

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed
Amendments to and Repeal of Rules
Governing Outpatient Mental Health
Services Payment,
Minn. R. Ch. 9505

**REPORT OF THE CHIEF
ADMINISTRATIVE LAW JUDGE**

The above-entitled matter came on for review by the Chief Administrative Law Judge pursuant to the provisions of Minnesota Rules, part 1400.2240, subpart 4. Based upon a review of the record in this proceeding, the Chief Administrative Law Judge hereby approves the Report of the Administrative Law Judge, dated January 6, 2011, in all respects.

In order to correct the defects enumerated by the Administrative Law Judge in the attached Report, the agency shall either take the action recommended by the Administrative Law Judge, make different changes to the rule to address the defects noted, or submit the rule to the Legislative Coordinating Commission and the House of Representatives and Senate policy committees with primary jurisdiction over state governmental operations, for review under Minnesota Statutes, section 14.15, subdivision 4.

If the agency chooses to take the action recommended by the Administrative Law Judge, or if the agency chooses to make other changes to correct the defects, it shall submit to the Chief Administrative Law Judge a copy of the rules as originally published in the *State Register*, the agency's order adopting the rules, and the rule showing the agency's changes. The Chief Administrative Law Judge will then make a determination as to whether the defect has been corrected and whether the modifications to the rules make them substantially different than originally proposed.

Dated this 7th day of January, 2011.



RAYMOND R. KRAUSE
Chief Administrative Law Judge

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HUMAN SERVICES

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and Repeal of Rules Governing Outpatient
Mental Health Services Payment, Minn. R.
Ch. 9505

**REPORT OF THE
ADMINISTRATIVE LAW JUDGE**

The proposed rules govern Medical Assistance payment for outpatient mental health services.

Administrative Law Judge Kathleen D. Sheehy of the Office of Administrative Hearings conducted a hearing on Monday, November 15, 2010. The hearing commenced at 9:30 a.m., in the fifth floor conference room of the Veterans Service Building, 20 West 12th Street, St. Paul, Minnesota.

The hearing and this Report are part of a larger rulemaking process under the Minnesota Administrative Procedure Act.¹ The Minnesota Legislature has designed this process so as to ensure that state agencies have met all of the requirements that the state has specified for adopting rules.

The hearing was conducted to allow agency representatives and the Administrative Law Judge to hear public comment regarding the impact of the proposed rules and what changes might be appropriate. Further, the hearing process provides the general public an opportunity to review, discuss and critique the proposed rules.

The agency must establish that the proposed rules are necessary and reasonable; that the rules are within the agency's statutory authority; and that any modifications that the agency may have made after the proposed rules were initially published in the *State Register* are within the scope of the matter that was originally announced.²

Robert Klukas, Legal Analyst, appeared at the rule hearing on behalf of the Department of Human Services (Department). The members of the Department's hearing panel were Sharon Autio, Director of the Adult Mental Health Division at the

¹ See Minn. Stat. §§ 14.131 through 14.20.

² Minn. Stat. §§ 14.05, 14.131, 14.23 and 14.25 (2008).

Department; and Glenace Edwall, Director of the Children's Mental Health Division at the Department.

Approximately 65 people attended the hearing and 54 signed the hearing register. The proceedings continued until all interested persons, groups or associations had an opportunity to be heard concerning the proposed rules. In addition to the Department's representatives, 19 members of the public made statements at the hearing.

After the hearing ended, the Administrative Law Judge kept the administrative record open for another 15 calendar days – until November 30, 2010 – to permit interested persons and the Department to submit written comments. Following the initial comment period, the hearing record was open an additional five business days so as to permit interested parties and the Department an opportunity to reply to earlier-submitted comments.³ The hearing record closed on December 7, 2010.

SUMMARY OF CONCLUSIONS

The Department has established the need for and reasonableness of all proposed rules, except for rule parts 9505.0371, subp. 7, 9505.0372 subp. 2 D, and 9505.0372, subp. 10 E and F.

Part 9505.0372, subp. 2 D, as proposed, requires that a neuropsychological assessment must be performed by a board-certified neuropsychologist. The Department has failed to support this proposed rule with an affirmative presentation of fact, and its choice to require board-certification consequently appears to be arbitrary and capricious.

Part 9505.0371, subp.7, as originally proposed, would permit a treatment provider to determine that an adult client, including a competent adult client, cannot sign his or her own Individual Treatment Plan. Part 9505.0372, subp. 10 E and 10 F, as originally proposed, would require national board certification for providers of Dialectical Behavior Therapy (DBT), despite the fact that such certification does not currently exist. The Department has proposed language to cure these defects, and parts 9505.0371, subp. 7, and 9505.0372, subp. 10 E and F, are approved, contingent upon the Department adopting the language proposed at paragraph 126 or 127 and at paragraph 182 to cure the defects.

Based upon all the testimony, exhibits, and written comments, the Administrative Law Judge makes the following:

³ See Minn. Stat. § 14.15, subd. 1 (2008). All references to Minnesota statutes are to the 2008 edition and supplements.

FINDINGS OF FACT

I. Nature of the Proposed Rules

1. The Department is the state agency charged with administering the medical assistance program, which is Minnesota's federally-funded Medicaid program.⁴

2. In January 2009, the Department published adopted rule amendments modifying Minn. R. 9505.0323 to bring it into compliance with federal regulations.⁵ The 2009 rule amendments were adopted under the good cause exemption in Minn. Stat. § 14.388, subd. 1(2), because the Department was required to promptly comply with federal regulations and did not have time to comply with the standard rulemaking process set forth in Minn. Stat. §§ 14.14 to 14.28.⁶

3. The rules adopted in January 2009 will expire in January 2011 because rules adopted pursuant to the good cause exemption at section 14.388, subd. 1, are effective for a period of two years from the date of publication in the State Register.⁷

4. With this rulemaking process, the Department seeks to permanently enact the changes made in 2009 and to make other changes needed to update the rules and remove obsolete requirements.⁸ The rules include standards for services and payment requirements that a vendor must meet to qualify for payment through the Medical Assistance program. The standards in the rule are based upon federal requirements at 45 CFR 162.1000 and 162.1002 regarding uniform electronic transactions and the federally-adopted Current Procedural Technology, Fourth Edition (CPT).

II. Procedural Requirements of Chapter 14

5. On April 5, 2010, the Department published in the *State Register* a Request for Comments seeking comments on its possible amendment to and repeal of rules governing medical assistance coverage of mental health services. The Request for Comments was published in the *State Register* at 34 S.R. 1333.⁹

6. On August 18, 2010, the Department requested approval of its Additional Notice Plan and filed with the Office of Administrative Hearings copies of the proposed Notice of Hearing, the proposed rules and a draft Statement of Need and Reasonableness (SONAR).¹⁰

⁴ 42 C.F.R. § 431.10.

⁵ See 33 S.R. 1251 (January 20, 2009).

⁶ *Id.*

⁷ Minn. Stat. § 14.388, subd. 1.

⁸ Hearing Ex. C, Statement of Need and Reasonableness, p. 1.

⁹ Ex. A.

¹⁰ Ex. G.

7. By letter dated August 30, 2010, the undersigned Administrative Law Judge approved the Department's Additional Notice Plan.¹¹

8. As required by Minn. Stat. § 14.131, by letter dated August 19, 2010, the Department asked the Commissioner of Minnesota Management and Budget (MMB) to evaluate the fiscal impact and benefit of the proposed rules on local units of government.¹²

9. In a memo issued September 28, 2010, MMB reviewed the Department's proposed rule and concluded:

Since the proposed rule amendments are directed to providers of mental health services and not local governments, they do not appear to impose a cost on local governments. However, since some counties own and operate community mental health centers, any fiscal impact to providers could be considered a fiscal impact to counties depending upon how payments flow between the two entities. . . . [A]ssuming the counties that own and operate community mental health centers are not legally considered to be impacted by fiscal activities at such centers, I do not believe that the proposed rule will have significant fiscal impact on local units of government.¹³

10. By letter dated September 25, 2010, the Department requested approval of its Notice of Hearing. The undersigned Administrative Law Judge approved the Department's Notice of Hearing in a letter dated October 4, 2010.

11. On October 8, 2010, the Department mailed a copy of the SONAR to the Legislative Reference Library as required by Minn. Stat. §§ 14.131 and 14.23.¹⁴

12. On October 8, 2010, the Department sent by U.S. mail a copy of the Notice of Hearing and the proposed rules to all persons and associations who had registered their names with the Department for the purpose of receiving such notice and to all persons and associations identified in the additional notice plan.¹⁵

13. The Department sent a copy of the Notice of Hearing and the Statement of Need and Reasonableness to Legislators on October 8, 2010, as required by Minn. Stat. § 14.116.¹⁶

14. The Notice of Hearing identified the date and location of the hearing in this matter.¹⁷

¹¹ Ex. G.

¹² Ex. I.

¹³ Ex. I.

¹⁴ Ex. D.

¹⁵ Exs. F and G.

¹⁶ Ex. M.

¹⁷ Ex. E.

15. On October 11, 2010, a copy of the proposed rules and Notice of Hearing were published in the *State Register*.¹⁸

16. At the hearing on November 15, 2010, the Department filed copies of the following documents as required by Minn. R. 1400.2220:

- a. the Department's Request for Comments as published in the *State Register* on April 5, 2010;¹⁹
- b. the proposed rules dated August 16, 2010, including the Revisor's approval;²⁰
- c. the agency's Statement of Need and Reasonableness (SONAR);²¹
- d. the certification that the Department mailed a copy of the SONAR to the Legislative Reference Library on October 8, 2010;²²
- e. the Notice of Hearing as mailed and as published in the *State Register* on October 11, 2010;²³
- f. Certificate of Mailing the Notice of Hearing and the proposed rules to the rulemaking mailing list on October 8, 2010, and Certificate of Accuracy of the Mailing List;²⁴
- g. proof of mailing the Notice of Hearing and the proposed rules to the parties identified in the Additional Notice Plan on October 8, 2010, and the mailing lists used as of those dates;²⁵
- h. the written comments on the proposed rule that the Department received during the comment period that followed the Notice of Hearing;²⁶
- i. memorandum from Minnesota Management and Budget and cover correspondence;²⁷

¹⁸ Ex. E; 35 S.R. 571 (October 11, 2010).

¹⁹ Ex. A.

²⁰ Ex. B.

²¹ Ex. C.

²² Ex. D.

²³ Ex. E.

²⁴ Ex. F.

²⁵ Ex. G.

²⁶ Ex. H.

²⁷ Ex. I.

- j. *Baseline of Competency: Common Licensing Standards for Mental Health Professionals, A Report to the State Legislature*, dated January 15, 2007;²⁸
- k. *Measurement of Health Status for People with Serious Mental Illness*, Parks, Radke, Mazade, editors, National Association of State Mental Health Program Directors, Medical Directors Council, October 16, 2008;²⁹
- l. rule standards comparison;³⁰ and
- m. Certificate of Sending the Notice and Statement of Need and Reasonableness to Legislators on October 8, 2010.³¹

III. Statutory Authority

17. The Department cites several sources of statutory authority for these proposed rules. Minn. Stat. § 256B.04, subd. 2, requires the Department to make rules “not inconsistent with law, for carrying out and enforcing the provisions [of the Medical Assistance Program] in an efficient, economical and impartial manner” The Department is also required to cooperate with the federal government “in any reasonable manner necessary to qualify for federal aid in connection with the medical assistance program”³²

18. In addition, the Department is required by Minn. Stat. § 245.484, to adopt permanent rules to carry out the state mental health laws in Chapter 245.³³

19. The Administrative Law Judge concludes that the Department has the statutory authority to adopt rules governing outpatient mental health services payment.

IV. Impact on Farming Operations

20. Minn. Stat. § 14.111 imposes additional notice requirements when the proposed rules affect farming operations. The statute requires that an agency provide a copy of any such changes to the Commissioner of Agriculture at least 30 days prior to publishing the proposed rules in the *State Register*.

21. The proposed rules do not impose restrictions or have an impact on farming operations. The Administrative Law Judge finds that the Department was not required to notify the Commissioner of Agriculture.

²⁸ Ex. J.

²⁹ Ex. K.

³⁰ Ex. L.

³¹ Ex. M.

³² Minn. Stat. § 256B.04, subd. 4; see also SONAR at 2.

³³ SONAR at 2.

V. Additional Notice Requirements

22. Minn. Stat. §§ 14.131 and 14.23 requires that an agency include in its SONAR a description of its efforts to provide additional notification to persons or classes of persons who may be affected by the proposed rule; or alternatively, the agency must detail why these notification efforts were not made.

23. On October 8, 2010, the Department provided the Notice of Hearing and the proposed rules to the following groups, according to the Additional Notice Plan approved by the Office of Administrative Hearings:

- Minnesota Council of Child Care Agencies;
- Minnesota Medical Association;
- Minnesota Psychological Association;
- Minnesota Association of County Social Service Administrators;
- County Board Chairs;
- Tribal Mental Health Directors and Supervisors;
- Minnesota Association of Community Mental Health Programs;
- Minnesota Association of Residential Treatment Facilities;
- National Alliance on Mental Illness, Minnesota (NAMI-MN);
- Pacer Center;
- Association for Children's Mental Health;
- Consumer/Survivor Network of Minnesota;
- Mental Health Association of Minnesota;
- Mental health centers and clinics approved under rule part 9520.0750, et seq.; and
- Minnesota Joint Council of Health Plans.

24. The Administrative Law Judge concludes that the Department has fulfilled its additional notice requirements.

VI. Statutory Requirements for the SONAR

25. The Administrative Procedure Act obliges an agency adopting rules to address seven factors in its Statement of Need and Reasonableness. Those factors are:

- (1) a description of the classes of persons who probably will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule;
- (2) the probable costs to the agency and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues;
- (3) a determination of whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule;
- (4) a description of any alternative methods for achieving the purpose of the proposed rule that were seriously considered by the agency and the reasons why they were rejected in favor of the proposed rule;
- (5) the probable costs of complying with the proposed rule, including the portion of the total costs that will be borne by identifiable categories of affected parties, such as separate classes of governmental units, businesses, or individuals;
- (6) the probable costs or consequences of not adopting the proposed rule, including those costs or consequences borne by identifiable categories of affected parties, such as separate classes of government units, businesses, or individuals; and
- (7) an assessment of any differences between the proposed rule and existing federal regulations and a specific analysis of the need for and reasonableness of each difference.

A. Regulatory Analysis

- (1) **A description of the classes of persons who probably will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.**

26. The Department states that the following groups will be affected by the proposed rules:

- Persons who seek or receive mental health treatment and their families;
- Counties, tribes, health plans, mental health clinics and others who provide mental health services to clients either directly or through a vendor;
- Insurance companies, health plans, self-insured entities, and persons who pay for mental health services; and
- Recipients who would be eligible for mental health treatment services.³⁴

(2) The probable costs to the Agency and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

27. According to the Department, the costs of rule training, rule implementation, and rule enforcement are a regular part of the cost of doing business and do not constitute separate identifiable costs resulting from the proposed rules.³⁵

28. Furthermore, the Department intends the proposed rules to be cost neutral and asserts that other state agencies will not experience additional costs as a result of the proposed rules. The Department does not anticipate that the proposed rules will have an effect upon state revenues. Failure to implement the proposed rules could jeopardize the state's eligibility for federal funding of medical assistance.³⁶

(3) The determination of whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

29. The Department asserts that there are no less costly or intrusive methods for achieving the purposes of the proposed rules. The proposed amendments include requirements that are overall no more costly or more intrusive than the current rules. Federal regulations require that enforceable treatment and billing standards be included in the state's application to the federal government for federal funds to pay for medical assistance. The proposed rules implement those treatment and billing standards.³⁷

³⁴ SONAR at 3.

³⁵ SONAR at 4.

³⁶ *Id.*

³⁷ *Id.* at 4-5.

- (4) **A description of any alternative methods for achieving the purpose of the proposed rule that were seriously considered by the agency and the reasons why they were rejected in favor of the proposed rule.**

30. The Department is required by law to adopt rules governing medical assistance and to comply with federal regulatory requirements in order to obtain federal funds for the medical assistance program. Accordingly, the Department asserts that rulemaking is the only way to ensure that the state and federal requirements are met by the industry.³⁸

- (5) **The probable costs of complying with the proposed rules.**

31. According to the Department, the proposed rules do not create any new general responsibilities for counties, tribes, and health plans. The Department estimates that, initially, the proposed rules may increase slightly the total costs to individual providers, but will ultimately create efficiency and improve quality once fully operational. The intent was that the proposed rules be cost neutral. The Department states that individual clients will not experience a direct cost increase as a result of the implementation of the proposed rules.³⁹

- (6) **The probable costs or consequences of not adopting the proposed rule, including those costs borne by individual categories of affected parties, such as separate classes of governmental units, businesses, or individuals.**

32. Failure to adopt the proposed rules would result in a reversion to the rules that were in place in 2008, prior to the adoption of the proposed rules through the good cause exemption. The Department argues that failure to adopt the proposed rules would put the Department out of compliance with federal regulations and jeopardize federal funding of the state medical assistance program.⁴⁰

- (7) **An assessment of any differences between the proposed rules and existing federal regulation and a specific analysis of the need for and reasonableness of each difference.**

33. As stated above, the proposed rules are intended to meet federal requirements and implement relevant state statutes. In some instances, where the federal regulation does not specify how to meet a federal regulatory requirement, state law requires the Department to develop rules to implement the federal regulations. The Department asserts that the proposed rules do not deviate from federal law.⁴¹

³⁸ *Id.* at 5.

³⁹ *Id.* at 5.

⁴⁰ SONAR at 5-6.

⁴¹ *Id.* at 6.

B. Performance-Based Regulation

34. The Administrative Procedure Act⁴² also requires an agency to describe how it has considered and implemented the legislative policy supporting performance based regulatory systems. A performance based rule is one that emphasizes superior achievement in meeting the agency's regulatory objectives and maximum flexibility for the regulated party and the agency in meeting those goals.⁴³

35. The Department asserts that the proposed rules continue the Department's attempt to eliminate old rule standards that were not focused on performance and to implement rules that are more oriented to improving the performance of outpatient mental health care in Minnesota. The proposed rules remove the references to units of time and generalized descriptions of procedures. Instead, the proposed rules allow providers the flexibility to help clients through a variety of proven treatments that are effective and efficient.⁴⁴

C. Consultation with the Commissioner of Minnesota Management and Budget (MMB)

36. Under Minn. Stat. § 14.131, the agency is also required to "consult with the commissioner of finance to help evaluate the fiscal impact and fiscal benefits of the proposed rule on units of local government."

37. The Department provided the proposed rules and the SONAR to MMB on August 19, 2010. In a memo dated September 28, 2010, after consulting with the Department, MMB concluded that the proposed rules would not have a significant fiscal impact on local units of government.

38. The Administrative Law Judge finds that the Department has met the requirements set forth in Minn. Stat. § 14.131 for assessing the impact of the proposed rules, including consideration and implementation of the legislative policy supporting performance-based regulatory systems, and the fiscal impact on units of local government.

D. Cost to Small Businesses and Cities under Minn. Stat. § 14.127

39. Minn. Stat. § 14.127, requires the Department to "determine if the cost of complying with a proposed rule in the first year after the rule takes effect will exceed \$25,000 for: (1) any one business that has less than 50 full-time employees; or (2) any one statutory or home rule charter city that has less than ten full-time employees."⁴⁵ The Department must make this determination before the close of the hearing record,

⁴² Minn. Stat. § 14.131.

⁴³ Minn. Stat. § 14.002.

⁴⁴ SONAR at 6.

⁴⁵ Minn. Stat. § 14.127, subd. 1.

and the Administrative Law Judge must review the determination and approve or disapprove it.⁴⁶

40. As noted previously, the proposed rules are intended to be cost neutral. As a result, the proposed rules should not increase the cost to providers of any size of providing outpatient mental health care to recipients. Furthermore, the Department states that statutory or home rule charter cities do not directly provide outpatient mental health services. The Department concludes that no small business or small city will be required to spend more than \$25,000 in the first year after the rules take effect.⁴⁷

41. The Administrative Law Judge finds that the agency has made the determination required by Minn. Stat. § 14.127 and approves that determination.

E. Adoption or Amendment of Local Ordinances

42. Under Minn. Stat. § 14.128, the agency must determine if a local government will be required to adopt or amend an ordinance or other regulation to comply with a proposed agency rule. The agency must make this determination before the close of the hearing record, and the Administrative Law Judge must review the determination and approve or disapprove it.⁴⁸

43. The Department concludes that the proposed rules do not necessitate local government action because the rules contain no provisions that would affect the law or regulations of a town, home rule charter or statutory city. In addition, the Department asserts that the proposed rules would not require a county to adopt or amend an ordinance to comply with the rules.⁴⁹

44. The Administrative Law Judge finds that the agency has made the determination required by Minn. Stat. § 14.128 and approves that determination.

VII. Rulemaking Legal Standards

45. The Administrative Law Judge must make the following inquiries: Whether the agency has statutory authority to adopt the rule; whether the rule is unconstitutional or otherwise illegal; whether the agency has complied with the rule adoption procedures; whether the proposed rule grants undue discretion to government officials; whether the rule constitutes an undue delegation of authority to another entity; and whether the proposed language meets the definition of a rule.⁵⁰

46. Under Minn. Stat. § 14.14, subd. 2, and Minn. R. 1400.2100, the agency must establish the need for, and reasonableness of, a proposed rule by an affirmative presentation of facts. In support of a rule, the agency may rely upon materials

⁴⁶ Minn. Stat. § 14.127, subd. 2.

⁴⁷ SONAR at 8-9.

⁴⁸ Minn. Stat. § 14.128, subd. 1.

⁴⁹ SONAR at 7-8.

⁵⁰ See Minn. R. 1400.2100 (2009).

developed for the hearing record,⁵¹ "legislative facts" (namely, general and well-established principles, that are not related to the specifics of a particular case, but which guide the development of law and policy),⁵² and the agency's interpretation of related statutes.⁵³

47. A proposed rule is reasonable if the agency can "explain on what evidence it is relying and how the evidence connects rationally with the agency's choice of action to be taken."⁵⁴ By contrast, a proposed rule will be deemed arbitrary and capricious where the agency's choice is based upon whim, devoid of articulated reasons or "represents its will and not its judgment."⁵⁵

48. An important corollary to these standards is that when proposing new rules an agency is entitled to make choices between different possible regulatory approaches, so long as the alternative that is selected by the agency is a rational one.⁵⁶ Thus, while reasonable minds might differ as to whether one or another particular approach represents "the best alternative," the agency's selection will be approved if it is one that a rational person could have made.⁵⁷

49. Because the Administrative Law Judge is suggesting changes to the proposed rules after original publication of the rule language in the *State Register*, it is also necessary for the Administrative Law Judge to determine if the new language is substantially different from that which was originally proposed. The standards to determine whether changes to proposed rules create a substantially different rule are found in Minn. Stat. § 14.05, subd. 2. The statute specifies that a modification does not make a proposed rule substantially different if:

- "the differences are within the scope of the matter announced . . . in the notice of hearing and are in character with the issues raised in that notice;"
- the differences "are a logical outgrowth of the contents of the . . . notice of hearing, and the comments submitted in response to the notice;" and
- the notice of hearing "provided fair warning that the outcome of that rulemaking proceeding could be the rule in question."

50. In reaching a determination regarding whether modifications result in a rule that is substantially different, the Administrative Law Judge is to consider:

⁵¹ See *Manufactured Housing Institute v. Petterson*, 347 N.W.2d 238, 240 (Minn. 1984); *Minnesota Chamber of Commerce v. Minnesota Pollution Control Agency*, 469 N.W.2d 100, 103 (Minn. App. 1991).

⁵² See generally *United States v. Gould*, 536 F.2d 216, 220 (8th Cir. 1976).

⁵³ See *Mammenga v. Board of Human Services*, 442 N.W.2d 786, 789-92 (Minn. 1989); *Manufactured Housing Institute v. Petterson*, 347 N.W.2d 238, 244 (Minn. 1984).

⁵⁴ *Manufactured Hous. Inst.*, 347 N.W.2d at 244.

⁵⁵ See *Mammenga*, 442 N.W.2d at 789; *St. Paul Area Chamber of Commerce v. Minn. Pub. Serv. Comm'n*; 312 Minn. 250, 260-61, 251 N.W.2d 350, 357-58 (1977).

⁵⁶ *Peterson v. Minn. Dep't of Labor & Indus.*, 591 N.W.2d 76, 78 (Minn. App. 1999).

⁵⁷ *Minnesota Chamber of Commerce v. Minnesota Pollution Control Agency*, 469 N.W.2d 100, 103 (Minn. App. 1991).

- whether “persons who will be affected by the rule should have understood that the rulemaking proceeding . . . could affect their interests;”
- whether the “subject matter of the rule or issues determined by the rule are different from the subject matter or issues contained in the . . . notice of hearing;” and
- whether “the effects of the rule differ from the effects of the proposed rule contained in the . . . notice of hearing.”

VIII. Rule-by-Rule Analysis

51. This Report is limited to the discussion of the portions of the proposed rules that received critical comment or otherwise need to be examined. Accordingly, the Report will not discuss each comment or rule part. Some sections of the proposed rules were not opposed by any member of the public and were adequately supported by the SONAR. For these reasons, it is unnecessary to engage in a detailed discussion of each part and subpart of the proposed rules in this Report. All comments were carefully read and considered. The Administrative Law Judge specifically finds that the Agency has demonstrated, by an affirmative presentation of facts, the need for and reasonableness of all rule provisions not specifically discussed in this Report. She also finds that all provisions not specifically discussed are authorized by statute and there are no other problems that would prevent the adoption of those rules.

A. Objections to the Proposed Rules

52. There were numerous concerns raised about the rules, both at the hearing and in the many pre- and post-hearing comments filed. There were broad concerns expressed about the apparent policy choices made by the Department in proposing the new rule language. In addition, there were numerous suggestions for language changes. This section discusses each section where significant critical comments were received, in the order in which the sections appear in the proposed rules. Because there were so many comments received, this report will generally refer to the comments by Comment number. Comments were numbered as they were received and were posted on the OAH website at <http://www.oah.state.mn.us/cases/180021529-MN-outpt-pmnt/index.html>.

Part 9505.0370 – Definitions

Adult Day Treatment: 9505.0370, subp. 2, and 9505.0372, subp. 8 A.

53. Many of the commenters expressed strong concerns about language in two parts of the rules that defined adult day treatment as “time-limited”⁵⁸ and “short-

⁵⁸ Minn. R. 9505.0370, subp. 2 (proposed).

term.”⁵⁹ Most of the comments focused on the concern that individuals who are mentally ill and who are also developmentally disabled and/or sex offenders need long-term treatment. Effective day treatment enables many of these individuals to live in the community rather than in residential treatment or in prison. Such programs also protect the broader community by preventing criminal activity.⁶⁰

54. In its November 30, 2010, Response to Comments, the Department proposed to delete the term “time-limited” from 9505.0370, subp. 2. The Department stated that the purpose of proposing the language originally was “to remind parties that adult day treatment requires prior authorization if it exceeds an annual maximum number of hours.” The existing rule, which the Department proposes to repeal, limits medical assistance payments for this service to 390 hours per calendar year, unless prior authorization is obtained for additional hours.⁶¹ A different section of this proposed rule limits medical assistance reimbursement for day treatment to 15 hours per week.⁶² Given the concerns that were expressed, however, the Department was willing to delete the “time-limited” language in part 9505.0370, subp. 2.⁶³ Similarly, the Department proposed to remove the words “short-term” from Minn. R. 9505, 0372, subp. 8 A.⁶⁴

The changes will modify the proposed rules as follows:

Line 1.7: program” means a ~~time-limited~~, structured program of treatment and care.

Line 29.12: ~~short-term~~ psychotherapeutic treatment. The services must stabilize the client’s mental

55. These changes are made in response to public comments. The changes do not make the rules substantially different than as originally proposed. The Department has shown that the proposed rule is needed and reasonable.

Clinical Summary: 9505.0370, subp. 5.

56. Several people commented on the definition of “clinical summary.” Ron Brand, representing the Minnesota Association of Community Mental Health Programs, Inc., recommended modifications to the language of the subpart, including clarification about whether the clinical summary is expected as part of the brief diagnostic assessment and whether the clinical summary is intended as a communication tool with

⁵⁹ Minn. R. 9505.0372, subp. 8 A (proposed); see generally comments 2, 3, 4, 5, 6, 7, 8, 9, 19, 21, 24, 32, 36, 38, 41, 44, 48, 49.

⁶⁰ Comments 2, 24, 32.

⁶¹ Minn. R. 9505.0323, subp. 15.

⁶² Minn. R. 9505.0372, subp. 8 B (3) (proposed).

⁶³ November 30, 2010 Response by Department of Human Services to Public Comments (Response), pp. 5-6; December 7, 2010 Rebuttal by Department of Human Services to Public Comments (Rebuttal), pp. 5-6.

⁶⁴ Rebuttal, p. 35.

other providers.⁶⁵ The Department stated in its Rebuttal that the clinical summary is not required as part of the brief diagnostic assessment, but is intended to be "an important tool the clinician can use to communicate the diagnostic conceptualization with the client, another clinician, or a referral source."⁶⁶

57. Mr. Brand also expressed concerns about the requirement that a clinical summary include statements not only about the client's prognosis, but also about the "likely consequences of the symptoms." He suggested that the definition be changed to refer to "reported" health problems and to replace the word "conceptualization" with the words "hypothesis or formulation" of the problem.⁶⁷ In addition to these comments, Sue Abderholden, on behalf of the National Alliance on Mental Illness of Minnesota (NAMI), objected to the references in subpart 5, and throughout the rules, to mental illness symptoms as "problems."⁶⁸

58. The Department agreed with the concerns expressed by these commenters and proposed to amend the language of subpart 5 at lines 1.11-1.18 as follows:

"Clinical summary" means a written description of a clinician's conceptualization of the cause of the client's mental health symptoms, ~~the client's prognosis, and the likely consequences of the symptoms~~; how the client meets the criteria for the diagnosis by describing the client's symptoms, the duration of symptoms, and functional impairment; an analysis of the client's other symptoms, strengths, relationships, life situations, cultural influences, and health ~~problems~~ concerns and their potential interaction with the diagnosis and ~~conceptualization~~ formulation of the ~~problem~~ condition; and alternative diagnoses that were considered and ruled out.⁶⁹

59. The Administrative Law Judge is uncertain what the Department means with regard to the phrase reading "analysis of the client's other ... health concerns and their potential interaction with the diagnosis and formulation of the condition." Is "formulation" something different than the conceptualization of the cause of the client's mental health symptoms? If so, what? If not, why change it at the end of the definition, but not at the beginning? Is the "condition" the original presenting set of mental health symptoms, or is it the "other health concerns" that must also be analyzed in the course of preparing a summary? The Department should clarify its intention in making these changes. Changes of this nature would be made in response to public comments and would be needed and reasonable; they would not make the rules substantially different than as originally proposed under Minn. Stat. § 14.05, subd. 2.

⁶⁵ Comment 9, p. 2-3.

⁶⁶ Rebuttal, p. 7.

⁶⁷ Comment 9, p.3.

⁶⁸ Comment 26, p. 1.

⁶⁹ Rebuttal, p. 8.

Clinical Supervision: 9505.0370, subp. 6.

60. The proposed rule defines clinical supervision, in part, as the documented time a clinical supervisor and supervisee spend together in planning, implementing, and evaluating the mental health services provided to a client. Mr. Brand commented that, if the definition of clinical supervision is intended to apply to other rules governing other services, such as children's therapeutic services and supports (CTSS), targeted case management, adult mental health rehabilitative services (ARMHS), and related services such as assertive community treatment, residential treatment for children and adults, and crisis services, the Department has exceeded its authority to apply the definition to outpatient services.⁷⁰ The Department stated, as a general matter, that it "intends that the rule apply to outpatient mental health treatment services that are paid for through the state's medical assistance program . . ." Further, the Department stated that the "rule is not intended to apply to rehabilitation services, except for psychotherapy under CTSS in Minn. Stat. § 256B.0943, subd. 9(b)(1), which is expressly subject to the rules governing outpatient treatment services."⁷¹ The Department did not propose any changes to part 9505.0370, subpart 6.

61. The Administrative Law Judge agrees that no change to subpart 6 is necessary. Part 9505.0370, subpart 1, defines and limits the scope of these rules. In addition, the Department's statement of its intent to apply the rules narrowly is sufficient to answer Mr. Brand's concerns.

Cultural competence or culturally competent: 9505.0370, subp. 8.

62. The proposed rule defines a mental health provider's cultural competence in terms of the provider's awareness of and ability to respond to a client's cultural differences. Several comments addressed these definitions. Mr. Brand suggested that subitems A through C be required, but that subitem D, at lines 2.10-2.11 (willingness to seek additional knowledge of cultural differences) be made an alternative to subitems A through C (which describe current awareness of and ability to respond to cultural differences).⁷² This change, Mr. Brand asserted, would be "a way to support developmental steps toward cultural competence . . ."

63. The Department acknowledged in its response that, while it is important that a provider's services be appropriate for the recipient, "it is understood that people grow and develop over time, so no one is ever fully cultural [sic] competent."⁷³ It proposed no changes to these subparts.

64. On behalf of Ramsey County, Kim Klose asked how a provider could demonstrate cultural competency.⁷⁴ The Department did not respond directly to this

⁷⁰ Comment 9, p. 3.

⁷¹ Rebuttal, p. 5.

⁷² Comment 9, p. 3.

⁷³ Rebuttal, p. 9.

⁷⁴ Comment 1, p.1.

question; however, the terms are used in the rule describing clinical supervision requirements (e.g., “developing the supervisee’s ability to assess their own cultural competence and to identify when consultation or referral of the client to another provider is needed” and “emphasizing the supervisee’s commitment to maintaining cultural competence as an on-going process”).⁷⁵ The rule appears to assume that clinical supervisors have these skills, and they are required to use them in supervising others so that effective treatment can be provided to clients. This requirement is not unduly vague or burdensome.

65. Sue Abderholden, on behalf of NAMI, commended the strong focus on cultural competency, asking only whether the section dealing with cultural competency also covers LGBTQ people.⁷⁶ The Department did not address this question, although it did acknowledge Ms. Abderholden’s appreciation of the inclusion of cultural competency in the rule.

66. Subitem 9 B includes, in the definition of “cultural influences,” any historical, geographical, or familial factors that affect assessment and intervention processes, including social orientation. It seems clear that the Department is intending to broadly construe the definition of cultural influences to include sexual orientation. The Administrative Law Judge agrees with the Department that no changes are necessary to subpart 8. The Department has shown that this subpart is necessary and reasonable as written.

Cultural influences: 9505.0370, subp. 9.

67. Patricia Stark, the Director of Professional Affairs for the Minnesota Psychological Association, commented that “[p]rimary language or language of origin should be included in the list of cultural influences.”⁷⁷ The Department did not respond to this specific suggestion. The Administrative Law Judge notes that the list of cultural influences does include “experience of cultural bias as a stressor” and “level of acculturation” as well as “verbal communication style,” all of which could be interpreted to include primary language or language of origin.⁷⁸ While the Department could have included this specific factor in the list, failure to do so does not render the rule defective.

68. In his comments, Mr. Brand asked whether each of the nine examples of cultural influences is required in each diagnostic assessment and supervision session. Mr. Brand expressed concern payment would be denied in the event that every factor is not addressed.⁷⁹ In its Rebuttal, the Department agreed to modify subpart 9 “to require that relevant cultural factors be considered.” The Department also asserted that it “does

⁷⁵ 9505.0371, subp. 4 A(c) and (d) (proposed).

⁷⁶ Comment 26, p.1.

⁷⁷ Comment 38, p. 4.

⁷⁸ Minn. R. 9505.0370, subp. 9.B, D, and G (proposed).

⁷⁹ Comment 26, p. 4.

not believe that missing one item in this part . . . would be a basis to deny a provider's reimbursement claim under the rules as proposed."⁸⁰

69. The Department's modification would change the subpart at lines 2.12-2.14 as follows:

"Cultural influences" means historical, geographical and familial factors that affect assessment and intervention processes. Cultural influences that are relevant to the client may include the client's:

70. The term "cultural influences" is used in the rule governing the development of individual treatment plans and requires that relevant cultural influences must be considered in planning interventions and in preparing a written diagnostic assessment.⁸¹ It is an over-reading of the rule to conclude that a provider must demonstrate that irrelevant cultural influences were considered and rejected. The changes proposed by the Department are needed and reasonable and do not make the rules substantially different than as originally proposed.

Diagnostic assessment: 9505.0370, subp. 11.

71. Several commenters wrote to express concerns that defining a diagnostic assessment as a "face-to-face" evaluation would preclude the use of telemedicine for performing such an assessment.⁸² The Department responded that the telemedicine requirements are set forth in part 9505.0371, subpart 10, and that use of telemedicine is permissible "[i]f it is medically appropriate to deliver specific medical service via telemedicine."⁸³

72. The Department also proposed to remove the word "report" from subpart 11, at page 3, line 10, based on Mr. Brand's comment that defining a diagnostic assessment as a process that includes the issuance of a written report does not reflect standard practice; that there is not a CPT (billing) code for such a report; and it is not necessary for the purpose of a diagnostic assessment. Mr. Brand noted that written documentation of the diagnostic assessment is included in the client record. Mr. Brand also expressed concerns about certain CPT codes.⁸⁴

73. The Department's modification would change the subpart at lines 3.6-3.10 as follows:

"Diagnostic assessment" means a clinical and functional face-to-face evaluation of the client's mental health, including the nature, severity and impact of behavioral difficulties, functional impairment, subjective distress

⁸⁰ Rebuttal, p. 10.

⁸¹ 9505.0371, subp. 7 B (proposed); 9505.0372, subp. B 2(h) (proposed).

⁸² Comments 9, 37 and 47.

⁸³ Response, p. 11.

⁸⁴ Comment 9, p. 4.

of the client and identification of the client's strengths and resources, that results in the issuance of a written diagnostic assessment report.⁸⁵

74. The Department also noted that the word "report" also modifies the term diagnostic assessment in the rule at lines 16.6 and 18.15 and proposed to delete the word "report" in each of those places.⁸⁶

75. The Department stated that its intent was to "continue the requirement for a written diagnostic assessment as stated in the existing rule at part 9505.0323, subpart 1, item H" and "the inclusion of the word 'report' is not necessary" In addition, the Department noted that CPT codes are beyond the scope of this rule.⁸⁷

76. It might be simpler to define a diagnostic assessment as "a written assessment that documents a clinical and functional face-to-face evaluation of the client's mental health, including the nature, severity, and impact of behavioral difficulties, functional impairment, and subjective distress of the client, and identifies the client's strengths and resources." This is merely a suggestion, not a requirement. The Department has demonstrated that the proposed rule is needed and reasonable, and that the proposed changes do not make the rule substantially different than as originally proposed.

Dialectical behavior therapy program (DBT): 9505.0370, subp. 12.

77. There were a number of comments made both in support of and in opposition to the definition of "dialectical behavior therapy" (DBT),⁸⁸ as well as to the section governing reimbursement for DBT (see below).⁸⁹ Drs. Schulz and Long of the University of Minnesota Medical School's Department of Psychiatry submitted comments strongly supporting the inclusion of DBT for treating individuals with Borderline Personality Disorder (BPD). They stated that individuals with BPD place a high demand on mental health services, are difficult to treat, and have "a high self-harm and suicide rate" Drs. Schulz and Long stated that "DBT is the most-researched treatment for these individuals, resulting in the best outcomes when practiced to adherence."⁹⁰ Six psychiatrists with the Park Nicollet Melrose Institute co-signed a letter that was similarly supportive of the proposed rule.⁹¹ In addition, Dr. Stephen Harker wrote, in collaboration with five additional psychiatrists, in support of implementation of financial incentives to improve DBT fidelity in Minnesota. Dr. Harker and his colleagues stated that "oversight of fidelity to a model, and training based on the best evidence, can produce improved delivery of services."⁹² Dr. Michael Trangle, Associate Medical Director for Behavioral Health at HealthPartners, stated that the proposed rule supports

⁸⁵ Response, p. 10.

⁸⁶ Response, p. 11.

⁸⁷ *Id.*, pp.10-11.

⁸⁸ Minn. R. 9505.0370, subp. 12 (proposed).

⁸⁹ Minn. R. 9505.03702, subp. 10 (proposed).

⁹⁰ Comment 22, p. 1.

⁹¹ Comment 17.

⁹² Hearing Ex. H, Harker letter (Nov. 8, 2010).

effective delivery of DBT and saves money by decreasing more expensive hospitalizations.⁹³

78. Dr. Suzanne Witterholt, a psychiatrist employed by the Department in its State Operated Services Division, served as the in-house DHS consultant to the Mental Health Division regarding this rule part. Following the hearing, Dr. Witterholt submitted a public comment regarding the background and context for the DBT portions of the proposed rule.⁹⁴ Dr. Witterholt has been instrumental in implementing DBT for court-committed individuals with BPD in Minnesota.⁹⁵ From 2006-2008, she took a sabbatical from her work in Minnesota to work with a team of people at the University of Washington to develop a system for accreditation of DBT programs and certification of DBT therapists. She remains on the working committee for development of fidelity standards. The committee is headed by Marsha Linehan, the researcher who developed DBT. Dr. Witterholt also works for a company called BehavioralTech, LLC, which does training on DBT techniques outside the research setting. Dr. Witterholt stated that she conducts training within Minnesota as an employee of DHS and is not paid separately to do it; she also conducts and is paid for training outside of Minnesota, on her own time.⁹⁶

79. A number of comments expressed strong concerns about the definition of DBT being restricted to a single model. Angelina Barnes, Executive Director of the Board of Psychology, stated "[t]he proposed rules are overly restrictive for consumers, both based on level of care and diagnostic restrictions to the extent that they seek to require the application of a 'standard' model of . . . [DBT]."⁹⁷ Lane Pederson and Mark Carlson of Mental Health Systems, PC, expressed similar concerns, along with worry that the diagnostic restrictions placed on DBT services would further restrict needed access. The commenters stated that "the intervention strategies used in DBT . . . all have been independently proven to be efficacious across diagnostic categories."⁹⁸

80. Dr. Witterholt proposed wording changes to 9505.0370, subp. 12, at lines 3.12-3.16, which the Department adopted as follows:⁹⁹

"Dialectical behavior therapy" means a an evidence based treatment approach provided in an intensive outpatient treatment program using a combination of individualized rehabilitative and psychotherapeutic interventions. A dialectical behavior therapy program is certified by the commissioner and involves the following service components: individual dialectical behavior therapy, group skills training, telephone coaching and case team consultation meetings.¹⁰⁰

⁹³ Hearing Ex. H, Trangle e-mail (Nov. 4, 2010).

⁹⁴ Comment 45.

⁹⁵ *Id.*, p.3.

⁹⁶ Comment 45, p.4.

⁹⁷ Comment 35, p.3.

⁹⁸ Comment 44, p.4.

⁹⁹ Comment 45. See Rebuttal, pp. 11-12.

¹⁰⁰ Rebuttal, pp. 11-12.

81. While the comments expressing concerns about the limited scope of the definition of DBT reflect a particular policy viewpoint, the Department has chosen a different, but also valid policy position. It is clear from the comments on both sides that people who are extremely knowledgeable and experienced in treating various kinds of mental illness can and do disagree about whether strict fidelity to a particular method of providing DBT is necessary. The Department's position—that the protocols for an evidence-based treatment such as DBT must be followed exactly in order to produce the greatest likelihood of success—is a reasonable one. While opposing commenters have expressed different reasonable opinions, it is not for the Administrative Law Judge to choose between various reasonable options. That is a policy decision the Department is entitled to make.¹⁰¹ The Administrative Law Judge concludes that part 9505.0370, subp. 12, is needed and reasonable. The changes based on Dr. Witterholt's suggestions are also needed and reasonable and do not make the rules substantially different under Minn. Stat. § 14.05, subd. 2.

Medication management: 9505.0370, subp. 16.

82. One commenter suggested that the definition of "medication management" seems very limited and should go beyond "need for and effectiveness of" medication and include interaction of medications, side effects, etc.¹⁰² The Department responded that it interprets the word "effectiveness" to include such concerns as side effects and interactions. The Department chose the broad term to avoid using a "laundry list" approach in the rule, which carries the risk of failing to include particular conditions or concerns. The Department declined to modify the rule.¹⁰³ The Administrative Law Judge concurs with the Department that the definition of "medication management" does not need to be changed. The Department has shown the proposed rule is needed and reasonable.

Neuropsychological assessment and testing: 9505.0370, subps. 22 and 23.

83. Dr. Trisha Stark, Director of Professional Affairs for the Minnesota Psychological Association, commented that "significant aspects" of neuropsychological assessments and testing are not mentioned in the definitions proposed by the Department. In addition to the cognitive abilities mentioned as the focus of the neuropsychological assessment and testing, Dr. Stark suggests that "it is equally important to document the interaction between cognitive functioning, emotional regulation, behavioral outcomes, current stressors and available supports."¹⁰⁴ The Department declined to modify the rules.¹⁰⁵ The Administrative Law Judge agrees that, while the definitions could be more detailed in their descriptions, such details are not necessary in a situation such as this one where only highly trained professionals are

¹⁰¹ *Peterson v. Minn. Dep't. of Labor & Indus.*, 591 N.W.2d 76, 78 (Minn. App. 1999).

¹⁰² Comment 26.

¹⁰³ Rebuttal, p. 12.

¹⁰⁴ Comment 38, p. 3.

¹⁰⁵ Rebuttal, p. 13.

authorized to perform the neuropsychological assessment and testing.¹⁰⁶ It is reasonable to rely on the professional standards of those performing the assessments and testing to ensure that all appropriate aspects of cognitive abilities are addressed.

Primary caregiver: 9505.0370, subp. 25.

84. There were two comments that asked why “parents” were explicitly excluded from the definition of “primary caregiver.”¹⁰⁷ The Department proposed to modify the definition on lines 5.13 through 5.15 as follows:

“Primary caregiver” means a person, other than the ~~client’s parent or~~ facility staff, who has primary legal responsibility for providing the client with food, clothing, shelter, direction, guidance, and nurturance.

85. This change is needed and reasonable and does not make the rule substantially different under Minn. Stat. § 14.05, subd. 2.

Psychotherapy: 9505.0370, subp. 27.

86. Several commenters made suggestions for changes to the definition of “psychotherapy.”¹⁰⁸ While the Department declined to add language specifying that psychotherapy is “based on a diagnostic assessment and is part of a treatment plan,” or to add the phrase “biopsychosocial methods” to the definition, it did adopt a suggestion to add “psychosocial” to the list of possible methods used in psychotherapy. The proposed change at lines 5.19-5.22 is as follows:

“Psychotherapy” means treatment of a client with mental illness that applies the most appropriate psychological, psychiatric, psychosocial, or interpersonal method that conforms to prevailing community standards of professional practice to meet the mental health needs of the client.

87. This change is needed and reasonable and does not make the rule substantially different under Minn. Stat. § 14.05, subd. 2.

Supervisee: 9505.0370, subp. 28.

88. Diane Cross, President and CEO of The Fraser Institute, recommended revising the definition of “supervisee” to limit it to those individuals who meet the clinical trainee standards in part 9505.0371, subpart 5, item C. Ms. Cross hoped to clarify that “the supervision requirements listed in 9505.0371 apply only to clinical trainees

¹⁰⁶ See Minn. R. 9505.0372, subpts. 2.D and 3.C (proposed).

¹⁰⁷ Comments 26, 52.

¹⁰⁸ Comments 37, p.2; 47, p. 2 and 52, p.2.

delivering the outpatient mental health services listed in 9505.0372.”¹⁰⁹ Ms. Cross goes on to explain:

The rules defining other mental health services, such as the Children's Therapeutic Services and Supports rehabilitative mental health services, have distinct supervision standards for mental health workers providing those services. It would be extremely burdensome to providers like Fraser if the clinical supervision practices outlined in 9505.0317 were administratively expanded to supersede those already in place for mental health practitioners and mental health behavioral aides.¹¹⁰

89. The Department declined to make the recommended change, stating:

[I]t is not the department's intention to limit clinical supervision to only those mental health practitioners who qualify as clinical trainees under part 9505.0371, subpart 5, item C. The department wants the clinical supervisor to provide clinical supervision to mental health practitioners who are qualified under part 9505.0371, subpart 5, items B and C.¹¹¹

90. While the Administrative Law Judge recognizes that the Department is increasing the administrative burden on providers employing mental health practitioners who are not clinical trainees, the Department's proposed rule is reasonable. These rules apply to practitioners providing services for which medical assistance (MA) reimbursement is sought. The rate and opportunity for medical assistance reimbursement is being increased in this rulemaking by the repeal of the 9505.0323, subp. 31, which limited reimbursement to certain mental health practitioners at the rate of one-half of the MA rate for the same service provided by a mental health professional. Even at that rate, the mental health practitioner was required to be supervised by a mental health professional.¹¹² In the Statement of Need and Reasonableness (SONAR), the Department states, "Because the rule permits practitioners to provide services that are typically performed only by those with professional status, it is necessary to define the standards under which the practitioners are qualified to deliver these services." It is reasonable for the Department to require increased levels of supervision for practitioners who are eligible to be paid at an increased rate. In the post-hearing comments, the Department has proposed changes to the supervision documentation, which may make the expanded requirement less burdensome.¹¹³ It is up to the Department to weigh the burdens imposed by the supervision requirements against the enhanced quality assurance those burdens may provide.

¹⁰⁹ Comment 10, p. 4, See Comment 9, page 6 (same issue in discussion regarding clinical supervision requirements).

¹¹⁰ *Id.*

¹¹¹ Response, p.11.

¹¹² 9505.0323, subp. 31.

¹¹³ Response, p. 14; Rebuttal, p. 18.

Part 9505.0371 Coverage Requirements

Client Eligibility for mental health services: 9505.0371, subp. 2.

91. This rule generally requires that providers must use an initial diagnostic assessment to determine eligibility for reimbursable mental health services, except that certain enumerated services are allowed prior to completion of an initial diagnostic assessment. If a brief diagnostic assessment has been done, certain other services are authorized. Finally, there are additional subparts governing the criteria for and frequency of assessments for children and adults.

92. One commenter stated that the proposed rules would increase the cost of supervision, but would not commensurately increase revenues.¹¹⁴ The Department responded that the payment limitation of one-half the normal reimbursement rate for mental health practitioners under clinical supervision is eliminated with the proposed rules.¹¹⁵

93. Ron Brand raised a number of questions concerning subpart 2, item A.¹¹⁶ For example, he asked whether payment would be withheld pending completion of a diagnostic assessment and whether any combination of the allowed services could be used prior to completion of the diagnostic assessment. He asked whether, for example, two 30-minute units of therapy would be authorized and what amount of psychological testing is authorized. Mr. Brand also asked whether the adult diagnostic assessment update requirement in subpart 2, item E could be fulfilled with a functional assessment and revisions to service plans.

94. Mr. Brand also stated that “[i]t would be helpful if the rule authorized the provision of motivational interviewing and/or preventative counseling” prior to a diagnostic assessment. He noted that the rule refers variously to events occurring within “12 months” and “one year” and suggested that uniformity in these time periods would alleviate confusion.¹¹⁷

95. The Department did not accept the suggestion that the rule specifically authorize motivational interviewing and/or preventative counseling, instead stating: “Providers should use their clinical judgment for an individual client in determining which evidence based practice or research informed practice will best meet the needs of the client.”¹¹⁸

96. The Department proposed changing the phrase “one year” to “12 month” period at line 6.21-6.23, stating that this would make the use of the phrase “12 months” consistent in item B:

¹¹⁴ Comment 11, p. 3.

¹¹⁵ Rebuttal, p. 15.

¹¹⁶ Comment 9, p. 5.

¹¹⁷ *Id.*

¹¹⁸ Rebuttal, p. 16.

may be used to allow up to ten sessions of mental health services as specified in part 9505.0372 within a ~~one-year period~~ 12-month period before a standard or extended diagnostic assessment is required when the client is:

97. The Administrative Law Judge notes that the phrases "one-year," "upcoming year" and "calendar year" are all used in subpart 2 (at lines 6.18, 7.6 and 7.11) and recommends that each of these be changed to "12-month."

98. With regard to the other questions raised by Mr. Brand, the SONAR explains that the rule allows payment for preliminary testing, consultation, and psychotherapy before completion of a diagnostic assessment. Department data indicates that a large percentage of clients receiving mental health services are dealing with temporary or situational concerns and do not have long-term needs. In such situations, the completion of a diagnostic assessment is unnecessary and would not promote the efficient delivery of appropriate services. Similarly, the abbreviated assessment enables clients with less severe mental health issues to access necessary services without completing the costly standard diagnostic assessment. The Department's data indicates that for a large percentage of clients, mental health issues were resolved with ten or fewer therapy sessions. For these clients, a standard diagnostic assessment would not be an efficient or effective use of resources.¹¹⁹ It is clear that the Department does not expect that a standard diagnostic assessment will always be performed.

99. Several people pointed out a typographical or drafting error at line 6.20.¹²⁰ The rule as originally proposed incorrectly referred to part 9505.0372, subpart 1, item C. The Department agreed that that reference is incorrect and proposed the following change at lines 6.19-6.20:

A brief diagnostic assessment must meet the requirements of part 9505.0372, subpart 1, item ~~C~~ D.¹²¹

100. The rule as proposed, and with the changes described above, is needed and reasonable. The changes do not make the rule substantially different under Minn. Stat. § 14.05, subd. 2.

Authorization for mental health services: 9505.0371, subp. 3.

101. A number of commenters objected to the prior authorization requirement set forth at part 9505.0371, subp. 3.¹²² One stated that the rule seemed to extend the requirement to "all mental health services governed by the rule" and asserted that the

¹¹⁹ SONAR at 16-17.

¹²⁰ Comments 9, 10, 12.

¹²¹ Response, p. 11; Rebuttal, p. 16.

¹²² Comments 9, 10, 26, 38.

requirement had not been discussed with the advisory committee.¹²³ Another recommended that the section be dropped or "clarified that it does not add new authority to the Commissioner. . . ."¹²⁴ A third claimed that the requirement would result in denying access to basic services.¹²⁵ Finally, one comment thought that the requirement conflicts with part 9505.0371, subps. 1 and 2.¹²⁶

102. The Department declined to remove the requirement, stating "the department must follow Minnesota Statutes, section 256B.0625, subdivision 25, as stated in the proposed rule on page 8, line 20."¹²⁷ The language of section 256B.0625, subd. 25 permits, but does not require, the Commissioner to require prior authorization:

The commissioner shall publish in the Minnesota health care programs provider manual and on the department's Web site a list of health services that require prior authorization, as well as the criteria and standards used to select health services on the list. The list and the criteria and standards used to formulate it are not subject to the requirements of sections 14.001 to 14.69. The commissioner's decision whether prior authorization is required for a health service is not subject to administrative appeal.

103. The last sentence of subdivision 25 quoted above makes is clear that the Commissioner has discretion to determine whether prior authorization should be required for a given service. The rule merely re-states the statutory authority to require pre-authorization. The rule is consistent with the statute, and the Department has shown it to be needed and reasonable.

Clinical supervision: 9505.0371, subp. 4.

104. There were numerous comments regarding the clinical supervision requirements in this subpart. Most of the comments were critical of the extensive documentation required by the proposed rules, and the unreimbursed cost of the supervision requirements.¹²⁸ Several pointed out possible overlap or conflict with licensing requirements.¹²⁹ Commenters who are involved in accredited clinical training programs were also concerned about the duplication of documentation requirements already in place in their training programs and asked whether practitioners engaged in such programs could be exempt from the documentation requirements in the rule.¹³⁰

105. The Department stated that its focus in this part of the rule is delivery of "good client-focused outcomes."¹³¹ The Department also pointed out that, in allowing

¹²³ Comment 9, p. 6.

¹²⁴ Comment 10, p. 6.

¹²⁵ Comment 26, p.2

¹²⁶ Comment 38, p. 4.

¹²⁷ Response, p. 13.

¹²⁸ Comments 1, 9, 10, 11, 12, 16, 20, 25, 29, 30, 32, 37, 38, 51, 52, 57.

¹²⁹ Comments 1, 30.

¹³⁰ Comments 29, 30, 31, 57.

¹³¹ Response, p. 13.

mental health practitioners who are not clinical trainees to be reimbursed for non-psychotherapy services, it was necessary to apply standards that ensure consistent, high-quality mental health services from all clinical supervisors.¹³²

106. In explaining its rejection of the training programs' requests to permit the use of their own supervision standards in lieu of the rule requirements, the Department pointed out the great difficulty, and potential unfairness, of enforcement of a number of different standards. The Administrative Law Judge agrees that consistency, enforceability and fairness are all appropriate reasons for the Department to determine that it must adhere to a single set of supervision standards for all practitioners. The Department rejected a suggestion that it pay a flat monthly fee per supervisee for clinical supervision service,¹³³ along with suggestions that rules governing clinical certification as a Community Mental Health Center in chapter 9520 apply to clinical supervision in lieu of the proposed rules.¹³⁴ The Department asserted that the program certification rules in chapter 9520 serve a different purpose than the proposed rules and are not an appropriate substitute for them.¹³⁵

107. The proposed rule allows people who are not clinical trainees to provide services, and the Department has established that supervision documentation is reasonable and necessary to ensure that clients receive high-quality mental health services.

108. The Department did propose to modify subpart 4, item D, by deleting subitems 4 and 5 on lines 11.4 through 11.14 as follows:

~~(4) de-identified summary of client information discussed with the supervisee including:~~

~~(a) high risk or safety concerns;~~

~~(b) report of client's progress in accomplishing specific treatment plan goals and objectives;~~

~~(c) new presenting clinical issues; and~~

~~(d) identified concerns about administrative activity regarding the client's treatment and a plan to rectify the concerns;~~

~~(5) documentation of the supervisor's availability to the supervisee while the supervisee is providing client services. The supervisor may be available in person, by telephone, or by audio, or audiovisual electronic device;~~

~~(6) (4) subsequent actions that the supervisee must take; and~~

¹³² *Id.*

¹³³ Hearing Ex. H, Judisch e-mail (Nov. 12, 2010), Response, p. 15.

¹³⁴ Comment 10, Response at 16.

¹³⁵ Response, pp. 3 and 16.

(7) (5) date, time and signature of the clinical supervisor.¹³⁶

109. The Department also proposed to modify the documentation requirements on line 10.23-10.24 as follows:

D. ~~Each occurrence of clinical supervision must be documented and recorded in the supervisee's supervision record. The documentation must include.~~¹³⁷

110. These changes are needed and reasonable and do not make the rule substantially different under Minn. Stat. § 14.05, subd. 2.

Qualified providers: 9505.0371, subps. 5 A(1) and 5 A(2).

111. Two commenters made recommendations for technical corrections to this subpart. Kate Zacher-Pate, on behalf of the Board of Social Work, pointed out that the Board of Social Work's statutes will be recodified effective August 1, 2011, from chapter 148D to 148E.¹³⁸ In response to these comments, the Department proposed to modify the rule at lines 12.1-12.3 as follows:

(1) in clinical social work, a person must be licensed as an independent clinical social worker by the Minnesota Board of Social Work under Minnesota Statutes, chapter 148D until August 1, 2011, and thereafter licensed by chapter 148E.

112. The Administrative Law Judge agrees that a change is needed and reasonable and does not make the rule substantially different under Minn. Stat. § 14.05, subd. 2, but recommends the following re-phrasing of this modification, for the sake of clarity and consistency:

(1) in clinical social work, a person must be licensed as an independent clinical social worker by the Minnesota Board of Social Work under Minnesota Statutes, chapter 148D until August 1, 2011, and thereafter under chapter 148E.

113. Angelina Barnes, Executive Director of the Minnesota Board of Psychology, commented that the Board of Psychology is in the process of adopting proposed rules in the areas of licensure, continuing education, rules of conduct and terminology. As part of these rule updates, the Board of Psychology will seek to eliminate the requirement that licensees submit to the Board their declared areas of competence.¹³⁹ Ms. Barnes states that the parts of this proposed rule requiring that qualified providers who are psychologists have "stated to the board [of Psychology]

¹³⁶ Response, p. 14.

¹³⁷ Rebuttal, p. 18.

¹³⁸ Comment 37, p.1.

¹³⁹ Comment 35, pp. 1-2.

competencies in the diagnosis and treatment of mental illness,” that a neuropsychological assessment “be conducted by a neuropsychologist with competence in the area of neuropsychological assessment as stated to the Minnesota Board of Psychology,” and that psychological testing “be validated in a face-to-face interview between the client and a licensed psychologist with competence in the area of psychological testing” will become obsolete when the Psychology Board repeals the requirement that psychologists declare and maintain competencies with the Minnesota Board of Psychology.¹⁴⁰ In the Board’s view, the practice of declaring competencies is unsupported by empirical data to support such competence. Ms. Barnes did not make any specific suggestions for modifying the rule language.¹⁴¹

114. The Department did not respond to Ms. Barnes’ comments. However, in later parts of the rule, dealing with neuropsychological assessment and testing, the Department removed references to competencies “as stated to the Board of Psychology.” The Administrative Law Judge recommends, assuming that the Department intends to be consistent throughout the rule in its decision not to include the “stated competency” requirement for licensed psychologists, that the Department modify the language at lines 12.4-12.6 as follows:

(2) in psychology, a person licensed by the Minnesota Board of Psychology under Minnesota Statutes, sections 148.88 to 148.98, ~~who has stated to the board competencies in the diagnosis and treatment of mental illness;~~

115. This change is optional. There is no evidence in the record that the Board of Psychology has begun the rulemaking process about which Ms. Barnes testified. While the Board may be planning to make the changes regarding stated competencies at some point in the future, the Department cannot be required to change its proposed rule based on what may or may not happen in the future. Should the Department decide to adopt the recommended change, however, it would be needed and reasonable and would not make the rule substantially different under Minn. Stat. § 14.05, subd. 2.

116. Several commenters recommended adding additional providers to the list of mental health professionals whose services are eligible for reimbursement.¹⁴² Many of the comments specifically suggested that certified nurse practitioners, nurse practitioners and qualified psychiatric nurses be included as mental health professionals.¹⁴³ One commented that Board Certified Behavior Analysts should be funded.¹⁴⁴ One expressed concern that the definition of “mental health professional” for medical assistance funding purposes in the proposed rule is narrower than the definition of “mental health professional” in the Adult Mental Health Act (Minn. Stat. § 245.462,

¹⁴⁰ Comment 35.

¹⁴¹ *Id.*, p.2.

¹⁴² Comments 1, 10, 26, 15, 37, 46.

¹⁴³ Comments 1, 10, 15, 26.

¹⁴⁴ Comment 46.

subd. 18), in that the rule language does not include social workers who have not attained licensure status with the Board of Social Work.¹⁴⁵

117. The Department did not respond directly to these latter two comments, except to state that it "does not intend to add other occupations to the list of qualified mental health professionals except for [those discussed below]."¹⁴⁶ The Administrative Law Judge agrees that it is reasonable not to include Board Certified Behavior Analysts unless these persons are otherwise eligible as qualified providers (for example, as licensed psychologists). It is also reasonable not to include individuals who have not yet attained licensure by the Board of Social Work, when all other mental health professionals (except tribally approved professionals)¹⁴⁷ require licensure status.

118. The Department did agree to modify the rule by adding a new sub-item to proposed rule 9505.0371, subp. 5 A, beginning with line 12.18 and continuing as follows:

and who is serving a federally recognized Indian tribe; or
(7) in psychiatric nursing: a registered nurse who is licensed under Minnesota Statutes, section 148.171 to 148.285; and who is certified as a clinical specialist and
(a) for children; as a nurse practitioner in child or adolescent or family psychiatric and mental health nursing by a national nurse certification organization; or
(b) for adults; as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization.¹⁴⁸

119. This change is needed and reasonable and does not make the rule substantially different under Minn. Stat. § 14.05, subd. 2.

Qualified Providers: 9505.0371, subp. 5 B 1 (Language fluency).

120. In response to a comment from Trisha Stark of the Minnesota Psychological Association,¹⁴⁹ recommending a wording change for the sake of consistent use of language within the rule, the Department proposed to modify the rule at line 13.3 as follows:

(b) is fluent in the non-English language of the ethnic cultural group to which¹⁵⁰

¹⁴⁵ Comment 37, pp. 2-3.

¹⁴⁶ Response, p. 18; Rebuttal, pp. 20-21.

¹⁴⁷ See Minn. R. 9505.0371, subpt. 5.A. (6), and Minn. Stat. § 256B.02, subd. 7 (b) and (c).

¹⁴⁸ Rebuttal, p. 21.

¹⁴⁹ Comment 38, p. 4.

¹⁵⁰ Rebuttal, pp. 21-22.

121. The Administrative Law Judge agrees that this change is needed and reasonable and does not make the rule substantially different under Minn. Stat. § 14.05, subd. 2.

Qualified Providers: 9505.0371, subp. 5 C (Explanation of findings by clinical trainees).

122. In response to a comment by Mr. Brand,¹⁵¹ the Department proposed to modify the rule at lines 13.20-13.21 so that explanations of findings by clinical trainees will be a covered service, as follows:

C. Medical assistance covers diagnostic assessment, explanation of findings and psychotherapy performed by a mental health practitioner working as a clinical trainee when:

123. This change is needed and reasonable and does not make the rule substantially different under Minn. Stat. § 14.05, subd. 2.

Qualified Providers: 9505.0371, subp. 5 D (Clinical supervisor).

124. Ms. Diane Cross, writing on behalf of Fraser, recommended that the requirement that supervisors be "recognized as a qualified clinical supervisor by the person's professional licensing board" be eliminated because not all licensing boards provide such recognition.¹⁵² In response, the Department proposed to modify the rule at line 14.15-14.16 as follows:

(3) be approved, certified, or in some other manner recognized as a qualified clinical supervisor by the person's professional licensing board when this is a board requirement.

125. This change is needed and reasonable and does not make the rule substantially different under Minn. Stat. § 14.05, subd. 2.

Individual Treatment Plan: 9505.0371, subp. 7.

126. Ms. Siebert, of the Minnesota Disability Law Center, commented on subpart 7, the individual treatment plan (ITP) requirements. Ms. Siebert was particularly concerned with the language permitting a mental health professional or practitioner to determine whether it is appropriate for a client to sign the ITP.¹⁵³ The Department agreed with Ms. Siebert's comments and proposed to change to proposed rule language at lines 16.16-16.21 as follows:

¹⁵¹ Comment 9, p. 10.

¹⁵² Comment 10, pp. 3-4.

¹⁵³ Comment 19, p. 4.

~~If the mental health professional or practitioner determines that it is not appropriate for the client to sign the ITP, the mental health practitioner or mental health professional shall document the reason why it was not signed. The mental health professional or practitioner shall request the client or other person authorized by statute to consent to mental health services for the client, to sign the client's individual treatment or revision of the plan. In the case of a child, the child's parent, primary caregiver, or other person authorized by statute to consent to mental health services for the child, will be asked to sign the child's individual treatment plan and revision of the plan. If the client or authorized person refuses to sign the plan or a revision of the plan, the mental health professional or mental health practitioner shall note on the plan the refusal to sign the plan and the reason or reasons for the refusal.~~¹⁵⁴

127. The Department's proposed changes will result in some duplication of language and lack of clarity. While retaining the sense of the proposed changes, the Administrative Law Judge recommends that the Department modify the subpart at lines 16.8-16.22 in the following manner:

Subp. 7. Individual treatment plan. Except as provided in subpart 2, item A, subitem (1), a medical assistance payment is available only for services provided in accordance with the client's written individual treatment plan (ITP): The client must be involved in the development, review, and revision of the client's ITP. For all mental health services, except as provided in subpart 2, item A, subitem (1), and medication management, the ITP and subsequent revisions of the ITP must be signed by the client before treatment begins. ~~The ITP shall be signed by the client, or in the case of a child, the child's parent, primary caregiver, or other person authorized by statute to consent to mental health services for the child, shall sign the client's ITP. If the mental health professional or practitioner determines that it is not appropriate for the client to sign the ITP, the mental health practitioner or mental health professional shall document the reason why it was not signed. The mental health professional or practitioner shall request the client, or other person authorized by statute to consent to mental health services for the client, to sign the client's ITP or revision of the plan. In the case of a child, the child's parent, primary caregiver, or other person authorized by statute to consent to mental health services for the child, will be asked to sign the child's ITP and revision of the plan. If the client or authorized person refuses to sign the plan or a revision of the plan, the mental health professional or mental health practitioner shall note on the plan the~~ If the client refuses to sign the plan or a revision of the plan, the mental health professional or mental health practitioner shall document the client's refusal to sign the plan and the client's reason or reasons for the refusal. A client's individual treatment plan must be:

¹⁵⁴ Rebuttal, p. 23.

128. By proposing these changes, the Department remedies what would otherwise have been a defect in the rule because the rule was vague and ambiguous and could have been interpreted to allow providers to prevent competent adults from signing their own treatment plans. These changes are needed and reasonable and do not make the rule substantially different under Minn. Stat. § 14.05, subd. 2.

Service Coordination: 9505.0371, subp. 9 B.

129. As proposed, this subpart required a mental health provider to coordinate with a physical health provider if the client's physical health impacted the client's mental health. Sue Abderholden, on behalf of the National Alliance on Mental Illness (NAMI) of Minnesota, recommended that language be added to subpart 9 to ensure coordination in the corollary situation, when the client's mental health has an impact on physical health.¹⁵⁵ The Department agreed with this comment and proposed to modify the rule at lines 18.1-18.3 as follows:

B. The mental health provider must coordinate mental health care with the client's physical health provider ~~if the client's physical health has an effect on the client's mental health functioning.~~

130. This change is needed and reasonable and does not make the rule substantially different under Minn. Stat. § 14.05, subd. 2

Part 9505.0372: Covered Services

Diagnostic assessment: 9505.0372, subp. 1 (Generally).

131. A number of commenters expressed concerns about reimbursement rates for diagnostic assessments. One commenter stated her agency has "significant concerns that increased reimbursement will not be significant enough to offset the current and additional costs."¹⁵⁶ Another requested that implementation of the diagnostic assessment requirements be denied, or at least delayed "until service providers are given information as to what the rates will be paid for each of the specific [diagnostic assessment] services proposed."¹⁵⁷ A third stated that his agency's "concerns relate to the rate changes that will come into play when the new rule is implemented,"¹⁵⁸ and a fourth stated that the agencies she represents "are concerned that the costs of completing these new levels of diagnostic assessments will not be covered by the yet to be disclosed rates."¹⁵⁹ Jana Judisch, on behalf of Village Family Service Center, commented that reimbursements for diagnostic assessments should be

¹⁵⁵ Comment 26, p. 2.

¹⁵⁶ Comment 11, p. 2.

¹⁵⁷ Comment 20.

¹⁵⁸ Comment 42.

¹⁵⁹ Comment 43, pp. 1-2.

set at \$100.00 per hour and that certain types of assessments should be allowed specific numbers of hours for completion.¹⁶⁰

132. The Department responded to Ms. Judisch's e-mail, stating that it "did not set rates in part 9505.0323 and does not intend to expand the scope of these proposed rules to cover rate setting for specific services described in this rule."¹⁶¹ The Department speculated that "[a]n attempt to set rates through this rule might be viewed as a substantial change to the rule."¹⁶² The Administrative Law Judge recognizes that rate-setting was not within the scope of this rulemaking proceeding and agrees with the Department's decision to decline to address specific payment rates in the rule. The Administrative Law Judge does recommend that the Department make certain that these commenters, and others who may have similar concerns, are involved in the process as the Department moves forward with rate-setting for the services covered by this rule.

Diagnostic assessment: 9505.0372, subp. 1 B.

133. Mr. Brand made a number of recommendations for modifications to the language setting forth the factors to be addressed in the standard diagnostic assessment. The Department proposes to adopt some of Mr. Brand's recommendations, as follows:

At line 19.2:

(a) age and ~~stage of life~~;

At line 19.13:

(h) contextual nonpersonal factors contributing to the client's presenting ~~problems~~ concerns;

At line 19.18:

(b) description of symptoms ~~or problems~~, including reason for referral;

At line 19.19-19.20

(c) history of mental health ~~problems, trauma, and~~ treatment, including review of the client's records;

134. Mr. Brand also pointed out that there was a word missing from subpart 1, item B, subitem (8). The Department proposes to modify this subitem at line 20.16, as follows:

(8) the client data that is adequate to support the findings on all axes of the

¹⁶⁰ Hearing Ex. H., Judisch e-mail (Nov. 12, 2010).

¹⁶¹ Response, p. 22.

¹⁶² *Id.*

135. These changes to the proposed rule are needed and reasonable and do not make the rule substantially different under Minn. Stat. § 14.05, subd. 2.

Diagnostic assessment: 9505.0372, subps. 1 B and 1 C.

136. Ms. Cross recommended that the Department clarify that “relevant information” is what is required in the standard and extended diagnostic assessments. Ms. Cross noted that “it is not always clinically appropriate to collect all of the components for every client. In many cases, that level of information is too excessive or unrealistic for hard-to-serve or vulnerable clients.”¹⁶³ Other commenters expressed similar concerns.¹⁶⁴

137. The Department agreed to modify the language in subpart 1 B at lines 18.24-18.25, which governs the standard diagnostic assessment, as follows:

The standard diagnostic assessment must be done within the cultural context of the client and must include relevant information about:¹⁶⁵

138. The Department did not address Ms. Cross’ second recommendation, which was to modify the language in subpart 1 C at lines 21.7-21.8, which governs the extended diagnostic assessment, as follows:

The components of an extended diagnostic assessment include relevant information about:

139. The Administrative Law Judge recommends that the Department adopt this second modification suggested by Ms. Cross. It is reasonable that both the standard and the extended diagnostic assessments contain only information which is relevant to the particular client being assessed. Failure to adopt this second recommendation will not result in a defect in the rule, but the Administrative Law Judge concludes that adopting this change will improve the rule and make it internally consistent.

140. These changes are needed and reasonable and do not make the rule substantially different under Minn. Stat. § 14.05, subd. 2.

Extended diagnostic assessment: 9505.0372, subp. 1 C.

141. This rule part describes the circumstances in which an extended diagnostic assessment is made, based on the complex needs of the client. Two commenters asked for clarification of the meaning of the phrase “need to disentangle prior disorders” as a basis for an extended diagnostic assessment.¹⁶⁶ One of the

¹⁶³ Comment 10, p. 5.

¹⁶⁴ Comments 9, 11, 12, 43.

¹⁶⁵ Rebuttal, p. 25.

¹⁶⁶ Comment 9, p. 9; Comment 38, p. 4.

requests suggested modifying the language by inserting the words “and current” after the word “prior” in the phrase.¹⁶⁷ The Department proposed to modify the rule at line 20.24-20.25 as follows:

Complex needs are those caused by acuity of psychotic disorder; cognitive or neurocognitive impairment; need to disentangle prior and current disorders;¹⁶⁸

142. The Administrative Law Judge agrees that adding the words “and current” clarifies the rule to some extent; however, it is still not clear what the word “disentangle” means. In its first response to comments, the Department explained that “this requirement is intended to ensure that provide[r]s consider prior diagnoses and determine their current applicability.”¹⁶⁹ If “disentangle” is not a term of art, the Administrative Law Judge recommends that the Department consider modifying the language further by using the explanatory phrase in its response, “need to consider past diagnoses and determine their current applicability.” This is a recommendation intended to clarify the rule. Failure to make this change would not result in a finding of a defect in the rule.

Extended diagnostic assessment: 9505.0372, subp. 1 C.

143. Lucas Kunach, who commented on behalf of Fraser, requested clarification that a child’s extended diagnostic assessment is permitted, but not required, to include observation of the child in out-of-office settings.¹⁷⁰ Mr. Brand made essentially the same comment, along with several other recommendations for modifications of adult and child diagnostic assessments.¹⁷¹ The Department agreed with the need for clarification and change and proposed the following modification of the rule language, at lines 21.3-21.7:

For child clients, the appointments may be conducted outside the diagnostician’s office for face-to-face consultation and information gathering with family members, doctors, caregivers, teachers, and other providers, with or without the child present, and ~~must~~ may involve directly observing the child in various settings that the child frequents such as home, school, or care settings. To complete the diagnostic assessment with adult clients, the appointments may be conducted outside the diagnostician’s office for face-to-face assessment with the adult client. The appointments may involve directly observing the adult client in various settings that the adult frequents such as home, school, job, service settings, or community settings. The appointments may include face-to-face meetings with the adult client and the client’s family members,

¹⁶⁷ Comment 9, p. 10.

¹⁶⁸ Rebuttal, p. 27.

¹⁶⁹ Response, p. 27.

¹⁷⁰ Hearing Ex. H, Kunach e-mail (Nov. 14, 2010).

¹⁷¹ Comment 9, pp. 9-10.

doctors, caregivers, teachers, social support network members, recovery support resources representatives, and other providers for consultation and information gathering for the diagnostic assessment. The components of an extended diagnostic assessment include:¹⁷²

144. These changes are needed and reasonable and do not make the rule substantially different under Minn. Stat. § 14.05, subd. 2.

Diagnostic assessments: 9505.0372, subps. 1 D and 1 E.

145. Ms. Donna Baker, on behalf of LMHC, expressed concern that the brief diagnostic assessment and the adult diagnostic assessment update are not clearly distinguishable from other kinds of diagnostic assessments.¹⁷³ While the Department did not propose to change any of the rule language, it did offer this clarification:

The brief diagnostic assessment allows a clinician to create a provisional hypothesis in situations where minimal information is known about a client The brief assessment authorizes 10 sessions in which a therapist can focus on brief interventions and if more sessions are needed, the clinician may conduct a standard assessment utilizing the knowledge gained about the client and the client's situation from the previous 10 sessions.

The adult diagnostic assessment update is a means for updating information (see item E, subitems (1) to (7)) without having to conduct a complete standard or extended assessment for on-going clients. The adult diagnostic assessment update was previously an uncovered service that will be covered under the proposed rule amendments.¹⁷⁴

146. Peg Hayes and Tony Yang, on behalf of the Wilder Foundation, commented on the importance of permitting mental health professionals to use their clinical judgment to determine which diagnostic assessment to use, as well as how to conduct the assessment.¹⁷⁵ The Department affirmed that it "encourages clinicians to use clinical judgment to determine which diagnostic assessment is warranted. In general, the department agrees with respecting the judgment of the professional."¹⁷⁶

147. These comments highlight the intent of the rule language, but do not change what is already apparent from a careful reading of the rule as proposed. It is not necessary to make any additional changes to part 9505.0371, subpart 1.

¹⁷² Rebuttal, pp. 27-28.

¹⁷³ Comment 12, pp. 1-2.

¹⁷⁴ Response, p. 27.

¹⁷⁵ Comment 16, p. 2.

¹⁷⁶ Response, p. 28.

Neuropsychological assessments: 9505.0372, subp. 2 C:

148. This rule part provides that a client is eligible for a neuropsychological assessment if certain criteria are met, including a known or strongly suspected brain disorder based on medical history or neurological evaluation, or cognitive or behavioral symptoms that suggest the client has an organic condition that cannot readily be attributed to functional psychopathology.

149. Karen Wills, a neuropsychologist certified by the American Board of Clinical Neuropsychology (ABCN), who practices exclusively with children and adolescents at Children's Hospitals and Clinics of Minnesota, commented in detail about her concerns about the proposed rule.¹⁷⁷ Specifically, Dr. Wills expressed concern that the proposed eligibility standards for neuropsychological assessment do not take into account the particular needs and circumstances of children and adolescents with a variety of disorders.

150. The Department accepted the revisions proposed by Dr. Wills and has agreed to modify lines 24.9 through 24.16 as follows:

B. In the absence of a medically verified brain disorder based on medical history or neurological evaluation, there are cognitive or behavioral symptoms that suggest that the client has an organic condition that cannot be readily attributed to functional psychopathology, ~~or suspected neuropsychological impairment in addition to functional psychopathology.~~ or suspected neuropsychological impairment in addition to functional psychopathology. Examples include:

.....

- (4) marked behavioral or personality change; and
- (5) in children or adolescents, significant delays in academic skill acquisition or poor attention relative to peers;
- (6) in children or adolescents, significant plateau in expected development of cognitive, social, emotional, or physical function, relative to peers; and
- (7) in children or adolescents, significant inability to develop expected knowledge, skills, or abilities, as required to adapt to new or changing cognitive, social, emotional, or physical demands.

151. These changes are needed and reasonable and do not make the rule substantially different under Minn. Stat. § 14.05, subd. 2.

Neuropsychological assessments: 9505.0372, subp. 2 D.

152. The proposed rule provides that neuropsychological testing must be conducted by a neuropsychologist who is (1) validated by a diploma awarded by the American Board of Clinical Neuropsychology (ABCN); (2) approved by the

¹⁷⁷ Comment 51.

commissioner as an eligible provider of neuropsychology assessment prior to December 31, 2010; (3) granted provisional approval by the commissioner, pending board certification by the ABCN; or (4) credentialed by another state that has equivalent diploma status requirements.

153. A number of commenters wrote to express concerns about the certification standards proposed for neuropsychologists.¹⁷⁸ The professional community raised concerns that reliance on the ABCN alone will exclude well-qualified professionals who are certified by other boards, including the American Board of Professional Neuropsychology (ABN) and the American Board of Pediatric Neuropsychology (ABPdN).

154. In addition, a number of commenters pointed out that, unlike the field of medicine, in which specialty physicians are almost uniformly board-certified, there is no precedent in the field of psychology for requiring board certification in order to practice a specialization. They note that only a small percentage (estimates vary from about 5% to 20%) of psychologists nationwide have any form of board certification in any specialty. Within Minnesota, there are very few neuropsychologists (about 29) who are certified by the ABCN, and a rule requiring board certification would severely restrict access to providers in the state.¹⁷⁹ More than half of those providers are located in Minneapolis. Dr. Steve Hughes, President of the ABPdN, noted that certification by the ABCN does not demonstrate whether a neuropsychologist has pediatric training or experience.¹⁸⁰ According to a letter from the National Academy of Neuropsychology, only 6 neuropsychologists in Minnesota are certified by the ABN, and one is certified by the ABPdN. This means that there are approximately 37 neuropsychologists in the state who could meet the board certification requirement. Given the number of MA-eligible children in Minnesota, that results in a ratio of approximately 1 certified neuropsychologist available to serve every 100,000 MA-eligible children.¹⁸¹

155. Many of the commenters, including the Minnesota Board of Psychology, the Minnesota Psychological Association, and the National Academy of Neuropsychology, recommended that board certification not be required, but proposed language that would require providers to demonstrate their qualifications through documentation of training and experience.¹⁸²

156. In the SONAR, the Department stated that increasing numbers of clients want to determine the reason for failing memory or other cognitive problems, and it is necessary and reasonable to establish criteria for neuropsychological assessment because the use of such assessments is increasing. It maintains the rule criteria are reasonable because demand for a specialized service must be met with the development of standards that ensure the service is delivered by qualified providers

¹⁷⁸ Comments 13, 14, 28, 33, 34, 35, 38, 40, 50.

¹⁷⁹ Comments 13, 33, 34, 38, 50.

¹⁸⁰ Comment 50.

¹⁸¹ Comment 50.

¹⁸² Comments 13, 14, 28, 33, 34, 35, 38, 50.

with sufficient expertise and ensure that the services are medically necessary. The Department found it necessary and reasonable to require professional credentialing to promote competency and high quality treatment, to protect persons receiving services, and to ensure appropriate use of public resources. It maintains that "using this well-accepted credential will prevent unproven representation of specialty competence by practitioners, which could otherwise do public harm and waste limited public resources."¹⁸³

157. In response to the above comments, the Department proposed to modify the rule language at lines 24.19 through 25.3 as follows:

D. The neuropsychological assessment must be conducted by a clinical neuropsychologist with competence in the area of neuropsychological assessment. As stated to the Minnesota Board of psychology and be in addition to basic training as a psychologist, specialty education and training in neuropsychology is essential. The International Neuropsychological Society (INS) and Division 40 of the American Psychological Association (APA) have developed guidelines for specialty training in clinical neuropsychology. Psychologists seeking enrollment as a neuropsychologist must meet one of the following:

- (1) have been awarded validated by a diploma awarded to the neuropsychologist by the American Board of Clinical Psychology, the American Board of Professional Neuropsychology, or the American Board of Pediatric Neuropsychology;
- (2) have been approved by the commissioner as an eligible provider of neuropsychological assessment prior to December 31, 2010¹⁸⁴;
- (3) have been granted a provisional approval by the commissioner to an individual for up to ~~two~~ four years pending validation by a diploma granted to the neuropsychologist by one of the American Boards in item (1) of Clinical Neuropsychology; or¹⁸⁵

158. The language regarding the importance of specialty education and training and the existence of INS and APA guidelines for such training is not the language of rule. It does not instruct the reader about qualifications for reimbursement for neuropsychologists. It would be appropriate in a SONAR, but is not needed in a rule and the Department should delete it. The Administrative Law Judge recommends that the proposed changes to Item D. at lines 24.19-24.21 be modified as follows:

D. The neuropsychological assessment must be conducted by a clinical neuropsychologist with competence in the area of neuropsychological assessment. As stated to the Minnesota Board of psychology and be in

¹⁸³ SONAR at 26-27.

¹⁸⁴ The Rebuttal letter listed this date as December 31, 2020, but Department staff confirmed that this was a typographical error and was intended to remain December 31, 2010.

¹⁸⁵ Rebuttal, p. 30.

addition to basic training as a psychologist, specialty education and training in neuropsychology is essential. The International Neuropsychological Society (INS) and Division 40 of the American Psychological Association (APA) have developed guidelines for specialty training in clinical neuropsychology. Psychologists seeking enrollment as a neuropsychologist must meet one of the following:

159. The Administrative Law Judge agrees that it is perfectly reasonable for the Department to conclude that expertise in clinical neuropsychology should be a prerequisite for MA reimbursement of neuropsychological assessment and that public dollars should not be spent on unnecessary testing. The Department has failed to establish, however, that board certification is the "well accepted" credential described in the SONAR. The greater weight of the evidence demonstrates that board certification in neuropsychology is not a well accepted credential, within the state or the nation. The Department has presented no evidence that neuropsychologists who lack board certification have damaged the public welfare or have generated disproportionate numbers of complaints as compared to board-certified neuropsychologists. There are no studies that document that board-certified neuropsychologists provide better care. The Department points to no data showing that neuropsychologists who are not board-certified (or in fact any neuropsychologists, regardless of certification) have ordered unnecessary testing.

160. The Department has not responded specifically to these comments, other than to propose modifications that would accept board certification from any of the three organizations that provide the credential, and to provide for a longer period of conditional approval pending such a credential. It has not addressed the alternative qualifications recommended by several of the commenters or indicated how these recommendations would fail to protect the clients, the providers, or the public funds at issue. Moreover, in other portions of the rules, the Department has agreed to accept documentation of training and experience as a credential for providers of DBT, a type of therapy that appears to be more open-ended and controversial, and potentially more costly, than any neuropsychological assessment. The Administrative Law Judge concludes that the Department has failed to adequately support the portion of the proposed rules requiring board certification in neuropsychology with an affirmative presentation of fact, and as a result, the proposed rule appears to be arbitrary and capricious. It would almost certainly result in fewer reimbursable neuropsychological assessments, but there is no evidence to show that limiting reimbursement to a handful of neuropsychologists will achieve the goal of ensuring the provision of quality services or reducing unnecessary testing. This portion of the rule is defective.

161. The defect could be cured by deleting lines 24.22 through 25.3 and replacing the language as follows:

(1) been awarded a diploma by the American Board of Clinical Neuropsychology, the American Board of Professional Neuropsychology, or the American Board of Pediatric Neuropsychology; or

- (2) earned a doctoral degree in psychology from an accredited university training program; and
- (3) completed an internship, or its equivalent, in a clinically relevant area of professional psychology; and
- (4) completed the equivalent of two fulltime years of experience and specialized training, at least one of which is at the post-doctoral level, in the study and practice of clinical neuropsychology and related neurosciences, supervised by a clinical neuropsychologist; and
- (5) a license in at least one state to practice psychology and/or clinical neuropsychology.

162. The alternative qualification language listed as subitems (2) through (5) is primarily taken from Comment 33, which was submitted by the National Academy of Neuropsychology. While this specific language is not required, some alternative method of demonstrating qualification other than board certification is necessary in order to cure the defect discussed above.

163. These changes would be needed and reasonable and would not make the rule substantially different under Minn. Stat. § 14.05, subd. 2.

Neuropsychological testing: 9505.0372, subp. 3 A.

164. In connection with her comments regarding subpart 2, Dr. Wills also commented that the proposed rule failed to adequately address the need for psychological testing in children and adolescents.¹⁸⁶ The Department agreed with Dr. Wills' comments and proposed changes to the rule language at lines 25.9-25.12 and 26.1-26.8 as follows:

- (1) a significant mental status change that is not a result of a metabolic disorder that has failed to respond to treatment; or
- (2) in children or adolescents, a significant plateau in expected development of cognitive, social, emotional, or physical function, relative to peers; or
- (3) in children or adolescents, a significant inability to develop expected knowledge, skills or abilities, as required to adapt to new or changing cognitive, social, emotional, or physical demands; or
- (4) a significant behavioral change, memory loss, or other organic brain injury or suspected neuropsychological impairment in addition to functional psychopathology, or one of the following:

...

- (k) exposure to systemic or intrathecal agents or cranial radiation known to be associated with cerebral dysfunction; or
- (l) systemic medical conditions known to be associated with cerebral dysfunction, including renal disease, hepatic encephalopathies, cardiac

¹⁸⁶ Comment 51.

anomalies, sickle cell disease and related hematologic anomalies, and autoimmune disorders such as lupus erythematosus or celiac disease;
(m) congenital, genetic, or metabolic disorders known to be associated with cerebral dysfunction, such as phenylketonuria, craniofacial syndromes, or congenital hydrocephalus;
(n) severe or prolonged malnutrition or malabsorption syndromes;
(o) a condition presenting in a manner making it difficult for a clinician to distinguish between:
(i) the neurocognitive effects of a neurogenic syndrome such as dementia or encephalopathy; and
(ii) a major depressive disorder when adequate treatment for major depressive disorder has not resulted in improvement in neurocognitive function, or another disorder such as autism, selective mutism, anxiety disorder, or reactive attachment disorder.¹⁸⁷

165. These changes are needed and reasonable and will not make the rule substantially different under Minn. Stat. § 14.05, subd. 2.

Neuropsychological testing: 9505.0372, subp. 3 B.

166. Based on a comment made at the hearing about conflicting requirements at items 3 B and 3 C in this subpart, the Department proposes to delete item B at lines 26.9-26.10:

~~B. Neuropsychological testing must be validated in a face to face interview between the client and a licensed neuropsychologist as defined in subpart 2, item D.~~¹⁸⁸

167. This change is needed and reasonable and will not make the rule substantially different under Minn. Stat. § 14.05, subd. 2.

Psychological testing: 9505.0372, subp. 4.

168. Dr. Eli Coleman of the University of Minnesota Medical School commented that psychological testing could be delivered by a mental health practitioner who is supervised by a licensed psychologist who signs the report.¹⁸⁹ The Department agreed, and proposed a change based on Dr. Coleman's comments, along with a change based on the comment by Angelina Barnes on behalf of the Board of Psychology.¹⁹⁰ The Department's proposed changes to this subpart, at lines 26.22 through 27.5 are as follows:

¹⁸⁷ Rebuttal, pp. 31-32.

¹⁸⁸ Rebuttal, p. 30.

¹⁸⁹ Comment 31.

¹⁹⁰ Comment 35, pp. 1-2.

A. The psychological testing must:

- (1) be administered or clinically supervised by a licensed psychologist ~~with competence in the area of psychological testing as stated to the Minnesota Board of Psychology;~~ and
- (2) be validated in a face-to-face interview between the client and a licensed psychologist ~~with competence in the area of psychological testing~~ or a mental health practitioner working as a clinical psychology trainee, as required by part 9505.0371, subpart 5, item C, under the clinical supervision of a licensed psychologist as required in part 9505.0371, subpart 4, item A, subitem (2).¹⁹¹

169. These changes are needed and reasonable and will not make the rule substantially different under Minn. Stat. § 14.05, subd. 2.

Psychotherapy: 9505.0372, subp. 6.

170. Dr. Coleman commented that the language of this subpart is unclear as to whether a mental health practitioner could provide psychotherapy under the supervision of a mental health professional.¹⁹² In response to Dr. Coleman's comments, the Department proposes to modify lines 27.24-25 and 28.15-29.2 as follows:

Subp. 6. Psychotherapy. Medical assistance covers psychotherapy as conducted by a mental health professional or a mental health practitioner as defined in part 9505.0371, subpart 5, item C as provided in this subpart.

C. Group psychotherapy is appropriate for individuals who because of the nature of their emotional, behavioral, or social dysfunction can derive mutual benefit from treatment in a group setting. For a group of three to eight persons, one mental health professional or practitioner is required to conduct the group. For a group of nine to 12 persons, a team of at least two mental health professionals or two mental health practitioners or one mental health professional and one mental health practitioner ~~as defined in part 9505.0371, Subpart 5~~ is required to co-conduct the group. Medical assistance payment is limited to a group of no more than 12 people.

D. A multiple-family group psychotherapy session is eligible for medical assistance payment if the psychotherapy session is designed for at least two but not more than five families. Multiple-family group psychotherapy is clearly directed toward meeting the identified treatment needs of each client as indicated in client's treatment plan. If the client is excluded, the mental health professional or practitioner must document the reason for and the length of time of the exclusion. The mental health professional or

¹⁹¹ Rebuttal, p. 32.

¹⁹² Comment 31.

practitioner must document the reasons why a member of the client's family is excluded.¹⁹³

171. These changes are needed and reasonable and will not make the rule substantially different under Minn. Stat. § 14.05, subd. 2.

Adult Day Treatment: 9505.0372, subp. 8 B.

172. Ron Brand commented that subpart 8 should be modified to allow for weekly progress notes.¹⁹⁴ In response, the Department proposed to clarify the language at line 30.11 as follows:

(6) document the interventions provided and the client's response progress daily.

173. This change is needed and reasonable and will not make the rule substantially different under Minn. Stat. § 14.05, subd. 2.

Adult Day Treatment: 9505.0372, subp. 8 C.

174. Ms. Patricia Siebert, of the Minnesota Disability Law Center, commented that the language in subpart 8, item C, subitem (4) requiring cognitive capacity to participate in day treatment, could too easily be applied in an arbitrary manner.¹⁹⁵ To address this concern, the Department proposed to remove the word "cognitive" from line 30.19 as follows:

(4) have the cognitive capacity to engage in the rehabilitative nature, the .
...

175. This change is needed and reasonable and will not make the rule substantially different under Minn. Stat. § 14.05, subd. 2.

Dialectical Behavior Therapy (DBT): 9505.0372, subp. 10.

176. Karen Frees, Senior Clinical Social Worker at the Courage Center, wrote "[t]he process for a program to 'be certified by the Commissioner' needs to be clarified." Ms. Frees was commenting on the reference to certification by the Commissioner in part 9505.0370, subp. 12, of the rule.¹⁹⁶

177. Others wrote with comments about the certification requirements set forth in Minn. R. 9505.0372, subp. 10 E. Lane Pederson and Mark Carlson, of Mental Health Systems, PC, pointed out that no organization currently exists to provide

¹⁹³ Rebuttal, p. 34.

¹⁹⁴ Comment 9, p. 10.

¹⁹⁵ Comment 19, p. 3.

¹⁹⁶ Comment 52, p. 2.

"nationally recognized certification" for DBT providers and programs. They also expressed concerns that "ceding certification and accreditation powers to any such bodies would make it more difficult for DHS to recognize the breadth of evidence-based DBT programs that currently service consumers with demonstrated clinical outcomes."¹⁹⁷ In addition, Mr. Pederson and Mr. Carlson asserted that such national certification "inappropriately infringes upon the Minnesota licensing boards who already have the legislative mandate to regulate practitioners and their competencies."¹⁹⁸ Finally, Ron Brand commented that:

[r]eliance on certification of individual professional and programs is a very high standard that will exclude many providers. There is considerable debate within the field regarding methods and best practices and related certification methods. We encourage language stating that the Commissioner will provide multiple pathways to certification.¹⁹⁹

178. In discussing certification for purposes of DBT, Dr. Witterholt stated that "[T]he availability of a way to access a legitimate, standardized, independent credentialing mechanism as described above is not yet operational and so DHS . . . cannot look to the equivalent of the 'American Board of Medical Specialties' to examine these individuals and programs. For this reason, DHS has had to write the rule in a way that allows them to make use of the standards derived from the evidence and carry out the function of certifying programs themselves."²⁰⁰

179. Dr. Witterholt strongly opposed the idea of "multiple avenues to certification" which would "violate the spirit of the practice of evidence based medicine which implies that for a treatment to work, the providers must do the treatment according to the evidence."²⁰¹

180. Dr. S. Vincent, the Care Center Director for Behavioral Health Services at St. Cloud Hospital, also wrote in opposition to "alternative means or paths to certification."²⁰² Dr. Vincent maintained that "[p]rograms should be certified base[d] on their adherence to evidence based practice, and this should be demonstrated by a consistent set of standards and measures, which are, in turn, consistently applied by the certifying body." Dr. Vincent stated "it is appropriate to have the State determine that the standards are evidence based."²⁰³

181. In its response to the comments about certification, the Department noted these supportive comments. It also noted a drafting error where the term "recipient" was used instead of the preferred term "client." The Department proposed to replace

¹⁹⁷ Comment 44, p. 3.

¹⁹⁸ *Id.*

¹⁹⁹ Comment 9, p. 9.

²⁰⁰ Comment 45, p. 7.

²⁰¹ *Id.*, pp. 7-8.

²⁰² Comment 53, p. 1.

²⁰³ *Id.*

the word "recipient" with the word "client" on page 32, lines 19, 20, 21 and 22.²⁰⁴ These changes are needed and reasonable and are consistent with language used elsewhere in the rule. They do not make the rule substantially different under Minn. Stat. § 14.05, subd. 2.

182. The Department acknowledged the many comments regarding the current impossibility of complying with the certification requirements in part 9505.0372, subp. E 1 as proposed. In response to these comments, the Department proposed changes to subparts 10 E and 10 F. The proposed changes, extending from page 34, line 21 through page 35, line 7 would read as follows:

E. A program must ~~apply to the commissioner and receive certification~~ be certified by the commissioner as a DBT provider. To qualify for certification, a provider must ~~demonstrate the following~~:

(1) ~~the program~~ holds current accreditation as a DBT program from a nationally recognized certification body approved by the commissioner; or submit to the commissioner's inspection and provide evidence that the DBT provider will continuously meet the requirements of this subpart;

(2) ~~be~~ is enrolled as a MHCP provider; ~~and~~

(3) ~~collects and reports individual client outcomes as specified by the commissioner;~~ and

(4) have a manual that outlines the DBT program's policies, procedures and practices which meet the criteria in this subpart.

F. The DBT treatment team must consist of persons who are trained in DBT treatment. The DBT treatment team may include persons from more than one agency. Professional and clinical affiliations with the DBT team must be delineated. ~~The DBT multidisciplinary team must have at least one member who is certified as a DBT clinician by a nationally recognized certification body that is approved by the commissioner, and meets the following qualifications and supervision standards:~~²⁰⁵

183. These changes provide an alternative means of certification by the commissioner that does not rely on accreditation by a non-existent nationally recognized certification body. By proposing these changes the Department remedies what would otherwise have been a defect in the rule. These changes are needed and reasonable and do not make the rule substantially different under Minn. Stat. § 14.05, subd. 2.

184. The Department also agreed with additional wording change suggestions by Dr. Witterholt, proposing to modify lines 34.12 through 34.17 by eliminating the

²⁰⁴ Rebuttal, p. 37.

²⁰⁵ Rebuttal, pp. 38-39.

proposed clauses (a), (b) and (c) on page 34, lines 34.12 through 34.17 and replacing them with new clauses (a) through (d) as follows:

- (a) mindfulness;
- (b) effectiveness;
- (c) emotional regulation; and
- (d) distress tolerance.²⁰⁶

185. Based on Dr. Witterholt's comments, the Department also proposed a new subitem (5) on page 34, after line 20:

(5) The need for individual DBT skills training must be determined by a mental health professional or a mental health practitioner working as a clinical trainee, according to part 9505.0371, subpart 5, item C, under the supervision of a licensed mental health professional according to part 9505.0371, subpart 5, item D.²⁰⁷

186. These changes, which align the requirements for DBT with the language used in the treatment model, are needed and reasonable and do not make the rule substantially different under Minn. Stat. § 14.05, subd. 2.

187. The Department declined to make additional suggested changes, based on the limitations established by the statute authorizing DBT payments and on the professional credential level required for DBT training.²⁰⁸ The Administrative Law Judge agrees that these changes are not necessary.

Effective Date.

188. The Department originally included an effective date of January 1, 2011 in the proposed rule. Due to the timing of the hearing and comment periods, it is apparent that the rulemaking process will not be complete in time for the rule to be effective on that date. The rule will become effective on the date established by operation of Minn. Stat. § 14.18, subd. 1.

Based on the Findings of Fact, the Administrative Law Judge makes the following:

CONCLUSIONS

1. The Minnesota Department of Human Services gave proper notice in this matter.
2. The Department has fulfilled the procedural requirements of Minn. Stat.

²⁰⁶ *Id.*

²⁰⁷ Rebuttal, p. 38.

²⁰⁸ Comment 43, Hearing Ex. H, Dale e-mail (Nov. 10, 2010).