as a mental health center.

   The approval does not extend to individual staff. It is necessary to clarify this point in the definition because the statutory authority granted to the Commissioner is only for approval of mental health centers. Minn. Stat. 62A.152, Subd. 2 specifies those individuals who are mandated reimbursable. It is necessary to clarify the approval does not extend to Medical Assistance, because Medical Assistance is another form of third party reimbursement for mental health services and the

Department does determine the eligibility of a mental health center and individuals to claim this form of reimbursement. The authority to promulgate these rules was specifically for Minn. Stat. 62A.152, insurance reimbursement. Medical Assistance is regulated by a completely different set of state and federal statutes and regulations. The Department has an established vendor eligibility and enrollment procedure for the Medical Assistance Program in DPW Rule 47, administered by another division of the Department. It is reasonable to clarify the scope of approval, to ensure centers are aware of the limits on the privilege for which they are applying.

D. Case Review. Minn. Stat. 245.69, Subd. 2 and 12 MCAR §2.0293 F and 2.0294 D.2. require case review, but do not define the process. The definition is necessary to distinguish the term from the more general process of consultation and ensure the center understands the scope of the rule requirement for standards of case review. It is reasonable that the review will be of a client, since "case" is a synomyn for patient or client. It is reasonable, since review means critical evaluation, that all pertinent aspects of the case will be considered in the review. 12 MCAR §2.0293 F.1 requires case review standards as part of the treatment procedure. It is necessary that the definition be sufficiently specific to include the Department's minimum expectation for the review. Presenting problem, diagnoses and assessment, treatment plan and outcome are reasonable areas of review, all required as part of the client record and treatment standards in 12 MCAR §2.0293 and together represent what is being treated, how it is treated, and the result. Judgments regarding appropriateness and recommendations are reasonable as an expression of the value of another's professional expertise and handling of the case, fitting with the critical nature of review.

E. Center. This definition is necessary to ensure potential applicants know who can or should apply. Minn. Stat. 245.69, Subd. 2 permits both public and private centers to be approved. The center is required by Minn. Stat. 245.69, Subd. 2 to have a multidisciplinary staff, and mental health disciplines are a mix of the health disciplines (physician, nursing) and human service disciplines (social work). Thus, it is reasonable to define center as a health and human service facility. Since the centers are approved for reimbursement pursuant to Minn. Stat. 62A.152 and this statute mandates insurance benefits for the treatment of mental illness, it is reasonable that the applicant provide services to treat mentally ill persons. The definition is also necessary to explain the abbreviation and to shorten the rules by decreasing the number of words used to refer to an entity which is frequently mentioned in the rules.

F. Client. This definition is necessary to clarify that the requirements of the rule apply to the center's treatment to all clients, not just insured clients. The term "accepted" implies the intake procedure was carried out (12 MCAR §2.0293 B.1) and client need for services and the center's appropriateness as an assessment and treatment facility was determined; thus this term excludes persons who come to the center for information, are initially referred elsewhere, or receive services other than clinical services in the treatment of mental illness. This is necessary and reasonable as the scope of the rule and the review does not extend beyond the center as a provider of clinical services in the treatment of mental illness.

The objection has been raised that the rule was to establish standards for insured clients only. The authority granted to the Commissioner is the authority to approve centers for purposes of Minn. Stat. 62A.152; this authority is not limited to approval of procedures to treat insured clients. Clients cannot be reliably differentiated into insured and non-insured. The mandated coverage is for a certain amount annually. The insured client may become uninsured in mid-treatment when coverage runs out, and become reinsured when the policy year for benefits starts again. Different policies have different levels of benefits, and so the center cannot be certain that the treatment will be covered. Change in employment or union contract can change benefits. Minn. Stat. 245.69, Subd. 2 also stipulates several conditions, which must be met for clients regardless of insured status. Hospital access is mandated by Minn. Stat. 245.69, Subd. 2(b), to be available to all clients. Private data on individuals collected by the center is part of the welfare system, irrespective of the client's insurance status (Minn. Stat. 245.69, Subd. 2(f)). Thus, it seems reasonable that the statute intended that the treatment and quality assurance standards be adhered to for all clients. Minn. Stat. 245,69, Subd. 2(b) outlines treatment standards for services "reimbursable through insurance or public assistance". As these rules and statutes do not authorize or in anyway apply to Medical Assistance, General Assistance, or state/county co-pay for services, it is reasonable for the Department to interpret the intent of the "public assistance" term to be the prevention of discrimination based on ability to pay for the service, and thus requiring the same standards of care for all clients.

The center, by Minn. Stat. Subd. 2(d), is to "establish mechanisms for quality assurance... as required by rule." It is reasonable that the Commissioner require by rule that the center establish treatment standards and procedures, and that these be applied to all clients as a quality assurance mechanism. If procedures only apply to certain clients, or certain clients at certain points in the treatment process, compliance by center staff may become lax, as it is sporadic rather than ongoing. Documentation of compliance with the rule may be more difficult, as the center would not only have to document that procedures were followed for all insured clients while they were insured, but also that in the cases where procedures were not followed, clients were not insured.

When the Department approves the center, it maintains its "approval" by the Department whether or not the clients seen by the center are insurance reimbursable under Minn. Stat. 62A.152. Centers, rightly or wrongly, view their approval as an accreditation or status symbol. Their approval is noted on stationary and in brochures; it may be required as a condition for a referral, county contract or vendor status under Medical Assistance. It is reasonable to expect that, if approval is to be interpreted in this manner by the centers and the public, all clients receive treatment in line with the approved procedures.

G. Clinical Services. This definition is necessary, in conjunction with the definition of mental illness, to clarify the use of the term in defining a center and to determine compliance with staffing standards. In order to identify the parameters of the program to be reviewed, some

definition of the service must be provided. Staffing standards are based on percentages of time spent in clinical services. Quality assurance and treatment standards (supervision, case review) are ancillary to the direct treatment provided to the client, but make available to the client the multidisciplinary support and expertise necessary to differentiate the services of the center from those of an individual provider. These standards are required by statute and rule as necessary to ensure a consistent quality of care and thus it is reasonable to clarify these are considered clinical services for purposes of staff time. Other common services that are not clinical services but may involve staff time include administrative duties, and those additional services listed in 12 MCAR §2.0292 A. This definition was adapted from the National Institute of Mental Health recommended definition for clinically oriented services.[8]

H. Commissioner. The Commissioner of Public Welfare is designated in Minn. Stat. 245.69, Subd. 2 as having certain authority and responsibilities in carrying out these rules. The definition is necessary to clarify that the term is an abbreviation, reasonable in deleting unnecessary words in a reference frequently repeated in the rule. Since it would be physically impossible for the Commissioner to personally carry out all the statutory duties assigned to the position, it is necessary and reasonable to permit these duties to be carried out by another under the Commissioner's authorization. Minn. Stat. 245.69, Subd. 2 specifically allows this designation including contracting with another Department or outside agency, except for the final decision of approval.

I. Competent. This definition is necessary as the rules 12 MCAR §§2.0293 B.2 and 2.0294 D.1., require centers to determine individual staff clinical competence and assign clients and treatment responsibility in line with these determinations. It is a reasonable definition given that much of mental health treatment involves extended periods of staff-client contact without other persons present, and treatment depends on staff ability to recognize, interpret and respond appropriately and usually immediately to client behavior, statements and characteristics. This definition is similar to 7 MCAR §10.001 C.

J. Consultation. This definition is necessary to clarify that use of the term in Minn. Stat. 245.69, Subd. 2 (b) and (c) and 12 MCAR §2.0293 F. refers to case consultation (client-specific) rather than program consultation (advice on the development or improvement of a particular program or service). This distinction is consistent with Minn. Stat. 245.69, Subd. 2(f) specifically classifying the minutes of consultation sessions as private data on individuals under the Data Practices Act and thus "...data in which any individual is or can be identified as the subject of that data..." and "is not public; and (b) accessible to the individual subject of that data." (Minn. Stat. §15.162, Subd. 3 and Subd. 5a). This definition is reasonable as the distinction between case and program consultation already exists in most centers.

K. Deferral. This definition is necessary as an explanation of the status given to some applications, the status in between approval (C) and disapproval (M). It is reasonable in that the Commissioner cannot approve a center which is not in compliance, but does provide a second

chance without the costs of a second fee and the time delay (applications are generally reviewed in the order received to meet time deadlines, and disapproved centers have a 90 day wait before an application can be re-submitted; 12 MCAR §2.0296 A.5 and B.1). Conditions of deferral are listed in 12 MCAR §2.0296 C. This status is used in lieu of a "provisional" approval or permitting the operation of the center as approved but under certain restrictions and with the understanding that noncompliance will be corrected within a certain time period. (Provisional licensure of programs is common practice, permitted by Minn. Stat. 245.782, Subd. 12). This is necessary since Minn. Stat. 245.69, Subd. 2(e) does not permit approval of a center in noncompliance with the rule and statute, and reasonable since approval is not necessary for a center to operate.

L. Department. The Department of Public Welfare is designated in Minn. Stat. 245.69, Subd. 2, through references to the "commissioner of public welfare', as having certain responsibilities in carrying out these rules. The term is used in rule to identify general information or a resource for those sections addressing Department duties which are not the actual review and decision. The term is an abbreviation, reasonable in deleting unnecessary words.

M. Disapproval. This term is used in Minn. Stat. 245.69, Subd. 2, which provides the commissioner the authority to make a decision of approval or disapproval. Section (e) of this statute mandates a decision of disapproval if findings of the review indicate noncompliance with the requirements of the rules and statute. The definition is reasonable in that noncompliance is the only reason for disapproval.

N. Discipline. Minn. Stat. 245.69 requires a multidisciplinary team of professional staff; this definition is needed to define what is meant by discipline so the staff of "multiple disciplines" can be understood. It is reasonable in that the major accepted mental health disciplines are listed,[9] but it does not limit recognition to these four. Section R relates the qualifications for these accepted disciplines and allied fields category; discipline ratios are used as staffing standards in 12 MCAR §2.0295.

O. Documentation. The term is used throughout the rules. The definition is necessary to emphasize to centers that observable documentation is required and that a written procedure or statement that something will happen is sufficient only in 12 MCAR §2.0296 B.2. This is reasonable in that the commissioner is responsible for determining compliance with the rules, and acceptance of nonobservable documentation is a questionable if not poor review practice. It is reasonable in that it does not require a specific modality of record storage.

P. Individual Treatment Plan. The definition is necessary to define the use of the term in rule. Minn. Stat. 245.69, Subd. 2(b) requires a written treatment plan for each client, and that this plan include treatment goals and strategy. 12 MCAR §2.0293 D. specifies the planning process. Complex cases may have more than one therapist, and a client may be the responsibility of a professional while being seen by a practitioner who writes the case notes, so it is reasonable that

the responsible staff be noted in the plan. Minn. Stat. 245.69, Subd. 2(b) also requires that the plan include the client history and statement of diagnosis; 12 MCAR §2.0293 C and E requires that this information be obtained and a part of each client record, but the rules do not require that it be part of the plan. The statute uses the term "plan" in a general sense that seems to be equivalent to the rule term "client record". The term "plan" in Minnesota (see 12 MCAR §2.036 A.1) and nationally[10] is generally interpreted as being the goals but not history - and based on the background data of history and disgnosis. It was seen as necessary and reasonable to maintain consistent definitions of terms within the Department, and definitions consistent with their use in the professional community, provided the intent of the statute was met. By requiring this data be collected and maintained according to the same privacy and security standards as the treatment plan (in client record), and requiring the plan be developed "on the basis of assessment results" (2.0293 C defines assessment as history and diagnosis), the intent of legislation appears to be met.

Q. Mental Health Practitioner. This definition is necessary to clarify its use in the rule as one category or level of staff and the qualifications for this level. The rule has two levels of staff, professional and practitioner.[8] It is necessary and reasonable that there be some minimal training requirements for staff providing clinical services as a quality assurance mechanism, to ensure there is mastery of various technical skills and methods of treatment in mental health. There is sufficient documentation of the effectiveness of nonprofessional staff in provision of certain mental illness clinical services to warrant their inclusion as optional staff.[4,11]

1. As a minimum standard, a bachelor's degree in behavioral sciences is reasonable in that it will be the first academic exposure of the person to relevant vocabulary and theories of human action and emotion. Generally, the first two years of undergraduate classes are introductory or survey coursework in many fields (English, Chemistry, History, Psychology), with junior and senior coursework providing a more indepth study in one's major field (abnormal, social, developmental and experimental psychology, statistics). Since the undergraduate coursework does not train in application of this knowledge, the 2000 hours or year's supervised experience is a reasonable and necessary component of the staffing qualification. Supervision is necessary for training and guidance during this period. One year is a reasonable minimum to learn some very basic counseling and therapy skills, how to relate to clients and to apply knowledge acquired in school.

2. The 6000 hours or three years full-time experience, no education requirement, is necessary and reasonable because of Equal Employment Opportunity statutory requirements, and because the experience can provide on-the-job training or an apprentice situation, where it is reasonable the person will gain theoretical information and clinical techniques through supervision, watching others and doing. Three years is a reasonable period of time to learn the basics of a field and gain a minimal level of skill through practice when there was no prior skill or knowledge, in comparison to the professional's requirement of two years experience after graduate school and learning the basics.

3. Practicums and internships are an important part of many graduate school clinical programs, providing an opportunity to apply the recently acquired clinical knowledge in a real life setting under close supervision. These training periods occur after extensive graduate coursework and are required prior to conferring the degree. It is necessary that these students continue to have access to outpatient centers to ensure that mental health professionals of the future are educated in providing outpatient, non-hospital based services in concert and consultation with other disciplines.

   These students are completing a fairly extensive clinical education (generally 2-5 years of graduage schools), but do not necessarily have a degree or experience that would indicate their mastery of the field and application of skills; therefore, it is reasonable to consider them practitioners.

4. Recent graduates with a master's degree have an extensive clinical education and training, but little or no experience in applying this information on a day to day basis. The distinction between this category and the professional is the lack of two years post master's experience; this distinction is reasonable in that it is used by many professional associations and boards as a standard prerequisite for membership or accreditation at a professional level. It is also reasonable that this person will move up to the professional level when the experience requirement is met. This provision also ensures persons without experience have the opportunity to gain experience.

R. Mental health professional. This definition is necessary to clarify its use in the rule as one category or level of staff. The rule has two levels of staff, professional and practitioner. Minn. Stat. 245.69, Subd. 2 permits the center to employ mental health professionals and other health care providers; this section outlines who is considered a professional. This section is also necessary to clarify how the disciplines are differentiated within the rule.

   A master's degree and two years post degree supervised experience is the standard for this level. This is a necessary and reasonable standard as specific clinical education and training in treatment of mental illness is not provided until graduate school; the master's degree is the lowest graduate level degree offered; supervised experience provides the setting to ensure correct transfer and application of training; and because the standard for most mental health professional associations accreditation or acceptance as a professional is two years of post-graduate supervised clinical experience. The term "equivalent" is necessary under the Equal Employment Opportunity guidelines when specifying educational requirements to prevent discrimination. An "accredited" college is necessary to ensure the standard of educational training met by the school. It is reasonable that the accrediting body and school be listed in "Accredited Institutions of Postsecondary Education, Programs, Candidates", published for the Council on Postsecondary Accreditation by the American Council of Education,

Sherry S. Harris, Editor, for the year the degree was received, the standards employed by the Minnesota Department of Education to determine their acceptance of the accrediation of a particular school. This is necessary to prevent substandard or unknown criteria for determining accreditation.

The mental health professionals by major accepted disciplines are:

1. Nurses are licensed and registered as competent in providing physical health nursing services. The two year and four year education programs are training in general nursing; specialization in psychiatric nursing is provided at the masters level.[9]

2. The master's degree in social work (MSW) is considered necessary for professional status as a clinical social worker by the discipline.[13,14,15] It is possible to acquire a non-clinical MSW degree in the development and administration of social programs; since this degree does not indicate any knowledge of clinical skills in the treatment of mental illness; it is necessarily an inadequate credential for a professional in this discipline.

3. Only persons licensed under Minn. Stat. 148 may practice psychology. The masters degree and two years supervised experience are minimal requirements for licensure under 7 MCAR §§10.001 - 10.008.

4. Psychiatry does not meet the norm for this definition, in that physicians rarely receive masters degrees. Qualifications for eligibility for the certification examin psychiatry are licensure as a physician and a three year residency in psychiatry.[17] The Minnesota Medical Association agreed that eligibility for certification in psychiatry was the professional standard for psychiatrist.

5. Allied includes all other health care providers in the areas of mental health. Physicians other than psychiatrists are included in this section, because their license authorizes the practice of medicine, seen as inclusive of at least some of the area of mental health, but they do not have extensive training in the area of psychiatry or mental health. The master's in behavioral science is reasonable to ensure some relevant specialty in human services. To ensure the degree is strong enough to be given professional status in the area of clinical services, it is necessary to require some work be in the theory and practice of clinical services. Twenty-eight semester hours is reasonable, since 30 semester hours is generally the minimum for a masters program, and clinical graduate coursework equivalent to a master's degree is seen as necessary for this level of staff.

S. Mental Illness. This term is used to clarify the scope of clinical services in approving a center under these rules. "Mental or nervous disorder" is the term used in Minn. Stat. 62A.152. This term is used at the federal level to mean mental illness, chemical dependency and mental retardation. It is used in state statutes and rule to mean both 1) the combination of chemical dependency, mental illness, and mental

retardation, and 2) just mental illness. A review of Minnesota Laws reveals two statutes providing insurance for outpatient services which fit under the broader definition, Minn. Stat. 62A.152 and 62A.149. Minn. Stat. 62A.149 mandates insurance reimbursement for the treatment of chemical dependency, alcoholism and drug addiction under certain circumstances, including the requirement that services be provided in licensed or approved treatment programs. The Department requires that outpatient treatment of chemical dependency services be provided in facilities licensed under Rule 43. In light of the separate insurance statute for chemical dependency and requirement that chemical dependency services be provided in programs licensed under Rule 43, it is reasonable for the Department to determine that the Minn. Stat. 62A.152 appears to focus on mental illness alone.

The Commissioner's duty under Minn. Stat. 245.69, Subd. 2 is to review centers as to their treatment of the mentally ill. This definition is an interpretation of the scope of the Department's authority and responsibility in promulgating these rules, and is not determinative in establishing what services are reimbursable under Minn. Stat. 62A.152. It is necessary then to provide a definition that limits the scope to mental illness. It is reasonable to require that there be some level of dysfunction or impairment to indicate a need for treatment. Minn. Stat. 245.69, Subd. 2(b) requires a statement of diagnosis to be part of the clinical record. Since centers are approved to obtain reimbursement for the diagnosis and treatment of mental illness, it is implied that this be a diagnosis of mental illness. The two major diagnostic systems are listed in the rule. ICD-9 was developed by the World Health Organization and is used internationally to diagnose medical illnesses and abnormalities. A statement of diagnosis written in this coding system is currently required by the federal Health Care Financing Administration and most insurers as a prerequisite for determining the reimbursable nature of the condition and service submitted on claims for third party pay. The DSM-III is more recently developed specifically for mental and nervous disorders and adopted by the American Psychiatric Association as their diagnositic coding system. The numberical codes of the two systems are very similar. Utilization of these diagnostic systems is reasonable since they are accepted nationally and internationally by both professionals and third party payors as the standard for a statement of diagnosis. There are no other widely used or accepted systems.

The only codes omitted from these systems listed as mental or nervous disorders are the codes for chemical abuse and dependency without psychosis, and mental retardation. DPW Rule 185 sets out standards for services to mentally retarded persons and gives the county the responsibility to establish services which meet these standards; it is not reasonable to include review of services for these persons under 12 MCAR §§2.0290 - 2.0298 when the responsibility has already been established as belonging to the county. This definition of mental illness is similar to 12 MCAR §2.036 A.19.

T. Multidisciplinary staff. This term is similar to the term used in statute, multidisciplinary team, and is used throughout the rule. The definition is necessary so readers will know its meaning in rule. It

is reasonable as a substitute for the longer "all mental health professionals and mental health practitioners", to increase the readability of the rule. The terms multidisciplinary team and multidisciplinary staff are used interchangeably in DPW Rule 28 to refer to clinical staff.

U. Treatment Strategy. Minn. Stat. 245.69, Subd. 2(b) requires that the treatment plan include the treatment strategy. It is necessary to clarify the use of this term in statute and rule so that readers will understand the meaning. This information is necessary and reasonable to record the planned means of obtaining the planned goals so adherence to the individual treatment plan may be determined. Review of the plan and treatment provided is required for peer review and for case review of clients receiving clinical services from a mental health practitioner (12 MCAR §2.0294 B and D.2).

A. Organizational Structure. Minn. Stat. 245.69 Subd. 2 authorizes the Commissioner to promulgate rules for the approval of mental health centers. This section is necessary to further clarify what characteristics are required of an applicant center.

1. It is necessary that the center be a legal entity, to establish that the center does exist and will continue to exist until legal action is taken to dissolve it. This is reasonable, since the approval is for a center and not for a group of individual multidisciplinary professionals practicing privately (12 MCAR § 2.0291 B).[16] The rule is flexible, providing several options for the type of legal entity the center may be. Examples of units within a larger facility that may apply for approval include a mental health unit within a social services department, a mental health clinic within a physical health general practice clinic, an employees mental health clinic within a large business corporation, and a mental illness treatment unit within a comprehensive community mental health center.

   It is necessary and reasonable to clearly determine the parameters of a center applying for approval, so the Department can determine what it is reviewing and the center and insurance companies will know what is approved. It is also necessary, to ensure operation as a center and not individual private practice, that business be conducted as a center -- the center rather than individual staff would lease the offices, bill insurers and clients, collect fees and employ staff. This is reasonable, assuming the practice is a center, in order to reduce the possibility of fraud, misrepresentation, or client confusion as to who is the provider and responsible party. A possible exception is Medical Assistance, which is not always available to the center as a center, but may be to an individual. To prevent discrimination against MA clients, individual enrolled providers may bill for these services.

2. It is necessary and reasonable to require that the center's purpose be the diagnosis and treatment of mental illness (12 MCAR § 2.0291 R), to ensure appropriate application of the rules (approval pursuant to Minn. Stat. 62A.152) and delineation of the center from the rest of the facility. The rule standards were developed for provision of clinical services in the treatment of mental illness; any other use of the standards may be inappropriate If other units within the facility provide outpatient mental health services, it will not be possible for the third party payor to distinguish between claims from the approved unit and the non-approved unit. This section is necessary to clarify the limits of the review and thus the approved center, and that these are not necessarily the limits of the organization. It is reasonable to allow flexibility in the provision of additional services in order to meet the needs of the community and the organization.

3. It is necessary to require a governing body to identify who has the authority to make decisions for the center and with whom the reviewer is to communicate in determining compliance. The

rule is reasonable, in that the center is free to determine which person or persons will form the governing body. Examples of possible governing bodies are the corporate Board of Directors, the clinical director, and the entire center staff. It is necessary to require documentation of this authority, to ensure it is recognized by the center. The responsibilities of this body required by rule are reasonable, relating to implementation and compliance with rule standards. This is necessary to ensure the ongoing compliance with the rule, once initial approval is granted by the Department. Certain written policies and procedures are required in 12 MCAR § 2.093 - 2.0295, and adherence to these procedures documents ongoing compliance with the rule.

4. This section is necessary for the reviewer to determine the center's organizational structure for verification of compliance with the rule. It establishes that a center within a larger facility is administratively and clinically separate (12 MCAR §2.0292 A.1); establishes the governing body's responsibilities for the center (A.3); establishes the existence of additional sevices and thus the parameters for review (A.2); identifies center purpose through staff responsibilities (A.2); establishes how staff interact to provide services in a multidisciplinary manner (2.0293A); establishes how staff interact to meet supervision requirements (2.0294D). The section is reasonable as this information is not necessarily in the required policy and procedures and may not be readily apparent during the site visit, but is information about the center that is well known to the center and will document compliance with the rule.

B. Secondary location. This section is necessary to clarify the extension of the privilege of an approval to satelite offices, to distinguish between a satellite and affiliate or the individual private practice of staff, and to establish standards for the satellite office.[16]

1. It is necessary and reasonable for the Department to be informed of all locations, for purposes of conducting the site visits, establishing the parameters of the center, and determining when satellites occur. It is necessary that at least the main office location operate completely in compliance with the rules, particularly the staffing requirements, to ensure the center operates as a center and not as a series of offices of individual practitioners. This is reasonable, in that the rule does not require each satellite office to meet all of the staffing requirements of 12 MCAR 2.0295. It is necessary and reasonable that the center, defined here to include the main office and each satellite office, meet the staffing standards as compliance with the rules and statute is required by statute for approval of a center. Since providers must maintain personnel and client records (2.0293E, 2.0295C) this standard requiring records be stored at main office is verification the satellite sees itself as part of the center. It is reasonable that administration of a program would be centralized at the point where most staff worked and records were maintained.

1a. This section is a restatement of A.1, necessary and reasonable to clarify and to ensure that the satellite is, legally, part of the corporation or agency and not a separate individual or center desiring approval without meeting the rule standards.

1b. This provision is necessary because policy and procedures set by the governing body are the documents which specify the expected and required behaviors for staff in various situations, and are reviewed by the Department to determine compliance with the rules and statutes. If the same procedures are not used, compliance with the rules has not been determined.

1c. This section is necessary to determine this governing body can speak for the satellite and is responsible for its operation and services, and that the satellite does not operate independently. This is reasonable since otherwise the Department hs not assurance or agreement the satellite will maintain compliance.

1d. This section is necessary to ensure records are available at the main center for quality assurance procedures, for secure storage, and for review during a site visit. It is reasonable for a single center to consolidate records for central accessability, administration and protection of records which are private data on individuals. It is reasonable to permit client records to be maintained at the satellite while the client continues in treatment at that site, prior to termination, if it is more convenient for center staff and the privacy of the record can be ensured.

1e. This section is necessary to ensure that no mental health practitioner would staff a satellite office without a professional present, recognizing the differences in education and training (12 MCAR § 2.0291 P-Q) and that the practitioner works only under the supervision of a professional. The rule is reasonable in that the only requirement for the professional staffing is competence to supervise and intervene in the services provided, which is necessary and reasonable to ensure quality of the clinical services.

1f. This section is necessary, as Minn. Stat. 245.69 Subd. 2(b) requires ongoing consultation and availability of all staff members, and Minn. Stat. 245.69 Subd. 2(d) (2) and (3) require peer review and supervision procedures. The staff interaction is necessary to ensure the satellite does not operate as a separate center, and because the satellite is not required to meet the staffing standards of 12 MCAR § 2.295. It is reasonable in that no specific procedures for interaction and access are required by rule but are devised by center.

1g. This section is necessary to ensure each client has the full benefit of receiving services from the approved center, not just those found at the satellite office. This is reasonable, in that only access to center services and staff is required, not that each clinical service be offered and that each mental health discipline be on staff at each satellite office.

2. This section is necessary to clarify the status of a secondary location when the requirements for a satellite office are not met. This section repeats 12 MCAR 2.0292 A.2., a non-approved site could not provide clinical services in treatment of mental illness. This is a necessary and reasonable requirement to limit the possibility of misrepresentation of services to clients or third party payors.

A. Multidiciplinary Approach. This section is necessary to emphasize and clarify how the center will document compliance with Mi~n. Stat. 245.69, Subd. 3(b), the ongoing consultation and availability of all members of the multidisciplinary team. Documentation is required to ensure compliance can be determined during the review. The requirement is reasonable as this will already be recorded in client record (what services are needed and who will provide, consultation and supervision notes) and consultation minutes.

B. Intake and Case Assignment.

1. The intake section is necessary to clarify when the person becomes or is accepted as a client (12 MCAR §2.0291 F.) of the center. The provision is reasonable as the decision to accept a person for evaluation or treatment is necessarily an initial step in establishing the client-therapist relationship. This provision stipulates the Department's standards for this procedure. These standards are necessary to ensure the client is offered appropriate services. The standards are reasonable in that the center has identified itself and its staff competent (12 MCAR 2.0294 D.1.) and actually providing certain services, (12 MCAR 2.0292 A.) and is to facilitate referrals when the center cannot meet client needs (12 MCAR §2.0293 G).

2. The case assignment section is necessary to establish responsibility of staff member(s) for the care and services provided to a client. 12 MCAR 2.0294 D.1 requires that each staff member's competence areas be determined and the supervision or guidance needed to provide clinical services be provided. To the extent the individual is not competent to provide the clinical services needed by the client, it is necessary that the staff member not be given treatment responsibility for that client. It is necessary and reasonable that responsibility for treatment decisions remain with those who are determined to be competent to make such decisions. In the situation of the mental health practitioner, defined in 12 MCAR §2.0291 Q. as an individual lacking either experience or education in the treatment of mental illness, it is reasonable that the treatment decisions and responsibility remain with the professional supervisor.

C. Assessment and Diagnostic Process. The statutory authority for this section is Minn. Stat. 245.69, Subd. 2(b), requiring a client history and statement of diagnosis. This section sets the standards for what will be accepted as history and diagnosis by the Department. The standard established for history is multidisciplinary data on past and current condition. Minn. Stat. 245.69 (a) and (b) mandate multidisciplinary staffing who consult on treatment plans and ongoing client care, and 12 MCAR §2.0291 P. requires the individual treatment plan be based on the assessment or history of the client. To adequately assess and plan for mental health treatment provided by and involving the multiple disciplines, it is necessary that the history be as broad as the approaches and training of the center staff. This provision is

reasonable as the standard is consideration of this range of client data, and does not require a complete evaluation on every client. The term history is clarified to mean both past and current history; this is necessary since treatment will address the current condition and use past history for confirmation of disorder and prognosis. This is reasonable since the diagnostic coding systems rely on both current and past symptoms and client characteristics. As noted in 12 MCAR §2.0291, the ICD-9 and DSM II diagnostic coding systems are the accepted standards for a statement of diagnosis in the mental health field, and thus it is reasonable to assume that this was the intent of the legislature in requiring the diagnostic statement.

The ICD-9 coding system is a medical coding system, including psychiatry. The DSM-III was developed as the standard for the American Psychiatric Association. Diagnosis has historically been the exclusive domain of the physician, within the practice of medicine. As the mental health field developed, other professional disciplines were established and defined as encompassing a certain range of assessment and diagnostic skills. In Minnesota, the licensure of psychologists in 1973 under Minn. Stat. 148.88 - 148.99 established the practice of psychology as inclusive of "psychological assessment". The nature of this assessment was clarified for licensed consulting psychologists in 1975 with the passage of Minn. Stat. 62A.152, providing coverage for "mental or nervous disorder consultation, diagnosis and treatment services...if such services are furnished by...a consulting psychologist licensed under the provisions of sections 146.87 - 148.99." The interpretation of psychological assessment as somewhat synonomous with diagnosis was further clarified in correspondence from the Board of Psychology[18] when the licensing process at both levels was deemed to require competence in the diagnosis of mental or nervous disorders. The psychologists have not developed a separate diagnostic coding system, but use ICD-9 adn DSM-III systems.

The licensed registered nurse is licensed by Minn. Stat. 148.171 - 148.285 to practice professional nursing, inclusive of a "nursing assessment of the actual or potential health needs of individuals, families and communities." This definition and the developing national Classification of Nursing Diagnosis clearly differentiate between the medical diagnosis and nursing assessment,[12] with the assessment identifying health problems related to health care or secondary to a medical illness and identifying an appropriate referral. These assessments identify characteristics or symptoms which are necessary but not sufficient for a medical diagnosis.

Other mental health workers are not specifically recognzied in Minnesota as health and human service occupations. The Department of Health has the authority to determine the need for such recognition and regulation, granted by Minn. Stat. 214.13 including a determinatio of "the scope and range of practice for the registered occupation and the degree of supervision required". It is thus necessary that the Department of Public Welfare not define the practice or scope of any unregulated occupation as it relates to diagnosis, as this would directly infringe upon the authority and responsibility of the Department of Health.

As the purpose of these rules is approval of the center for purposes of insurance reimbursement for the diagnosis and treatment of mental illness, as the reimbursement is directly dependent upon the diagnosis of mental illness, and as there were assurance to the legislature that these rules would not be de facto licensing process, it is necessary to restrict the practice of diagnosis to those professions whose scope of practice as defined by the Minnesota Department of Health includes diagnosis. The provision is reasonable in establishment of the supervision clause, recognizing the role and competence of other disciplines in assessment of the client.

Comments received have argued that this provision restricts the practice of clinical social work. The Department of Health is responsible for defining the scope of human service occupations in Minnesota (Minn. Stat. 214.13) and has determined the social work field should be regulated.[19] This process is not yet complete. The Department of Health indicated support for the Temporary Rule particularly in regard to the handling of unregulated mental health workers.[20] Comments also argue that these rules restrict the client's freedom of choice of provider; these rules in actuality expand the number of setting, far beyond the original community mental health centers and hospitals, where a client may select a clinical social worker as a provider and know the treatment is eligible for the mandated reimbursement. A third argument is that this provision requires "unnecessary evaluation". The authorizing statute requires a statement of diagnosis, and this section requires consideration of a range of multidisciplinary data and assessment procedures as a basis for that diagnosis. The actual diagnostic procedures to achieve this are up to the individual center. "Diagnosis by or under the Supervision" is the standard, not a duplication of services.

There are also comments that this section discriminates against the licensed psychologist by making a distinction between the role of the licensed consulting psychologist and licensed psychologist. The standard recognizes that the licensed psychologist is competent to diagnose and engage in the independent private practice psychology.[18,21] The standard also recognizes the legislative distinction in Minn. Stat. 62A.152 between the two levels of psychologist licensure for purposes of reimbursement. This statute was amended in 1981 and reaffirmed this legislative distinction for reimbursement purposes is intentional. 7 MCAR § 10.001 - 10.008 defines the scope of individual private practice of psychology; 7 MCAR § 10.008 I. indicates that aiding or abetting an unlicensed person in the private practice of psychology is a breach of the rules of conduct. This is later clarified[22] to mean signing - off for reimbursement signing a claim that states in your judgment as a psychologist the diagnosis is accurate and service provided was necessary treatment when the psychologist did not provide the service. Since a licensed psychologist cannot function in this manner in private practice, the rule does not restrict the scope of practice. 7 MCAR § 10.004 A.2 and 10.008 I. do indicate that a psychologist licensed at either level may supervise a person seeking licensure; this is consistent with this section and 12 MCAR § 2.0294 D. - with the exception of the diagnosis. As the diagnosis is related to reimbursement and the

legislature has made the distinction between the two levels for purposes of reimbursement, it is necessary to maintain the licensed consulting psychologist (or psychiatrist) as the supervisor. This distinction is reasonable as the education and training differences between licensed consulting psychologists and licensed psychologists supports a marked difference in expertise.[23]

D. Treatment Planning. Minn. Stat. 245.69, Subd. 2(b) requires a treatment plan for each outpatient, and includes the history and diagnosis as part of the plan. As noted in 12 MCAR § 2.0291 P, the rules use the term plan in a narrower sense than the statute. The requirement that the plan be based on the diagnostic assessment ensures the legislative intent of connecting the goals to client condition is achieved. Statutory authority for client involvement, and sharing treatment information is Minn. Stat. 245.69, Subd. 2(b), plans shall be developed in accordance with the rules. This provision is reasonable as the client involvement improves the client's understanding and response to treatment.[10] It is necessary that services be appropriate as a quality assurance mechanism.

This is reasonable as centers are to make referrals when the necessary service is not available. It is reasonable to expect that the statutory intent of requiring individual treatment plans is that they will be followed. Mental health professionals in private practice are required by their rules of conduct and associations to act according to certain professional standards; it is reasonable to require these standards be adhered to within the center.

E. Client Record. This section is necessary to clarify the Department's standards for maintaining private information on a client necessary to document the client condition and the clinical services planned and provided to the client, as well as documentation that the center clinical procedures were followed by staff. The presenting problem and assessment data (client history), diagnosis and treatment plan are required by Minn. Stat. 245.69, Subd. 2(b). To document that the treatment plan was followed, it is necessary to state what services, including medication, were provided. Progress throughout the treatment process and at termination is necessary to determine the treatment plan remains appropriate. This is a reasonable provision as the center must be able to document to the third party payor that the service was provided in treatment of a mental illness. Most centers currently maintain records with this information.[24] These standards are similar to 12 MCAR 2.064 C.1.c.(2). This standard does not mandate use of any particular form or format, just the information. The Government Data Practices Act (Minn. Stat. 15.1611 - 15.1698) requires that only necessary and relevant private information be collected or maintained on an individual, and that the client's authorization to release private information be obtained in most situations. Minn. Stat. 245.69, Subd. 2(f) requries that private information be maintained in accordance with the Government Data Practices Act.

F. Consultation; Case Review. The section is mandated by Minn. Stat. §245.69, Subd. 2(c). Multidisciplinary staff are required to meet twice each month for case review, treatment planning and consultation. Minutes of these meetings are to be maintained at the center for three years. The Department set the time requirement (4 and 2 hours) as the

minimal standard for these meetings to ensure the consultation purpose could reasonably be achieved. These numbers were determined by examining the smallest clinic (two full-time and two part-time staff), assuming a minimum of four clients seen per day by a full-time staff, one per week by part-time staff for a total of 42 per week, and that these same 42 are seen each week so the total client population of the center is 42. Assuming the four hour minimum, this averages to just

under six minutes of time per month available to review each case. Six minutes is not an excessive amount of time to verbalize the client's history, discuss treatment goals and strategy, and review services provided to the client to date. Since approved centers tend to be larger and staff carry higher caseloads than this minimal example, and because the case load does not remain stable (clients start and end treatment, so the actual number of cases is higher); since there is no requirement that all cases be reviewed or that all center staff meet as one group to discuss cases (i.e., larger centers may divide staff into teams) the four hours were deemed to be a reasonable time. For part-time clinical staff with a smaller caseload, it is reasonable to set a lower minimal time standard.

G. Referral. Referral is a necessary treatment procedure to ensure continuity of care for clients when the center cannot or does not offer the needed service or has become an inappropriate provider. Statutory authority for this section is Minn. Stat. 245.69, Subd. 2(d), the Commissioner shall establish when there is a need for referral, referral becomes a part of the treatment plan. The client is to be involved in the development of the plan (12 MCAR § 2.0293 D). This provision is reasonable as it only applies to persons the center has accepted as clients. It does not mandate that the center find or develop the appropriate service, just assist the client in the process.

H. Emergency Service. Emergency services are necessary to ensure the client knows how to access and has access to services in a crisis situation exacerbated by their mental illness. Statutory authority for this section is Minn. Stat. 245.69, Subd. 2(d), the Commissioner shall establish mechanisms for quality assurance. This provision is reasonable since the center has accepted treatment responsibility for the client, and it does not require that the center itself provide the emergency service, just where and how they are available.

I. Access to Hospital. This section is necessary to clarify what is required by rule to show compliance with Minn. Stat. 245.69, Subd. 2(b). The statute requires that the center provide access as needed. It is necessary and reasonable to clarify the requirement is not general hospitalization, since the center is only required to offer treatment for mental illness, and is for psychiatric hospitalization, since the center's need for access relates to their treatment of the client for mental illness. Direct admitting privileges are generally limited to hospital staff; it is not necessary or reasonable to require that the center employ hospital staff.

A. Policies and Procedures. Minn. Stat. 245.69, Subd. 2(d) requires that quality assurance mechanisms be established and documentation of such submitted to the Commissioner. The statute and rules also require certain treatment standards be followed. Written procedures are partial documentation of these mechanisms and standards, necessary to ensure a common understanding of how standards will be maintained and services delivered, that the governing body has fulfilled its policy-making role required by 12 MCAR §2.2092 A.3., and that center staff have reasonable access to exactly what the center says it does and staff will do to comply with the rule and deliver treatment services. The requirement is reasonable as procedures manuals are the common format for informing staff of their rights, responsibilities, and expectation of how these responsibilities are to be carried out and their response to certain situations. The access requirement is reasonable in that it just requires availability, not a copy, to each staff person. The clear statement of procedure, noting what, who and how documented, is necessary to make compliance easy to determine by comparing written procedure with rule requirements and with actual performance (clients records, staff knowledge, reports, etc.). Since centers' fees pay all review expenses, it is reasonable to set documentation standards that can reviewed expediently. To the extent specific procedures prevent or resolve misunderstandings or disputes with staff, the center derives additional benefit.

B. Peer Review. Peer review is required by Minn. Stat. 245.69, Subd. 2(d)(2). This section is necessary to describe the purpose and minimal procedure accepted by the Department as compliance with this provision.[25,26,27] It is necessary that the review be multidisciplinary in order to further encourage staff consultation and establishment of common center perceptions and standards of treatment quality. Small clinics may only have one staff person in each of several disciplines and thus "peer" review in its usual sense of same discipline is impossible internally. The 5 percent or six cases is reasonable, small enough to allow time for indepth review while large enough to be reasonably representative of the work of a person. The randomness allows for an analysis of cases without the professional able to select the cases to be reviewed; this is a reasonable procedure to ensure all cases are equally likely to be treated and records maintained in accordance with procedures. The peer review reports document that the procedure was carried out. The mental health practitioners are not subject to mandated peer review because they have no cases (responsibility for the client is retained by the professional supervisor - 2.0293 B.2). These cases may be selected in reviewing the supervision professional. 12 MCAR §2.0294 D.2. clarifies the required supervision, including a bimonthly case review of 100% of practitioner treated clients. It is necessary and reasonable that review findings be discussed with the staff person and corrective action taken to ensure the quality assurance purpose of the mechanism is realized.

C. Internal utilization review. Utilization review is mandated by Minn. Stat. 245.69, Subd. 2(d) (2). This section is necessary to describe the purpose and minimal procedure accepted by the Department as compliance with this provision.[25,26,27] The history of utilization review is as a quality assurance and cost efficiency measure in hospitals, pulling client charts for review when they have overstayed the norm for their diagnosis or medical procedure. Hospital review is external, based on regional standards and with review teams from outside the agency.[28] This section of the statute mandates an internal review. Standards for utilization review of outpatient mental health programs are still developing and so there are no widely accepted utilization standards. The rule requirements are reasonable, broadening the hospital procedure to include a range of quality assurance and evaluation functions but maintaining the focus on services provided to a particular client condition. This section requires a review and interpretation of data but does not mandate specific data. The standard does specify three areas to be reviewed; this is necessary to provide the applicant-requested guidelines for what is the focus of this procedure and to ensure the purpose of utilization review is met. The requirement is reasonable in that a several year period to complete reviews in these areas is provided, and other areas may also be reviewed. This data could identify the long-term and drop-out clients, more effective versus less effective treatment strategies with a certain kind of client, prevalence of certain types of clients or delivered services, etc. This data would identify problems in the services delivered compared to good clinical practice and the match of staff skills with the needs of clients for services, thus achieving the purposes of reviewing quality and efficiency. These data review requirements would not conflict with any mandated reporting requirements and could be used as part of a needs assessment. Analysis could be done by hand in small centers or by computers. Analysis and application of findings is necessary to ensure the quality assurance purpose of the mechanism is achieved. Since the governing body is a policy-making body, it is reasonable that they review the findings since application may require policy or staffing change. A report is necessary to document the procedure was carried out.

D. Staff Supervision.

1. Supervision is mandated by Minn. Stat. 245.69, Subd. 2(d) (3). The section requires the center set up a procedure to determine supervision needs and then provide them. It is reasonable in that it allows flexibility with a center establishing a system which meets the needs of each professional without a set standard, but still requiring the accountability of making a determination of competence of each person to provide services at that center. It is necessary and reasonable given the center's liability for the actions of its staff and the center's determination of the services it will provide.

2. Practitioner staff, by definition lacking either education or experience in providing clinical services to mentally ill persons, are to be supervised as a necessary quality assurance measure. The approval of the treatment plan and case reviews ensures compliance with and documentation of 12 MCAR §2.0293 D. and B.2. The rule standard is reasonable, at approximately one hour per

week of supervision for the full-time practitioner, with allowances for sick time, vacation and emergencies. It is reasonable in that any professional the center designates competent may provide the supervision. The ratio is to clinical service hours, and the practitioner will probably see between 25 and 50 clients in the 40 hour time period. One hour of contact with a professional is a reasonable minimum for supervision of services to 25 clients assuming review of assessment data and treatment plan alternatives for two to three new clients, or questions on six to tehn other cases. This standard is similar to 7 MCAR § 10.001 I.

E. Continuing Education. Minn. Stat. 245.69, Subd. 2(d)(1) required continuing education. Some professions currently have standards as a licensing requirement (physician, nurses), others do not (psychologists). Usually the requirement is established in continuing education units (CEU's) with each hour of education equivalent to about 1/6 of a CEU, and the profession must have approved the education. It is necessary that the rule establish some standards for those without standards already set. The 36 clock hours over two years is a very reasonable minimum compared to 15 approved CEU's/year for nurses and 150 approved hours every three years for physicians. The requirement over two years provides time flexibility in achieving the requirement. The education is reasonable in that it is not limited to CEU's or university course work but includes workshops and inservices as well. Financial responsibility of this requirement is not set by rule, though it is the responsibility of the center to ensure that the education does occur; this is reasonable since the rule should not establish administrative procedures for center unless they are necessary to meet or document the requirements of statute.

F. Violation of standards.

1. This section is necessary to ensure that services are delivered in concert with the standards of good clinical practice and the procedures the center has established. This is a reasonable requirement since the center has alleged that the procedures required to comply with these rules are adhered to, and the center is legally liable for actions which occur on its premises or are performed by its staff. Professions that have accepted the privilege and responsibility of self-regulation have developed ethical standards that its membership is to adhere to in their practice to maintain their license; it is necessary and reasonable that the violation of these standards be reported to ensure the professions can carry out their responsibilities of self-regulation.[29] It is necessary and reasonable to require that centers respect and follow all state and federal statutes that pertain to their business. Negligence, not doing what should be done or doing what you do carelessly, is necessarily contrary to good clinical practice. It is reasonable to limit the requirement to "gross" negligence and "serious" violations, because minor violations are almost expected to happen on occassion and can be handled through the normal channels of supervision and consultation more efficiently than a mandated investigation. If a pattern of minor violations develops, it is necessary that this would become a "serious" violation, as a setting which tolerates ongoing minor abuses will foster carelessness in service delivery and disrespect of client rights.

Since approval is contingent on compliance with the rules, it is reasonable that alleged noncompliance be a serious violation. And it is reasonable to expect that services delivered to treat clients would not harm clients. The licensing statute, Minn. Stat. 245.801, Subd. 4, requires suspension of a license when the clients rights or safety are endangered. It is necessary and reasonable to require the report and investigation because the above are grounds for loss of individual license or approval of the center and legal action against the center. Once such behavior is substantiated, it is necessary and reasonable to expect the center to respond to prevent recurrence and make reparation. Minn. Stat. 245.69, Subd. 2(d) requires the establishment of quality assurance mechanisms and the documentation of these mechanisms. It is reasonable that this be considered a quality assurance mechanism and thus also be documented. It is necessary that reports come from both clients and staff as clients spend time alone with the therapist and will observe or experience situations staff will not, and staff are more knowledgeable of ethical codes and center procedures and thus more likely to recognize the significance of behavior. It is necessary that there be a check on this system, client or staff report to the Department, because the mechanism is internal and the tendency toward self-protection can be very strong. Also, center response to such behavior which is not timely, thorough and corrective is grounds for withdrawal of approval (12 MCAR §2.0297 D.2). It is reasonable in that reports would go to the Department only when not resolved by the center.

2. Approved centers, since they are not licensed or do not necessarily receive government funds, are not mandated reporters under Minn. Stat. §§626.556 and 626.557; however each multidisciplinary staff member of the center meets the definition of a mandated reporter and can be considered a care taker under these statutes. Licensed professionals and person who have worked in licensed facilities are generally aware of their responsibilities under these statutes; other multidisciplinary staff may or may not be aware. If there is a failure to report, the center may be found responsible because of their supervisory responsibilities. This section is necessary to ensure staff are aware of their responsibilities. It is necessary to require the center establish procedures since the rules apply to the center and not to individual staff. It is reasonable, because the minimal procedures are clearly established by statute and the probability of failure to report will be reduced if all staff are aware of these procedures.

G. Data Classification. This section is necessary to inform and clarify that Minn. Stat. 245.69, Subd 2(f) included all approved centers under the Government Data Practices Act. Except for these centers, the Act applies only to government agencies or government-funded agencies. The statute references only private welfare data so it is reasonable to assume the statutory requirements for public and confidential data do not apply unless the center is already a part of the welfare system. The Government Data Practices Act is frequently revised and the Department of Administration is authorized to promulgate rules on the statute, so it is reasonable that this rule not explain the requirements of the statute. The Commissioner will carry out his duty as the

responsible authority for all welfare data, through Departmental bulletins and the review process. Minn. Stat. 15.1691, Subd. 5 establishes client records as private data on individuals; Minn. Stat. 245.69, Subd. 2(f) specifically states the consultation minutes are private data on individuals. The statutory language "private data on individuals within the welfare system" is duplicated in rule, because these terms are defined in the Act and specific requirements are set out in statute and rule for handling data that meets these definitions. Use of any other terms may be confusing to the center by implying that something other than these definitions are intended.

This rule is necessary to list the standards for compliance with Minn. Stat. 245.69, Subd. 2, the employing or contracting with mental health professionals and other health care providers to provide a multidisciplinary team. There is little consensus within the mental health field as to what the ideal staffing of a center is, much less what the minimal standards should be. This rule draws heavily on the original approval mechanism for reimbursement pursuant to Minn. Stat. 62A.152, DPW Rule 28 Standards for Community Mental Health Centers, which was in effect from 1976, and from the earlier drafts of the bill which became Minn. Stat. 245.69, Subd. 2. Rule 28 was withdrawn as an approval mechanism in 1980 because the rule became seen as too narrowly defining the intended population of approved mental health centers and clinics (comprehensive programs receiving state grant in aid). Since Minn. Stat. 62A.152 did not specifically authorize the promulgation of a rule to establish standards for this reimbursement status, the Department added this approval privilege to its rule for center eligibility standards for grant-in-aid. Early drafts of the bill for Minn. Stat. 245.69, Subd. 2 established specific staffing patterns closely allied to those in DPW Rule 28. These were later withdrawn, to get "fewer specifics in the law" and give "the power to establish (staffing) specifics to the Department of Public Welfare".[16] The term "multidisciplinary team" was added to replace the specific staffing component. This term is used interchangeably with multidisciplinary staff in Rule 28 to refer to clinical staff, including the mandated:

> "The multidisciplinary professional mental health team is qualified by special mental health training and experience and shall include as a minimum the services of each of the following:
>
> 1) A licensed physician, who has completed an approved residency program in psychiatry;
> 2) A doctoral clinical, or counseling or health care psychologist who is licensed under Minn. Stat. 148.87 - 148.99;
>
> And one or both of the following:
>
> 3) A clinical social worker with a Masters Degree in Social Work from an accredited college or university;
>
> and/or
>
> 4) A clinical psychiatric nurse with a Master Degree from an accredited college or university and is registered under Minn. Stat. 148.171. (The Masters Degree shall be in Psychiatric Nursing or a related psychiatric nursing program such as Public Health with a mental health major, Maternal and child health with a mental health major.)
>
> The multidisciplinary team shall be sufficient in number to implement and operate the described program of the clinic. In addition to the above, this team should include other professionals, paraprofessionals and disciplines, particularly in the preventive and rehabilitative components of the program, subject to the review and approval of job descriptions and qualifications by the Commissioner."

A. Required staff. This section is necessary to establish the minimum staffing accepted by the Department as compliance with Minn. Stat. 245.69, Subd. 2, the employing or contracting with mental health professionals to provide a multidisciplinary team.

1. This requirement for four persons is necessary to ensure that a center is operating, rather than an individual in private practice. There must be enough staff to hold meetings and to represent the multiple disciplines. Four staff is a reasonable minimum to achieve this purpose, supported by an earlier statute draft requiring at least four professional staff[16] and the DPW Rule 28 standard which specified three staff and that "this team should include other professionals". It is necessary that the center be sufficiently established to be open for business on a consistent and regular basis to ensure continuity of care for clients, and so it is reasonable to require that some staff work 35 hours/week. To ensure continuity of knowledge and interpretation of procedures and what happens at the center, it is necessary that some staff be full-time, rather than a sequence entirely of part-time staff. This is consistent with the Rule 28 standard that the required three staff be full-time. The requirement that two clinical staff be on-site when the center is open is necessary as the minimum for a center rather than an individual provider to be operating and to ensure compliance with the statutory intent of staff interaction, ongoing availability and consultation. This provision is reasonable as a protective measure against possible harm to both client and therapist; the presence of a third party on-site may act as a deterent or interuption to illegal or unethical behavior.

   The requirement for two full-time staff of different disciplines is necessary and reasonable to ensure the center has a multidisciplinary staff for service delivery. Without this requirement, all disciplines except one could be represented on staff in a very limited amount. This would not protect against the legislative concern that the rules would by-pass the certification process and provide de facto licensing for purposes of reimbursement for those individuals the legislature has not chosen to provide mandatory reimbursement. The four disciplines listed are the most widely recognized and accepted mental health disciplines,[9] with the strongest training in the treatment of mental illness. If there are only two full-time staff, it is necessary that they be the well-trained and qualified staff. These staff are also listed as required professionals in the earlier statute drafts and are licensed or scheduled for certification by the Department of Health. This list excludes allied professionals and practitioners.

2. The psychiatrist is necessary to provide clinical medical treatment of the mentally ill, including the prescription of drugs, hospitalization and the practice of medicine.[30,31,32] Since centers are approved specifically for clinical services to treat mental illness rather than physical illness, it is necessary and reasonable that the physician have the specific training and experience to be certified or eligible for certification as a

psychiatrist. A psychologist is necessary to provide clinical psychological services, including administration and interpretation of psychological tests and the application of principles applying to learning, motivation, behavior, emotions and personality. The requirement of a licensed consulting psychologist rather than a licensed psychologist is reasonable since it is consistent with the standard for psychologist (doctoral) under Rule 28. Since the legislature has differentiated between the two levels of psychologist insurance reimbursement (Minn. Stat. 62A.152) and the legislature expressed concerns and were reassured that these rules would not circumvent their decision regarding certification or reimbursement, it is necessary that the rules differentiate between the licensed consulting psychologist and licensed psychologist to prevent a de facto mandated reimbursement of the licensed psychologist. This differentiation is reasonable as it requires a licensed consulting psychologist while allowing licensed psychologists, and does not infringe upon the scope of practice of the licensed psychologist as defined by legislation or the Board of Psychology. Earlier drafts of the authorizing legislation included the licensed consulting psychologist as a required staff member. The national standard for a psychologist is at the Ph.D. education level. These staff are necessary to represent two disciplines and thus begin the required "multi"-disciplinary staff. They are necessary to provide the diagnosis for the client, as licensed professionals their functions cannot be replaced by other nonlicensed staff.

3. Nurses and social workers are presented as options to ensure a third or "multi" - rather than "bi" - disciplinary staff. The social worker provides social work services, including psychosocial assessments, family counseling, and helping individuals or groups to obtain or provide services (case management services). The nurse provides nursing services, including administration of medication, physical assessments, observation of chemotherapy effects and gerontological services. It is reasonable to employ one or both at a mental health center. There are a very limited number of psychiatric nursing professionals in this state, and the requirement of a psychiatric nurse could unreasonably limit the number of mental health centers which could be formed. There is a perception within the mental health field that physicians and nurses are both of the "health" discipline, and that permitting both disciplines to the exclusion of clinical social work results in a staff with too strong an emphasis on medicine. Both DPW Rule 28 and the earlier statute drafts presented these two disciplines as an "and/or" provision. It is reasonable to continue this provision.

4. When a staff person is required, generally the intent is requiring that person as a full-time staff person. This was true of Rule 28. Since 12 MCAR §§ 2.0290 - 2.0298 centers do not necessarily have the catchment areas of 50,000-100,000 people and the responsibility to provide a comprehensive array of services to meet their mental health needs, it is reasonable to establish a lower

time standard for required staff. Since centers were anticipated to range from the minimal size permitted in A.1. to the comprehensive centers of 50+ clinical staff, it is reasonable to base the requirement on the size of the clinic. The Department determined that 5% of the clinical services provided by the center is minimal for these three positions. To ensure the ongoing availability and consultation of these staff required by Minn. Stat. 245.69, Subd. 2, the requirement of eight hours every two weeks was established. Eight hours every two weeks is 5% of the minimal center staffing two staff present for 35 hours and two staff present for an average of four hours each week.

This is the minimum necessary to meet the statutory requirements for ongoing consultation and availability of all multidisciplinary staff, and for attendance at the case review meetings, supervisory responsibilities, and seeing clients for diagnosis and treatment. This is also a reasonable bottom line to prevent only token involvement of the disciplines. The clinical or multidisciplinary staff of the Rule 28 community mental health centers were reviewed for F.Y. 1979, the latest available figures. Because staffing was not broken out by licensed consulting psychologist and licensed psychologist, or by experience and masters degree, it is not possible to interpret those data. Psychiatrists composed an average 4.3% of the comprehensive center staff in F.Y. 1979. Figures were adjusted for comparison with the noncomprehensive 12 MCAR §§ 2.0290 - 2.0298 programs, omitting chemical dependency, mental retardation and consultation and education staff which are not included in clinical services time. Psychiatric time was then 6% on the average, ranging from 0 to over 17%.[33] National figures have shown a decrease over the past decade in the percentage of time provided by psychiatrists in mental health centers been due to a staff increase in other disciplines. These percentages have not dropped so sharply as to preclude psychiatric involvement. There were an average of four full-time equivalent (FTEs) psychiatric positions to 7.7 FTE psychologist positions and 10.2 FTE clinical social work positions in 1978 in community mental health centers.[34] Assuming these centers keep hired practitioner staff, which would dilute the percentage of psychiatric time to other multidisciplinary staff, the 5% is a reasonable minimum. Other data indicate a minimum of 1.5 FTE psychiatric positions are needed for 100 clients/month.[35] Assuming the smallest clinic would have 42 clients (see need statement for 2.0293 F) and a number of these clients would have their private psychiatrist or not require psychiatric attention, the minimum psychiatric time of eight hours every two week or .10 - .15 FTE is very minimal.

Since the minimum standard in Rule 28 centers was one full-time person for each requirement, regardless of center size or services, it is reasonable that this provision continue. The eight hours every two weeks is reasonable alternative to requiring the services each week, to permit minimization of travel expenses for the staff person who lives a great distance from the center. To ensure consultation and availability, the person must be there at least once every two weeks. The requirement for 2 and 3 are each

met by one professional, necessary and reasonable to ensure continuity of care, availability, and development of good clinical and consultative relationships among staff. The person must be "on-site" to ensure they are really employed by the center for the minimum hours, as it is difficult if not impossible to provide high quality clinical services from a distance; to ensure that the center and staffing arrangement physically exist, that it is not just a "paper" clinic; to ensure that real consultation and supervision occur, rather than just listening to the person recount a situation over the phone or lunch.

B. Additional staff; staffing balance. It is necessary that the multidisciplinary nature of staffing be maintained as mandated by Minn. Stat. 245.69, Subd. 2. The Department has determined that a limit of 60% on any one discipline in the staff is necessary to ensure it is multidisciplinary. This percentage is reasonable in that it permits a center to specialize in one discipline, to the extent that over half of its clinical services are provided by those staff, while at the same time not permitting so strong a specialization that the center becomes a single discipline clinic with only the token involvement of staff trained in other disciplines. Because percentages are quite volatile in a very small clinic, shifting drastically with any staff change, it is reasonable to exclude them from this requirement given compliance with A, the provision of two full-time staff in different disciplines and minimal representation of the three required disciplines.

There is a trend toward utilization of paraprofessional or practitioner staff in the delivery of clinical services. Research has indicated there are legitimate and quality clinical services they can provide with proper training and supervision.[4] A great deal of controversy remains over the scope of this paraprofessional practice and the reimbursable nature of "health" services provided by persons of little training. In the field of medicine, non-certified paraprofessional services are seldom reimbursed as an individual service, and the physician remains the decision-maker and responsible professional for all care. The nature of psychotherapy, the staff person in a room interacting and talking privately with the client, requires sufficient expertise to act and react in the correct or appropriate manner without reliance on the supervisor. As a compromise between the view promoting no minimal requirements for clinical staff and the view requiring specific credentials of mental health education and training or certification to demonstrate competency in the provision of clinical services, factions arguing cost effectiveness of lower paid and trained staff versus the quality assurance of educated and licensed or certified staff, four categories were identified by the drafting committee as allowable practitioner staff (12 MCAR §2. 0291 Q), provided they were supervised and their presence in staff limited (see drafting committee minutes, January, 1981). The Department accepted the committee recommendations and determined it is necessary and reasonable that practitioner staff would be permitted as clinical service staff of an approved center, in concert with the research findings, provided the center can show competence to provide the service, and their presence as clinical staff would be limited to 25% of the clinical services in consideration of legislative, mental health professional and insurance

carrier concerns that staff be credentialed or at least well educated and experienced. Since practitioner staff spend a high percentage of time actually seeing clients while professionals spend an hour or two per week providing supervision and case review, this percentage will still provide significant cost savings for those centers who choose to employ practitioners. The rule drafting committee submitted both of the 60 and 25 percentage levels as a reasonable compromise to the staffing issues as a part of their recommendation.

C. Multidisciplinary records. This section is necessary to clarify how centers will document that staffing standards are met and where staff competencies will be recorded. 12 MCAR §2.0294 D., requires an evaluation process which determines staff competencies; 2.0295 requires certain staff be employed. Documentation is necessary to show compliance with the rule. It is reasonable, since review and verification of credentials and experience is a sound management practice to utlize in the hiring of an employee.

D. Credentialed occupations. This section is required by Minn. Stat. 245.69, Subd. 2(a). These rules are for a center, and do not supersede any other rules or statutes for credentialing requirements of individuals in a certain field or occupation. It is reasonable to assume that for any specific licensing or credentialing standard more restrictive than the like standard in these rules, the more restrictive standard would be followed.

DPW will not be reviewing the quality or competence of individual staff in a center. The Department may check to determine if a license is in effect to confirm receipt of a degree or supervised experience. There is a procedure to accept certain staff as allied professionals, and others as clinical social workers, but no certification or privilege has been granted beyond the scope of the rules. The Department conferred with the Department of Health on these rules to ensure the staffing and treatment procedures were not in conflict with Minn. Stat. 214.13.[20]

12 MCAR § 2.0296 Application procedure; review; decision.

A. Application.

1. Minn. Stat. § 245.69, Subd. 2 gives the Commissioner the authority and requires the promulgation of rules for the approval and disapproval of centers. It is reasonable to expect that the approval process will require a written application, and that the rule will indicate how forms may be obtained. As the decision is based on compliance with the rule and statute, it is reasonable that only information relevant to this compliance will be considered in the review process.

2. The authorization for requiring an application fee to cover costs is Minn. Stat. § 245.69, Subd. 2, requirement that the process be self-supporing. Minn. Stat. § 16A.128 has established the criteria to determine a fee, and requires six month reviews to ensure fees are commensurate with expenditures. Adherence to this statute is mandated, and it is reasonable that this adherence will meet all requirements for the fee established by the authorizing statute. The fee will be set to cover all Departmental expenses associated with implementation and administering Minn. Stat. 245.69, Subd. 2. It is reasonable for the fee to be nonrefundable to ensure that each applicant pays their share of review costs and because of the difficulty of making refunds from the State General Fund. Review begins shortly after receiving the application, and a refund would require other centers to absorb these review costs; partial refunds would be difficult to calculate. Department staff are available for consultation with potential applicants.

3. This section is necessary as the application cannot be reviewed or acted upon until the form has been filled out and all required information is provided. The fee is required by statute and it is not reasonable for the Department to provide the review service unless it is assured of payment. The provision is reasonable to ensure best use of staff time and efficient processing of the applications.

4. This requirement is necessary and reasonable to ensure that communication between Department and center is carried out at a clinical level (ensured by the "professional" staff person)with administrative support and approval (ensured by the center designation), and that there is ongoing responsible awareness of the requirements of the rule and the center's compliance with these requirements to ensure accountability.

5. The Department has established a waiting period following disapproval or withdrawal of approval as a necessary deterrent for a center's disregard of the rules and the responsibilities as an approved center. This is reasonable, given the procedures established by rule to prevent disapproval or withdrawal if the center takes positive and reasonable action. These procedures include:

-- a six month deferral period to gain initial approval before disapproval (12 MCAR § 2.0296 C.4);

-- the opportunity to report center changes that result in non-compliance with the rules and have six months to regain compliance while maintaining approved status (12 MCAR § 2.0297 D.1);
-- when laws were broken or procedures not followed, the opportunity to report this and indicate appropriate actions were taken by the center so that approval is maintained (12 MCAR § 2.0297 D.2).

The time periods in the first two of the procedures listed above are sufficient for the center to request a variance to the procedure with which they are out of compliance. The 90 days waiting period is reasonable, sufficient time to be a deterrent for center nonreporting and reluctant return to compliance. Since the center was unable or unwilling to maintain compliance prior to disapproval, it is reasonable to expect that the center will not immediately regain compliance. The two years is a reasonable deterrent for the more serious issue of the center's lack of responsible behavior to ensure its staff comply with center procedures (the rule) and with pertinent statutes and ethical standards. Minn. Stat. § 245.801, Subd. 2 requires a five year waiting period before renewal of a license following revocation or denial of renewal; in contrast, these 90 day and two year waiting periods appear quite reasonable.

B. Review of applicant centers.

1. The review process is necessary to determine compliance with the rules and statute, a prerequisite to the approval authorized by Minn. Stat. 245.69, Subd. 2. (c). The review of the application, site visit, staff interviews and examination of center records are reasonable and necessary to ensure the decision is based on first-hand knowledge of the center's statement of how they comply with the rule, and that this is documented by staff knowledge of procedures and records indicating these procedures were followed. The 60 day period is necessary to provide an estimate of processing time for applicants. It is a reasonable estimate of the time to review the appplications, solicit clarification and plan a site visit with sufficient advance notice to ensure staff are available. It is a reasonable estimate of the review time needed by the Department, given its duties to other applicants and ongoing monitoring of approved centers.

2. This section is necessary as it is unreasonable to expect each center to have a history of compliance with each rule requirement, particularly for new centers, for procedures which occur infrequently, or for procedures implemented solely to meet a requirement of Rule 29. It is reasonable to accept evidence of other accreditation, to make efficient use of Department and center staff time and to avoid unnecessary redundancy in the review process. Examples of when this may occur are accreditation by the Joint Commission for the Accreditation of Hospitals (Psychiatric Facility, Community Mental Health Center) or American Association of Family and Children Organizations (Mental Health Clinic), and licensure for this purpose by an adjoining State (Wisconsin).

3. The provision is necessary to allow the Commissioner to monitor or check for ongoing compliance with the rules and statute without specific forewarning of the review. A required warning before each visit would permit the center to quickly implement procedures and bring records up-to-date when they do not have day-to-day compliance. The rule provision is reasonable because it alerts the center that the visits may occur but does not make unreasonable demands on the center. (Unreasonable demands would be requiring the center to stay open late to accommodate the reviewer or cancel a scheduled appointment with a client to meet with the reviewer.)

C. Decision on application.

1. This section is necessary to inform the center that there is a written record of the review of their compliance with the rule, and to clarify and support the commissioner's decision. This record is reasonable for those occasions when the center wants to obtain clarifying information or to appeal the decision when a variance is granted.

2. This section is necessary to indicate a reasonable timeline for response, and to indicate that the review process is concluded with the site visit. Since approval is based on compliance with the rule and statute, it is necessary and reasonable that any decision other than approval will be based on noncompliance, and that information on the nature of this noncompliance is necessary for the center to make changes in order to comply or decide to appeal the decision.

3. The provison is required by Minn. Stat. 245.69 Subd. 2.(e). It is necessary and reasonable to clarify that noncompliance results in nonapproval. The deferral procedure is reasonable for first time applicants, to ensure the center's understanding of the rule standards and review procedures. It is conceivable that a misunderstanding of rule requirements could not be discovered until the site visit. Deferral is necessary to provide an opportunity for the center to react to the Commissioner's findings and comply with the rule, without requiring a new application. This is reasonable, since the Commissioner's decision is the first complete and written determination of compliance that the center receives. Reapplicants have been reviewed in the past and so are familiar with the review procedures and rule standards, and in most cases will currently be in compliance; the need and reasonableness of the deferral procedure for reapplicants is not apparent.

4. This section is necessary to clarify the deferral period and the center's rights and responsibilities as a deferred applicant. Assuming that the center had sufficient understanding of the rule to complete an application and appear on paper to comply with the rule, six months is a reasonable length of time to hire a staff person or develop and implement a new procedure to document compliance. It is also sufficient time to submit a request for a variance (12 MCAR § 2.0298) and have that request acted upon. It is reasonable to end the deferral period as soon as the center is determined to comply with the rule. It is reasonable to disapprove a center if they prefer disapproval to deferral; this might be true if the center felt they had wrongly been deferred and wanted to appeal the decision of noncompliance.

5. This section is necessary to clarify when the approval, deferral or disapproval period begins, to determine when reapplication must or can occur, and the date by which compliance for a deferred applicant must be determined. This date is reasonable, as it is the date of the Commissioner's determination of the center's compliance with the rule. It is also necessary to inform insurance companies of the effective date of the approval. Less than 5% of the applicants under the temporary rule were in full compliance with the rule and statute at the time they submitted their application.

D. Appeals.

This provision for the appeal process is required by Minn. Stat. 245.69 Subd. 2(e). It is necessary to establish a time-frame for this action because no time-frame is provided by statute. A time-frame is necessary to prevent the appeal of a decision made long ago, and to allow disapproved center files to be closed. It is reasonable to expect the center to decide to appeal within a few weeks of the Commissioner's decision, since the center is familiar with the statute and rule requirements, and the Commissioner's disapproval must be based on noncompliance with the rule or statute. Since the rule relates to insurance reimbursement for Minnesota residents, it is reasonable to assume the centers will be within the state or near its borders and thus could be expected to have legal counsel knowledgeable of Minnesota law and with access to file the appeal. Minn. Stat. § 245.801, Subd. 4, establishes a ten day appeal time period for welfare licensing decisions. Since licensing and approval are similar procedures, the 30 days for appeal of a disapproval decision seems quite reasonable.

12 MCAR § 2.0297 Post-approval requirements.

A. Duration of approval.

Establishing a definite length of time for approval is necessary to allow for the periodic review of the center. Periodic review is necessary to ensure the center's ongoing compliance with the rules. The time periods of one and two years are consistent with the welfare program licensure standards of Minn. Stat. 245.783 Subd. 4. Since approval and licensure are related procedures it is reasonable to adopt the same time periods as licensure. Approval will be for less than the established time period when the center has not maintained compliance with the rules, center procedures or state and federal statutes. Since approval requires compliance with the rule, it is necessary to have some process to remove approval when the center no longer complies with the rule.

B. Reapplication.

The Department is not responsible for maintaining the approval of centers. It is necessary, therefore, to state in rule how the center can reapply and indicate it is their responsibility. It is reasonable to require the center to submit the reapplication form prior to the expiration of approval to allow the Department sufficient time to process it. The Department has indicated in 12 MCAR 2.0296 B.1. and C.2. that it will offer a site visit within 60 days and make a determination of compliance within 30 days of the site visit. It is reasonable, therefore, to expect the center to submit the application early enough to allow this time for processing. It is also reasonable that the center would not be penalized (lose approval) for delay created by the Department in processing the application, so the rule allows for continued approval pending completion of processing.

C. Restrictions.

It is necessary to restrict approval to the center that was originally approved, because that was the entity the Department's records reflect was reviewed, found to comply with the rule and approved. It is the reviewed entity that agreed to maintain compliance with the rule and report loss of compliance. It is not reasonable to assume a second center will be in compliance, or that it would assume the compliance and reporting requirements of the approval status. This section is necessary because a change of center would require a Departmental review to determine compliance, in essence a reprocessing of the application, and the original fee would not cover these additional costs. The location restriction is needed because the Department must be able to contact the center, conduct on-site reviews, determine that records are stored at the center, and identify centers by address. It is reasonable to expect a center to maintain a permanent location, to ensure continuity of care to clients and stability of business and clientele. The 30 day notice is reasonable as leases for office space are generally negotiated at least a month in advance, to permit any remodeling, the re-establishment of offices and transfer of records. Further support for the reasonableness of these requirements is found in Minn. Stat. § 245.783 Subd. 6, welfare licensing procedures. A license, a similar status to approval, is mandated nontransferable to a new operation or location.

D. Noncompliance.

For the approval of centers to have meaning, it is necessary to ensure the continuing compliance with the provisions of the rule. It is not reasonable to expect the Department to be able to monitor the ongoing compliance of each center. It is reasonable to expect that a center that has been found to comply with the rule would be able to monitor changes in itself and report these to the Department if compliance was at issue.

1. The 180 days to regain compliance is a reasonable provision to ensure the center is not punished for its honesty in reporting the noncompliance. The provision for immediate withdrawal of approval if not reported provides further incentive for center reports, and is reasonable given the center's ability to choose a grace period. Examples of such changes that may be reported include loss of a key staff person or decision by the governing body to carry out a non-random peer review procedure. The 180 days would permit the center to recruit and hire a new person or to request a variance from the rule requirement of random peer review. The requirement for interim procedure is necessary to ensure the center institutes some procedure to compensate for the noncompliance and attempts to regain compliance, to try to meet the intent of the rule and maintain quality services at the center in spite of the lack of compliance.

2. This section is necessary to ensure the center meets its responsibilities outlined in 12 MCAR § 2.0294 F. 1., for the investigation of alleged behaviors and the appropriate corrective action. The reporting requirement is reasonable, in that only substantiated serious violations and convictions are to be reported, not alleged actions or minor violations. The review conditions of proper haste and thoroughness are reasonable, in that the center is required to have written procedures to comply with 12 MCAR § 2.0294 F.1 which are reviewed and approved by the Commissioner as adequate in determining compliance with the rule. It is easiest to confirm that a behavior did or did not occur and the circumstances surrounding it if the investigations takes place soon after the alleged event. It is reasonable to assume the correction of a misconception, allaying of rumors, punishment and restitution are most effective when they closely follow the behavior; it is also reasonable that a center would not permit noncompliance or an illegal act to continue after it is known. It is reasonable to hold the center "leaders" and policy makers, the governing body, to a higher standard of conduct, since their attitudes and behaviors set the tone and example for the rest of the center, and they have accepted responsibility for ensuring compliance with the rule. Since this review and check on center behavior is dependent upon the center's self-report, it is necessary to establish an incentive for reporting and a deterrent for non-reporting. Withdrawal of approval is a reasonable deterrent for this serious a behavior. Ten days is a reasonable time, since the investigation is over and the findings are made, to write and mail this report to the Commissioner.

E. Compliance Reports.

This section is necessary to permit the Department to monitor or check a center's ongoing compliance between the application reviews (every two years after initial approval period). The other monitoring option available to the Department is the unannounced site visit (12 MCAR § 2.0296 B.3); this report may be less expensive because it requires less staff time and travel costs. The requirement is reasonable as the report can only require documentation of compliance, and maintaining documentation is required by 12 MCAR § 2.0295 A.4, and C, and 12 MCAR § 2.0296 A.

12 MCAR § 2.0298 Variances.

This rule is necessary to comply with Minn. Stat. 15.0412 Subd. 1a, which requires that procedures and standards for granting a variance be set out in rule.

A. When allowed. Minn. Stat. 15.0412 Subd. 1a provides the statutory authority to grant a variance to a rule provision, but not to a provison required by statute. It is reasonable to state this in rule to ensure centers are knowledgeable of what can and cannot be varied, prior to submitting a variance request.

B. Application. The requirement of submitting the application (and the fee) with or before the variance request is necessary and reasonable to ensure the Department receives payment for reviewing the variance request and staff make the most efficient use of their time. The section is necessary to clarify the procedure for requesting a variance. It is necessary and reasonable, since the rule standards have been found to be necessary and reasonable, that the center present the information necessary to consideration of the request, including justification of the request and procedures to ensure that the purpose of the rule standard is achieved. It would be unreasonable to expect the Department to develop rationales as to why noncompliance with the rule should be allowed.

C. Decision Procedure. It is necessary to consult with other mental health professionals to ensure that the clinical issues from the perspective of the various disciplines are considered; this is reasonable since the centers are multidisciplinary and it is not reasonable to expect the Commissioner to be familiar with all standards of each discipline, the latest mental health research, and current accepted standards of good clinical practice for all disciplines.

The criteria for granting a variance are in B.2 and B.3 - "reasons", excluding hardship, why the standard cannot be met and an "equivalent procedure" that achieves the intent of the rule without risk to the client. Since approval is not required to operate a center and there are other means to obtain reimbursement pursuant to Minn. Stat. 62A.152, it is necessary and reasonable to ignore hardship as the sole reason for granting a variance. It is necessary and reasonable to deny a request that may harm clients, as this is contrary to the concept of treatment and to the provisions in the rule to assure quality. It is necessary and reasonable that the variance be written, to ensure that there is no misunderstanding as to what was varied and what will be done. It is necessary and reasonable to authorize the Commissioner to impose conditions in granting the variance, such as time limitations and required documentation, since the rule and thus its standards were established as necessary and reasonable and compliance with these is preferable to the varied procedure. The reviewer must be able to establish upon reapplication or monitoring that the equivalent measure is adhered to.

D. Notification. It is necessary and reasonable to provide an estimated timeline for a variance decision for those situations where the center is under time pressures to comply with the rule (deferred (12 MCAR A 2.0296 C.4) or operating under an approved interim procedure (12 MCAR § 2.0297 D.1). It is necessary to clarify that the review for approval as a center and review to grant a variance are separate, and that the decisions are separate; this is reasonable because meeting the criteria for a variance does not convey or imply that the other standards of the rules are met.

Addendum:

Minn. Stat. 245.69 Subd. 2(g) is not referenced in this rule. Procedures were included in the Temporary Rule 29 to provide for the continued approval of centers approved under DPW Rule 28:

> F.3.f. "The currently approved mental health center and clinic under Department of Public Welfare Rule 28 shall continue as an approved center or clinic for 180 days after the date this rule is effective provided that the center or clinic submits a completed application within 45 days after the date this rule is effective. Centers and clinics not submitting a completed application within 45 days shall lose their approval status effective 60 days after the effective date of this rule.
>
> F.3.g. "Each completed application received from a Rule 28 approved mental health center or clinic within the 45 days shall be reviewed. If the written application appears to meet all minimal standards, a letter of provisional approval by the Commissioner shall be issued. The provisional approval shall enable the center or clinic to submit claims for insurance reimbursement as an approved center or clinic for a time period not to exceed 30 days after the on-site review. If the application does not appear to meet minimal standards, the applicant shall be notified of the deficiencies. The applicant shall lose approval status effective 180 days after the date this rule is effective if the deficiencies have not been corrected."

Of the 35 centers approved under DPW Rule 28 on July 1, 1980, 34 had applied for temporary Rule 29 approval within the 45 days and were in compliance with the rule by September 30, 1981. One center never submitted a completed application. These 34 centers continued as approved for one year, and were reapproved after review of reapplication. Assuming compliance with the Temporary Rule is maintained, centers will retain approval through the two years for which they were reapproved, and make reapplications under the permanent rule in 1984.

C-DUN5

Footnotes

1. Hall, C. P. "Financing Mental Health Services Through Insurance," American Journal of Psychiatry, 131:10 October 1974, 1079-1088.

2. Kreitman N., Sainsbury P., et al., "The Reliability of Psychiatric Assessment: an Analysis," Journal of Mental Science, 107, 1961, 887-908

3. Spitzer, R. L., Endicott, J., Robins E., "Clinical Criteria and DSM III," American Journal of Psychiatry, 132, 1975, 1187-1192.

4. Hogan, D.B., The Regulation of Psychotherapists, Volume 1, Cambridge: Ballinger Publishing Company, 1979

5. American Psychiatric Association Committee on Financing Mental Health Care, "Mental Illness and Third Party Payment," Special Report, May, 1981.

6. Jones, D. R. & Vischi, T. R., "Impact of Alcohol, Drug Abuse, and Mental Health Treatment on Medical Care Utilization, a Review of the Research Literature," Medical Care 17:12, 1979.

7. Cooper, M. L., "Private Health Insurance Benefits for Alcohlism, Drug Abuse and Mental Illness," Intergovernmental Health Policy Project, George Washington University, July, 1979.

8. U.S. Department of Health, Education and Welfare, Public Health Service, Alcohol Drug Abuse and Mental Health Administration, National Institute of Mental Health, "Definitions for Use in Mental Health Information Systems," DHEW Publication No. (ADM) 80-833, 1980.

9. Albee, G. W., et al., "The Mental Health Disciplines, Notes on the Development of 13 Disciplines that Play Important Roles in the Treatment of the Mentally Disabled," Hospital and Community Psychiatry, 27:10, July, 1976, 495-504

10. U.S. Department of Health Education and Welfare, Health Standards and Quality Bureau and National Institute of Mental Health, "Individualized Treatment Planning for Psychiatric Patients," DHHS Publication N. (ADM) 60-299, 1977, reprinted 1980.

11. Wells, M., "An Emerging Occupational Group: Mental Health Workers National Education Center for Mental Health Workers," Synthesis Paper, NEC 1981.

12. Cunn, P. A. & Payne, D. B., Psychiatric Mental Health Nursing, 3rd Edition, Medical Examination Publishing Co., Inc., 1982.

13. Application Material, The Board of the NASW Register of Clinical Social Workers, 1981.

14. Application for Listing, National Registry of Health Care Providers in Clinical Social Work.

15. Correspondence from C. W. Walker, D.S.W., 7-21-80, re: Minnesota Society for Clinical Social Work.

16. Legislative history, including partial transcripts and bill drafts, of SF 2003 and HF 2149, 1980, (Minn. Stat. 245.69 Subd. 2).

17. American Psychiatric Association, "The American Psychiatric Association," 1974.

18. Correspondence from Board of Psychology, 1-26-81, re: differentiation of licensed psychologist and licensed consulting psychologist.

19. Memorandum from Department of Health, 2-31-80, re: regulation of social workers.

20. Memorandum from Department of Health, 3-9-81, re: Rule 29 and Minn. Stat. 214.

21. Correspondence from the Office of the Attorney General, 4-22-75, re: independent practice of licensed psychologists.

22. Minnesota Board of Psychology, Newsletter, Vol. I. No. 1, October, 1982.

23. Correspondence from University of Minnesota, 12-12-8-, re: differences between the M.A. and Ph.D. degree in psychology.

24. McAninch, M. & Weedman, R. D., "The Purpose and Content of Psychiatric Records in Accreditation Procedures," NAPPH Journal, 10:3, 35-39.

25. Racusin, R. & Krell, H., "Quality Assurance in Community Mental Health Centers." Administration in Mental Health, 7:4, Summer 1980, 292-303.

26. Langsley, D. G., "Quality Assurance in Psychiatric Treatment," NAPPH Journal, 11:3, 13-17.

27. Dorney, D. C., "Setting Resource Utilization Standards in a Community Mental Health Center," Quality Review Bulletin, 11/82, 14-21.

28. JCAH "Utilization Review," Accreditation Manual for Hospitals, 1982.

29. Standards of Care for Mental Health Professionals
- National Association of Social Workers, Code of Ethics
- National Association of Social Workers, Standards for Private Practice of Clinical Social Work
- American Association for Marriage and Family Therapy, Code of Professional Ethics
- American Psychiatric Association, Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry
- American Principles of Psychologists
- American Psychological Association, Specialty Guidelines for the Delivery of Services by Clinical Psychologists

30. Berlin, R. m., Kales, J. D., et al., "The Patient Care Crisis in Community Mental Health Centers: A Need for More Psychiatric Involvement," American Journal of Psychiatry, 138:4, April, 1981, 450-454.

31. Hall, R. C., Popkin, M. K., et al, "Physical Illness Presenting as Psychiatric Disease," Archives of General Psychiatry, 35, Nov., 1978, 1315-1320.

32. Koranyi, E. K., "Morbidity and Rate of Undiagnosed Physical Illnesses in a Psychiatric Clinic Population," Archives of General Psychiatry, 36, April, 1979, 414-419.

33. Staffing Patterns of Community Mental Health Centers Receiving Grant-in-Aid in Fiscal Year 1979.

34. Bass, R. D., "Trends Among Core Professionals in Organized Mental Health Settings: Where Have all the Psychiatrist Gone?" Mental Health Statistical Note No. 160, U.S. Department of Health and Human Services, December, 1981.

35. Knesper, D. J., "How Psychiatrists Allocate Their Professional Time: Implications for Educational and Manpower Planning," Hospital & Community Psychiatry, 32:9, September, 1981, 620-624.

The Department intends to support the Statement of Need and Reasonableness with the following expert witnesses:

Conley, Bill, Director of Public Affairs, Mental Health Association of Minneosta, Rule 29 Drafting Committee member - summation of key social policy and legal issues concerns to the development and implementation of the rules.

Dickinson, Margo, Research Associate in Health Care Services Division, Blue Cross and Blue Shield of Minnesota, Rule 29 Drafting Committee member - fiscal implementations and concerns of insurers rationale for definition of center.

McAllister, Loring W., Ph.D., Licensed Consulting Psychologist, Holbert-Martin Consulting Psychologists, Inc., former Chief Psychologist, Dakota County Mental Health Center, Assistant Commissioner for Comprehensive Programs, Minnesota Department of Public Welfare, Area Program Director, Western Mental Health Center, Marshall, Minnesota, Assistant Professor, Health Care and Clinical Psychology Programs, University of Minnesota; - rationale for the minimum standards of treatment and multidisciplinary approach to service delivery.

Duffy, William W., Ph.D., Licensed Consulting Psychologist, Executive Director and Clinician, Center for Behavior Therapy, Rule 29 Drafting Committee member - rationale for the minimum standards for quality assurance mechanisms.

Barron, Robert C., Ph.D., Licensed Consulting Psychologist, Director Burnsville Counseling Clinic, Rule 29 Drafting Committee member, member of steering committee of Action-Advocacy Committee of Minnesota Psychologists in Private Practice, member of Minnesota Psychological Association;- rationale for the minimum standards for multidisciplinary staff.

Bartz, Harvey A., M.S.W., A.C.S.W., Vice-President of Family Service of Greater St. Paul, Rule 29 Committee member - rationale for the application and approval process, reasons for disapproval and variance procedures.

Footnotes

1. Hall, C. P. "Financing Mental Health Services Through Insurance," American Journal of Psychiatry, 131:10 October 1974, 1079-1088.

2. Kreitman N., Sainsbury P., et al., "The Reliability of Psychiatric Assessment: an Analysis," Journal of Mental Science, 107, 1961, 887-908

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IN THE MATTER OF THE PROPOSED
ADOPTION OF RULES OF THE STATE
DEPARTMENT OF PUBLIC WELFARE
GOVERNING MENTAL HEALTH CENTER
STANDARDS (12 MCAR §§ 2.0290 - 2.0298)

STATEMENT OF COMPLIANCE
WITH RULE-MAKING PROCEDURES

I, Diane Masters, do hereby declare that I have examined the rules and all related documents and that, based on my examination and my personal familiarity with the applicable procedures, the Administrative Procedures Act, the rules of the Office of Administrative Hearings, and the rules of the Attorney General have been followed. Any exceptions are noted below.

Diane Masters

Special Assistant - Attorney General

IN THE MATTER OF THE PROPOSED
ADOPTION OF RULES OF THE STATE
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STANDARDS (12 MCAR §§ 2.0290 - 2.0298)

AFFIDAVIT OF MAILING
NOTICE OF SUBMISSION
TO THE ATTORNEY GENERAL

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

Wendy Johnson, being first duly sworn, deposes and says:

That on the 23 day of May, 1983, in the City of St. Paul, County of Ramsey, State of Minnesota, she served the attached Notice of Submission to the Attorney General by depositing in the State of Minnesota Central Mail System for United States mailing, a copy thereof, properly enveloped, with postage prepaid, on all persons and associations who requested notice that the rules in the above-entitled matter have been submitted to the Attorney General.

Wendy Johnson

Subscribed and sworn to before me
this 23 day of MAY, 1983.

Connie Thomas

CONNIE THOMAS
NOTARY PUBLIC-MINNESOTA
WASHINGTON COUNTY
MY COMMISSION EXPIRES SEPTEMBER 21, 1989

IN THE MATTER OF THE PROPOSED
ADOPTION OF RULES OF THE STATE
DEPARTMENT OF PUBLIC WELFARE
GOVERNING MENTAL HEALTH CENTER
STANDARDS (12 MCAR §§ 2.0290 - 2.0298)

NOTICE OF SUBMITTAL TO
THE ATTORNEY GENERAL

To all Interested Persons:

Pursuant to your request and in accordance with Minnesota Statutes, Section 14.16 and Rule HE 102, PLEASE TAKE NOTICE that the above-captioned rules have been submitted to the Attorney General's Office on May 23, 1983 for review as to form and legality. Pursuant to Rule ATTYGEN 305, any person may question the legality of the above-captioned rules within ten (10) days after receipt of the rule by the Attorney General. Thereafter, the Office of the Attorney General shall conduct its review. If you desire to question the legality of the above-captioned rules, you should direct your comments to the Attorney General's Office, G-25 Administration Building, 50 Sherburne Avenue, Saint Paul, Minnesota 55155.

If you are interested in determining what changes, if any, were made in the proposed rules after the hearing and before submission to the Attorney General you may contact Trudy Dunham, Mental Illness Program Division, Mental Health Bureau, Department of Public Welfare, Fourth Floor, Centennial Office Building, St. Paul, Minnesota 55155, telephone 612/296-4503.

AUTHORIZED SIGNATURE