

**STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE DEPARTMENT OF HUMAN SERVICES**

In the Matter of the Proposed Rules
Governing the Licensure of Treatment
Programs for Chemical Abuse and
Dependency and Detoxification Programs,
Minnesota Rules, Chapter 9530.

**REPORT OF THE ADMINISTRATIVE
LAW JUDGE**

Administrative Law Judge Kathleen D. Sheehy conducted a hearing concerning the above rules beginning at 9:00 a.m. on November 14, 2003, in the Department of Human Services Building, 444 Lafayette Road, St. Paul, Minnesota. The hearing continued until all interested persons, groups and associations had an opportunity to be heard concerning the proposed rules.

The hearing and this Report are part of a rulemaking process governed by the Minnesota Administrative Procedure Act.^[1] The legislature has designed the rulemaking process to ensure that state agencies have met all of the requirements that Minnesota law specifies for adopting rules. Those requirements include assurances that the proposed rules are necessary and reasonable, that they are within the agency's statutory authority, and that any modifications that the agency may have made after the proposed rules were initially published are not impermissible substantial changes.

The rulemaking process includes a hearing when a sufficient number of persons request that a hearing be held. The hearing is intended to allow the agency and the Administrative Law Judge reviewing the proposed rules to hear public comment regarding the impact of the proposed rules and what changes might be appropriate. The Administrative Law Judge is employed by the Office of Administrative Hearings, an agency independent of the Department of Human Services (Department or DHS).

Cynthia B. Jahnke, Assistant Attorney General, Suite 900 NCL Tower, 445 Minnesota Street, St. Paul, MN 55101, appeared at the rule hearing on behalf of the Department. The members of the Department's hearing panel were: Troy Mangan, Operations Manager for the Department's Chemical Health Division, and Jon Hall, a Legal Analyst with the Department. Forty members of the public signed the hearing register; sixteen members of the public spoke at the hearing.

The Department of Human Services received a substantial number of written comments on the proposed rules before the hearing. After the hearing, the record remained open for twenty calendar days, until December 4, 2003, to allow interested persons and the Department an opportunity to submit written comments. Following the initial comment period, the record remained open for an additional five business days to allow interested persons and the Department the opportunity to file a written response to the comments submitted. The deadline for responses to the comments was December 11, 2003. The OAH hearing record closed for all purposes on December 11, 2003. All of the comments received were read and considered.

NOTICE

This Report must be available for review to all interested persons upon request for at least five working days before the Department takes any further action on the proposed amendments. The Department may then adopt a final rule, or modify or withdraw its proposed amendments. When the rules are filed with the Secretary of State, the Department shall give notice on the day of filing to all persons who requested that they be informed of the filing.

SUMMARY OF CONCLUSIONS

With the following exceptions, the Department has established that it has the statutory authority to adopt the proposed rules and that the rules are necessary and reasonable: see Findings 84, 176, 182, and 197.

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

FINDINGS OF FACT

Nature of the Proposed Rules

1. This rulemaking proceeding involves revising the rules governing the delivery of chemical dependency treatment services. The Department proposes to repeal all existing rules related to chemical dependency treatment and detoxification services (Minn. R. 9530.4100 -.6400) and to replace them with these proposed rules.

2. In the past, the treatment rules were organized into two main sections. The first concerned residential rehabilitation programs^[2] offering different types of services: Category I – detoxification; Category II – primary therapeutic; Category III – long-term care; and Category IV – halfway house. The second section concerned outpatient programs.^[3] Other sections of the rules address chemical dependency care for public assistance recipients^[4] and the consolidated chemical dependency treatment fund.^[5] The new proposed rules abolish the distinctions between residential and outpatient programs, eliminate the definitions of Category I through IV services, and distinguish only between licenses for chemical dependency treatment and detoxification programs. The proposed new rules do not address in any substantial way the sections concerning public assistance recipients or the consolidated chemical dependency treatment fund.

3. The Department maintains that the proposed rules are designed to offer greater flexibility to providers in providing treatment programs that more effectively meet the needs of their clients. The proposed rules also reflect the essential differences between chemical dependency treatment services and detoxification. The goal of chemical dependency treatment is to assist clients in changing behavior related to the harmful use of mood altering chemicals. Many of the standards for this license are drawn from the current rules governing residential programs.^[6] Under the new rules, this license will govern primary residential facilities, extended care facilities, halfway house facilities, and outpatient programs. In contrast, the goal of detoxification programs is to provide a safe environment for withdrawal from chemicals and for assessment of the need for treatment. Clients in detoxification are more vulnerable,

both physically and emotionally. Detoxification must take place in a residential setting, whereas treatment services can be provided in an outpatient setting. Detoxification includes a significant medical services component. Because of the differences in their essential purposes, the Department proposes to license treatment and detoxification programs separately.

4. In general, the standards from the existing rules for residential programs are being carried over and applied to all chemical dependency treatment programs; however, new standards have been added that require the development of a central registry for programs serving intravenous drug users. These standards incorporate federal regulations enacted in 1995 and are required for all federally funded programs that serve intravenous drug abusers.^[7]

Procedural Requirements of Chapter 14

5. On December 9, 1996, the Department published a Request for Comments on Planned Revision of Rules Governing Chemical Dependency Treatment Programs. The Request indicated that the Department was considering restructuring the chemical dependency program licensing rules governing detoxification facilities and programs, residential primary care, extended care and halfway houses, and outpatient care. The Request for Comments was published at 21 State Register 834-835.^[8]

6. In the Request for Comments the Department noted that it had convened an advisory task force to assist in developing the revised rules. The Department stated that the task force represented counties, national associations related to the chemical dependency treatment field, service provider associations, programs for racial and ethnic minorities, regional treatment centers, programs currently providing both detoxification and mental health crisis services in the same facility, and the Office of the Ombudsman for Mental Health and Mental Retardation.

7. By letter dated July 25, 2003, DHS requested that the Office of Administrative Hearings schedule a hearing and assign an Administrative Law Judge. The Department also filed a proposed Dual Notice, a copy of the proposed rules and a draft of the Statement of Need and Reasonableness (SONAR).

8. In a letter dated August 5, 2003, Administrative Law Judge Kathleen Sheehy approved the Department's Dual Notice and Additional Notice Plan.

9. On September 25, 2003, the Department mailed the Dual Notice of Hearing to all persons and associations who had registered their names with the agency for the purpose of receiving such notice and to all persons identified in the additional notice plan. The Dual Notice was mailed to approximately 2,000 addresses. The Dual Notice stated that a copy of the proposed rules was attached to the notice.^[9]

10. On September 25, 2003, the Department sent a copy of the Dual Notice and Statement of Need and Reasonableness by inter-office mail to the legislators specified in Minn. Stat. § 14.116.^[10]

11. On September 25, 2003, the Department mailed a copy of the Statement of Need and Reasonableness to the Legislative Reference Library.^[11]

12. On September 29, 2003, the proposed rule and the Dual Notice of Hearing were published at 28 State Register 360.

13. On September 29, 2003, the Department mailed a correction memo to all persons who received the Dual Notice mailing, informing them that a copy of the proposed rule had not been included in the Dual Notice mailing as indicated and advising them that copies of the proposed rule could be requested from the Department or accessed directly on the Department's website.^[12]

14. As a result of the mailing error, the Department extended the end of the comment period to November 3, 2003.

15. On the day of the hearing the following documents were placed in the record:

A Notice of Solicitation of Outside Information or Opinions Regarding Proposed Amendments to Rules Governing Inpatient and Outpatient Alcohol and Drug Treatment Programs published February 20, 1990 at 14 SR 2054 (Ex. 66);

A Notice of Solicitation of Outside Information or Opinions Regarding Proposed Amendments to Rules Governing Chemical Dependency Care for Public Assistance Recipients published May 15, 1995 at 19 SR 2252 (Ex. 65);

The Request for Comments published December 9, 1996 at 21 SR 834 (Ex. 1);

A copy of the proposed rule with Revisor's approval dated September 22, 2003 (Ex. 2);

A copy of the Statement of Need and Reasonableness (SONAR) (Ex. 3);

The Dual Notice of Hearing as published in the State Register (Ex. 4);

Certificate of Mailing the Dual Notice of Hearing to the Rulemaking Mailing List dated September 25, 2003 (Ex. 5);

Certificate of Accuracy of the Mailing List dated September 25, 2003 (Ex. 6);

Correction of Dual Notice dated September 29, 2003 (Ex. 7);

Certificate of Sending the Dual Notice and SONAR to Legislators (Ex. 8);

Certificate of Mailing the SONAR to Legislative Reference Library (Ex. 9);

Certificate of Giving Additional Notice Pursuant to Additional Notice Plan, Dual Notice and mailing lists dated September 25, 2003 (Ex. 10);

Copies of letters and emails requesting a hearing and written comments on the proposed rules received by DHS (Exs. 11-61, 64 and 67);

Certificate of Mailing Notice of Hearing to Those Who Requested a Hearing dated November 5, 2003 (Ex. 62);

Certificate of Mailing Notice of Hearing to Those Who Requested via E-mail and E-mail mailing list (Ex. 63).

Additional Notice

16. Minnesota Statutes §§ 14.131 and 14.23, require that the SONAR contain a description of DHS's efforts to provide additional notice to persons who may be affected by the proposed rules. DHS submitted an additional notice plan to the Office of Administrative Hearings, which reviewed and approved it by letter dated August 5, 2003. In addition to notifying those persons on the Department's rulemaking list, DHS represented that it would also provide notice to the following groups and individuals:

licensed chemical dependency treatment facilities;

licensed alcohol and drug counselors;

chemical dependency professional organizations;

the Minnesota Hospital Association;

Minnesota hospitals;

major Minnesota health insurance plans;

county chemical dependency offices;

the Minnesota Department of Health's Alcohol and Drug Counselor Licensing Program;

Mothers Against Drunk Driving;

academic programs;

health licensing boards;

federally recognized Indian tribes in Minnesota, and

all others who request notification.

Statutory Authorization

17. The Commissioner is authorized by Minn. Stat. § 245A.09, subd. 1, to adopt rules for the operation, maintenance, and licensure of programs subject to licensure under chapter 245A. Section 245A.03, subd. 1, provides that residential and nonresidential programs are subject to licensure. A residential program means a program that provides "24-hour-a-day care, supervision, food, lodging, rehabilitation, training, education, habilitation, or treatment outside a person's own home."^[13] A nonresidential program means similar services provided outside a person's own home for fewer than 24 hours a day.^[14]

18. A "person" means a child (one who has not reached age 18) or an adult (one who is 18 years of age or older and who is mentally or physically impaired, chemically dependent, or abuses chemicals).^[15]

19. Minn. Stat. § 245A.09, subd. 6, further provides:

Consultation with affected parties. In developing rules, the commissioner shall request and receive consultation from: other state departments and agencies; counties and other affected political subdivisions that reflect the diversity of political subdivisions affected by

the rule; persons and relatives of persons using the program governed by the rule; advocacy groups; and representatives of license holders affected by the rule. In choosing parties for consultation, the commissioner shall choose individuals and representatives of groups that reflect a cross section of urban, suburban, and rural areas of the state.

20. The Department has not specifically addressed this requirement in its SONAR. It appears, however, that these groups were represented on the Advisory Task Force and that a sufficient cross-section of urban, suburban, and rural areas of the state was represented. In addition, the participants in the rule proceeding reflected the groups cited in the statute.

21. With the exceptions noted in Findings 84, 176, 182 and 197, the Administrative Law Judge finds that the Department has the statutory authority to adopt the proposed rules.

Regulatory Analysis in the SONAR

22. The Administrative Procedure Act requires an agency adopting rules to consider seven factors in its Statement of Need and Reasonableness. The first factor requires:

(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.

The Department lists the following as the classes of persons who will be primarily affected by the rules:^[16]

programs governed by the rules;

counties;

health plan companies that contract with licensed treatment providers;

law enforcement personnel who conduct chemical use assessments pursuant to court orders (e.g. pre-sentencing determinations); and

program participants.

The Department states that generally it does not anticipate the proposed rules will create “a significant cost for either providers or the licensing agency.”^[17] However, the Department identifies Methadone providers and one detoxification facility as groups that will bear specific costs. The Department states that the revised rule will affect Methadone providers with the addition of a central registry requirement. Each program serving intravenous drug abusers (Opiate Treatment Programs) must comply with State Central Registry requirements by submitting information concerning each client admitted. Based on a survey of these providers, the additional cost for all providers is estimated at \$8,750.50 per year.

In addition, the Department states that the new rule governing the licensing of detoxification facilities will impact the costs of one detoxification program that currently

conducts its medication counts on a monthly basis. This is a small facility with 12 beds. Under the current standards, the program does not dispense enough medications to warrant a weekly medication count. The new detoxification rule, however, requires a registered nurse to provide consultation and review of the license holder's administration of medication on a weekly basis regardless of the program's size. The program's costs will increase by \$1,200.00 annually to cover the weekly medication count review.

The Administrative Law Judge also notes that in general the proposed rules will create additional costs for license holders related to staff training and staff time spent complying with new requirements, especially for those license holders not previously subject to the rules for residential facilities. The Department has not addressed these costs, but no comments were received suggesting that the costs of compliance with the rule in general were unreasonable or would adversely affect the operation of a substantial number of facilities. Specific objections as to the cost of particular staffing requirements are addressed in the rule-by-rule analysis below.

The Department states that the potential beneficiaries of these proposed rules are the clients receiving treatment and detoxification services from treatment facilities. According to the Department, client health and safety will be better protected by rules requiring facilities to identify potential problems and to implement procedures to correct the problems at the earliest point possible. Clients will also benefit from the expanded range and intensity of services available within a given program. And clients will benefit from the flexibility granted to providers to offer a range of services and to adjust treatment options to meet individual client needs.^[18]

(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.

The Department estimates that the length of time it takes to review a license application under the proposed rule will not be substantially different from the current time schedules. The Department anticipates, however, that the new requirements for nonresidential treatment programs will result in an increase of about five hours for each program review, or about 550 additional hours of review time per year.

DHS also estimates that the number of complaints it receives will increase by approximately 138 per year, based upon the increased standards for nonresidential programs. According to the Department, this increase in the number of complaints will result in approximately 1518 additional hours of Department time investigating complaints for non-residential programs.

DHS states that there will also be one time costs associated with converting to the new rule, such as licenser training, answering questions from license holders and the public, developing and reprinting application and license forms, and programming changes to the license information system.

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

The Department states that in general the proposed rules consist of standards carried forward from the existing rules and new sections, such as the central registry for IV drugs users, that are required under federal regulations. The Department suggests that there were no less costly or less intrusive methods available 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.

DHS states that it did not consider or reject any alternative methods of achieving the purposes of the proposed rules.^[19]

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

The Department estimates that it will incur the following costs to establish and implement the new rules:

Licensure of Chemical Dependency Treatment Services Rule	\$ 8,750
Licensure of the Detoxification Facilities Rule	\$ 1,200
Licensing Division	\$ 77,405 (first year)
Licensing Division	\$ 61,345 (second year)
Estimated Cost for Rewrite of Rules	\$140,057
Total Costs	\$288,757

(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.

DHS suggests that the probable consequence of not adopting the proposed rule would be greater recidivism among those who have completed treatment and the continuing high costs associated with multiple readmissions to intensive treatment programs. According to the Department, research on treatment outcomes has found that the majority of individuals who enter treatment in any given year have been through treatment before and have physical and mental health problems. Licensed programs need flexibility in preventing recidivism and addressing recidivist client needs by decreasing or increasing treatment intensity over a longer period of time, if necessary. DHS maintains that the proposed rule will give treatment providers more flexibility in developing treatment plans that address a client's individual needs than the current system allows. In addition, DHS maintains that the new rules will result in improved continuing care that should reduce the number of costly readmissions to intensive treatment programs.^[20]

(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.

DHS states that there is no difference between the proposed rules and existing federal regulations. The proposed chemical dependency treatment services rules were drafted in part to incorporate federal requirements.

Performance Based Rules

23. The Administrative Procedure Act^[21] 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.^[22]

24. DHS states that the proposed rules are designed to offer flexibility to providers in designing treatment programs and providing services for clients. The rules focus on an outcome of meeting individual needs. Under the proposed rule, providers may select from a variety of treatment service options, based on the assessed needs of their clients. And the location of services may be tailored to meet the clients' needs, including offering services in the client's home. Within the treatment licensure, the provider can offer residential services, outpatient services, treatment services for adolescents and for clients with children.

Rulemaking Legal Standards

25. Under Minn. Stat. § 14.14, subd. 2, and Minn. Rule 1400.2100, a determination must be made in a rulemaking proceeding as to whether the agency has established the need for and reasonableness of the proposed rule by an affirmative presentation of facts. In support of a rule, an agency may rely on legislative facts, namely general facts concerning questions of law, policy and discretion, or it may simply rely on interpretation of a statute, or stated policy preferences.^[23] DHS prepared a Statement of Need and Reasonableness (SONAR) in support of the proposed rules. At the hearing, DHS primarily relied upon the SONAR as its affirmative presentation of need and reasonableness for the proposed amendments. The SONAR was supplemented by comments made by DHS representatives at the public hearing and in written post-hearing submissions.

26. The question of whether a rule has been shown to be reasonable focuses on whether it has been shown to have a rational basis, or whether it is arbitrary, based upon the rulemaking record. Minnesota case law has equated an unreasonable rule with an arbitrary rule.^[24] Arbitrary or unreasonable agency action is action without consideration and in disregard of the facts and circumstances of the case.^[25] A rule is generally found to be reasonable if it is rationally related to the end sought to be achieved by the governing statute.^[26]

27. The Minnesota Supreme Court has further defined an agency's burden in adopting rules by requiring it to "explain on what evidence it is relying and how the evidence connects rationally with the agency's choice of action to be taken."^[27] An

agency is entitled to make choices between possible approaches as long as the choice made is rational. Generally, it is not the proper role of the Administrative Law Judge to determine which policy alternative presents the “best” approach since this would invade the policy-making discretion of the agency. The question is rather whether the choice made by the agency is one that a rational person could have made.^[28]

28. In addition to need and reasonableness, the Administrative Law Judge must also assess whether the rule adoption procedure was complied with, whether the rule grants undue discretion, whether the Department has statutory authority to adopt the rule, whether the rule is unconstitutional or illegal, whether the rule constitutes an undue delegation of authority to another entity, or whether the proposed language is not a rule.^[29]

29. In this matter, the Department has proposed some changes to the rule language after publication in the State Register. Thus, the Administrative Law Judge must also determine if the new language is substantially different from that which was originally proposed.^[30]

30. The standards to determine if new language is substantially different 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.”

31. In determining whether modifications make the rules substantially different, the Administrative Law Judge is to consider 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.”^[31]

32. Any substantive language that differs from the rule as published in the *State Register* has been assessed to determine whether the language is substantially different. Because some of the changes are not controversial, not all of the altered language has been discussed. Any change not discussed is found to be not substantially different from the rule as published in the *State Register*.

General Objections Relating to the Revised Rules

33. The most concrete concern about the new rules expressed by many commenters before, during, and after the public hearing was the lack of coordination between the Department’s revision of the treatment rules and its yet-to-be revised rules concerning chemical dependency care for those receiving public assistance and the consolidated chemical dependency fund. As noted above, the new rules eliminate treatment Categories I through IV and no longer define those terms, which are an integral part of the structure of these other rule sections. For example, the rules

concerning placement criteria^[32] for persons receiving public assistance continue the reference to those categories; and in the rules concerning the consolidated fund, those categories similarly are used to define a rehabilitation program,^[33] determine the content of vendor agreements with local agencies,^[34] determine client eligibility,^[35] define a client's responsibility for fees,^[36] and describe a vendor's duty to collect client fees.^[37] The commenters express great trepidation and uncertainty about how the Department and local agencies will interpret these rules absent a definition of these crucial terms.

34. The Department's response to these substantial concerns was that they are "beyond the scope of this rulemaking proceeding." The Department maintains that the proposed rule is only for the licensure of chemical dependency treatment and detoxification programs; that it has begun the process of revising the public assistance rules,^[38] and that the rulemaking process is too lengthy and complicated to more closely coordinate these efforts. The Department maintains, without any specificity as to how this will happen, that client assessment, service authorization and payment for services will continue to operate under "Rule 24" (Minnesota Rules, parts 9530.6800 to 9530.7031) and "Rule 25" (Minnesota Rules, parts 9530.6600 to 9530.6655). These statements were insufficient to reassure treatment providers that depend on these sources of funding.

35. The Administrative Law Judge cannot conclude that the Department's decision to revise these rules in separate rulemaking proceedings is irrational or that the Department lacks the authority to proceed in this manner. Nor can the Administrative Law Judge say the elimination of these definitions makes the proposed rule unreasonably vague, although the proposed rules certainly make existing rules difficult to interpret without further guidance from the Department. The Administrative Law Judge recommends that the Department proceed as expeditiously as possible with the proposed revisions to other sections and that it provide some kind of interim guidance to consumers, providers, and county agencies as to how it intends to coordinate the process in the absence of any definition of treatment Categories I through IV.

36. The Department also received a fair number of comments to the effect that the Department has failed to demonstrate that there is a need to revise the chemical dependency treatment rules, because the existing rules have been effective and people are receiving and benefiting from treatment provided under those rules. The Department disagrees about the need for revision, maintaining that the existing rules are too prescriptive and are insufficiently flexible to respond to the needs of a client population that often requires multiple rounds of treatment. The Department has sufficiently demonstrated that there is a need for a comprehensive revision of the rules.

37. Some commenters noted their belief that the Department has rushed through the rulemaking process without allowing adequate input from the providers, while others stated that they believed the process of revising the rules took far too long, considering that the revision process has not included the public assistance rules or the consolidated fund rules. The Department began this process almost eight years ago. While commenters may disagree with the results of the process, the Department has established that it has complied with all the procedural requirements for making rules. Furthermore, the Department intends to develop training on the new standards and to offer training to providers throughout the state, and it recognizes that providers will need

time to make necessary organizational changes. Accordingly, the Department has proposed that these rules not become effective until September 1, 2004. The Repealer would also become effective on that date.^[39]

38. A few commenters expressed their belief that although the Department proposes to adopt many new requirements for licensees, it has failed to provide for due process in the event a licensee disagrees with the Department about the application of these rules. As the Department points out, these protections are required by statute. Minn. Stat. § 245A.05 - .08 contain detailed appeal procedures for license holders and applicants, including hearing procedures to address appeals filed under this chapter.

39. Finally, some commenters suggested that the rules should contain procedures by which licensees can seek variances from the application of particular rules. The variance procedures are contained within Minn. Stat. § 245A.04, subd. 9.

Analysis of the Proposed Rules

General

40. This report is limited to discussion of the portions of the proposed rules that received significant comment or otherwise need to be examined. When rules are adequately supported by the SONAR or DHS's oral or written comments, a detailed discussion of the proposed rules is unnecessary. The agency has demonstrated the need for and reasonableness of all rule provisions not specifically discussed in this report by an affirmative presentation of facts. All provisions not specifically discussed are authorized by statute and there are no other problems that would prevent the adoption of the rules.

Discussion of Proposed Rules by Topic

9530.6405 – Definitions.

41. This rule adds definitions to terms used in the statute and rules.

42. **Subpart 1a. Administration of medications.** As written, the proposed rule does not define the phrase “administration of medications.” Because part 9530.6435, subp. 3, would permit unlicensed staff to administer medications, the Minnesota Board of Nursing suggested that the Department define the phrase. The Board recommended language used by the Department of Health for home care, including assisted living facilities.

43. In its Second Response to Comments, DHS proposed adding the following definition, which was recommended by the Minnesota Board of Nursing, to rule part 9530.6405, as subpart 1a.

Subp. 1a. Administration of medications. “Administration of medications” means performing a task to provide medications to a client, and includes the following tasks, performed in the following order:

- A. checking the client’s medication record;
- B. preparing the medication for administration;
- C. administering the medication to the client;

- D. documenting the administration, or the reason for not administering medications as prescribed; and
- E. reporting information to a licensed practitioner or a nurse regarding problems with the administration of the medication or the client's refusal to take the medication.

44. DHS agrees with the Board of Nursing that the procedure should be defined and the methodology clarified so that the task is performed consistently and according to standard medical procedure.

45. The Administrative Law Judge finds the proposed amendment to this rule part to be needed and reasonable. The language is consistent with rules administered by the Minnesota Health Department for home care, including assisted living facilities found at Rule part 4668.0003, subpart 21a. The Administrative Law Judge concludes that this modification does not render the remaining proposed rules substantially different from the rule as published, because requirements for medication administration and monitoring were included in the published rule.

46. **Subp. 2. Adolescent.** This subpart defines “adolescent” to mean “an individual under 19 years of age.” The existing rule^[40] defines “adolescent” as an individual under 18, and the Human Services Licensing Act^[41] defines an adult as a person who is 18 years old or older.

47. The Department received many comments requesting it to change the definition of “adolescent” to an individual under 18 years of age, because if 18-year olds are considered adolescents, as opposed to adults, programs serving them would have to provide additional staff training in adolescent development and have 150 hours of supervised training in work with adolescents.

48. In its Second Response to Comments, DHS proposed changing the definition of “adolescent” to conform with Minnesota Statute § 245A.02, subd. 2. DHS will replace 19 with 18, so that the proposed definition of “adolescent” will read: “an individual under 18 years of age.”

49. The initial proposed definition of “adolescent” was inconsistent with the statute. The Administrative Law Judge finds that the proposed modification to rule part 9530.6405, subpart 2, is needed and reasonable and is not substantially different from the rule as published.

50. **Subp. 7a. Chemical Use Problem.** The Department has defined “chemical” as alcohol, solvents, controlled substances under Minn. Stat. § 152.01, subd. 4, and other mood altering substances.^[42] It has not proposed a definition of “chemical abuse” or “chemical dependency,” which are defined under existing rules.^[43] Some commenters objected to this lack of definition, but they did not propose their own definitions. The Department did not respond to these comments.

51. In its Second Response to Comments, however, the Department did propose to define the term “chemical use problem,” as the phrase is used in proposed rule 9530.6450 concerning staff qualifications.

52. In its Second Response to Comments, DHS proposed adding the following definition at subpart 7a:

Subpart 7a. **Chemical use problem.** “Chemical use problem” means one of the following:

- a. a staff member under part 9530.6450, subpart 1 receiving treatment for chemical use within the period specified in the staff qualification requirements;
- b. chemical use that has a negative impact on the staff member’s job performance;
- c. chemical use that affects the credibility of treatment services with clients, referral sources or other members of the community; or
- d. symptoms of intoxication or withdrawal on the job.

53. DHS maintains that it is necessary to define this term to ensure that it has a common understanding as it is used throughout the rule, and that the revision does not make the rule substantially different because this definition was already incorporated in the proposed rule concerning policy and procedure manuals (9530.6460, subp. 1E).

54. The Administrative Law Judge notes that the proposed definition for “chemical use problem” appears to be limited to staff members. The Department has not proposed defining “chemical use problem” for clients, even though 9530.6405, subp. 8, defines the term “client” as an individual accepted by a license holder for assessment or treatment of “chemical use problems.” In addition, the definition proposed above limits the meaning of “chemical use problems” to the four behaviors identified (A-D). Yet, similar language at 9530.6460, subp. 1E, suggests that the identical four behaviors are examples and are not meant to include all possible chemical use problems that might be grounds for employee discipline.^[44] The Administrative Law Judge recommends that the Department (1) delete this definition from the general definitions section, to avoid any confusion concerning the meaning of the term “client”; or (2) make it clear that this definition applies only to chemical use problems of staff members. In either case, the Department should resolve whether it wants this list of behaviors to be complete, or whether it intends to allow facilities to add other behaviors to the list. This is not a defect in the rule, and any changes made in response to the Administrative Law Judge’s recommendations would be needed, reasonable, and would not constitute a substantial change from the rule as published.

55. **Subpart 8. Client.** As noted above, the proposed rule defines a client as an individual “accepted by a license holder for assessment or treatment of chemical use problems.” In its SONAR, the Department stated that it is reasonable to limit the definition of “client” to persons “seeking or receiving services” because the rule is not intended to impact people outside these parameters. The ALJ notes, however, that the proposed rule does not include persons “seeking” services, whereas the existing rule does.^[45]

56. The Department received comments that the proposed definition ignores the current definition of the term “client” used by treatment facilities. Currently, the term “client” refers to outpatient treatment, and the term “patient” refers to inpatient treatment.

57. One commenter maintained that the proposed definition of “client” conflicts with the definition of “patient” under federal law. In the rule part, client is defined as an individual “accepted” for assessment or treatment of chemical use problems. Under federal law, 42 CFR 2.11, “patient” is defined as an individual who has “applied for or been given diagnosis or treatment for alcohol or drug abuse at a federally assisted program ...” Thus, under federal law, privacy rights occur at the moment the patient has *applied* for services as opposed to being *accepted* for services.

58. In its Final Response to Comments, DHS declined to modify the proposed language. DHS explained that the proposed rules are designed to recognize a continuum of treatment services and to eliminate the distinctions between levels of service, including inpatient and outpatient.

59. The Department may define “client” without using the word “patient,” and this choice will have no impact on whether the client is entitled to privacy rights under federal law. The Department may also limit the definition of “client” to those “accepted” for services. The definition does not conflict with federal law, and the Department has established that the proposed rule is needed and reasonable.

60. **Subp. 10. Co-occurring or co-occurring client.** The proposed rule defines this phrase as meaning “a diagnosis that indicates a client suffers from both chemical abuse or dependency and a mental health problem, or a client who suffers from both disorders.” In its Second Response to Comments, DHS has proposed deleting from the definition the phrase “or a client who suffers from both disorders.” DHS maintains that this change will clarify the definition by deleting redundancy.

61. The Administrative Law Judge finds the proposed deletion to this rule part clarifies the definition, is needed and reasonable, and is not a substantial change.

62. **Subp. 14a. Licensed Practitioner.** The proposed rule does not define “licensed practitioner,” because it does not use that term. In its Second Response to Comments, however, DHS proposed to modify 9530.6435, subp. 3, by replacing the word “physician” with “licensed practitioner” in recognition of the fact that health care professionals other than physicians are authorized to prescribe medications and to delegate medication administration responsibilities.

63. The Minnesota Board of Nursing proposed a definition of the phrase, which the Department has agreed to add to the rule. In its Second Response to Comments, DHS proposed adding the following definition of “Licensed practitioner” as subpart 14a:

Subp. 14a. Licensed practitioner. “Licensed practitioner means a person who is authorized to prescribe as defined in Minnesota Statutes, section 151.01, subdivision 23.

64. DHS maintains that the proposed amendment is needed to recognize that health care professionals other than physicians are authorized to prescribe

medications. In addition, the language is consistent with Minnesota Statutes chapter 151, governing the practice of pharmacy.

65. The Administrative Law Judge finds the proposed definition to be needed and reasonable, and it is not a substantial change from the rule as published.

66. **Subp. 15a. Nurse.** The Minnesota Board of Nursing also suggested that the Department add a definition for “nurse,” since rule part 9530.6435 references nurse, nursing and registered nurse. In its Second Response to Comments, DHS proposed adding the following definition of “Nurse” at subpart 15a:

Subp. 15a. Nurse. “Nurse” means a person licensed and currently registered to practice professional or practical nursing as defined in Minnesota Statutes, section 148.171, subdivisions 14 and 15.

67. The Administrative Law Judge finds the proposed definition is needed and reasonable to ensure the terminology used in the rule is understood and consistent with statute. The addition of this definition is not a substantial change in the rule as published.

68. **Subpart 16. Paraprofessionals.** The proposed rule defines a paraprofessional as “an employee, agent, or independent contractor of the license holder who performs tasks in support of the provision of treatment services. Paraprofessionals may be referred to by a variety of titles including technician, case aide, or counselor assistant.”

69. DHS received comments from persons concerned that the proposed definition did not properly define the role of paraprofessionals. In particular, the definition fails to require that paraprofessionals work under the direct supervision of a licensed chemical dependency counselor.

70. In its Final Response to Comments, DHS proposed adding the following sentence to the end of the definition of paraprofessional: “An individual may not be a paraprofessional employed by the license holder if the individual is a client of the license holder.” DHS maintains that this prohibition is reasonable to ensure client welfare and provider objectivity. DHS contends that this is not a substantial change to the rule but merely a clarification of the proper employment relationship between license holders and clients. DHS declines, however, to modify the definition to clarify the delegation of duties to paraprofessionals. DHS maintains that rule part 9530.6450, subpart 6, provides express limits on the duties of a paraprofessional. That provision prohibits paraprofessionals from admitting, transferring or discharging clients but allows them to be the person responsible for the delivery of treatment services under part 9530.6445, subp. 3.

71. The Administrative Law Judge finds that the rule as proposed with the changes made in the Department’s final response are needed and reasonable. It does not create a substantially different rule. The Department is not obligated to include duplicative language concerning the paraprofessional’s job responsibilities.

72. **Subpart 17. Program serving intravenous drug abusers.** A commenter suggested changing the term to “Program serving narcotic (or opiate) drug abusers with medication assisted therapy” to be consistent with the last sentence of the

definition and to clarify that the definition is specific to programs commonly known as “methadone programs.”

73. The Department declined to make the suggested change because the term “program serving intravenous drug abusers” is the same term used in the federal regulation governing state compliance. The Department maintains that because the term and its standards are governed by federal law, it is reasonable to maintain consistency between the proposed rules and federal standards.

74. The Administrative Law Judge finds the proposed subpart to be needed and reasonable as written.

75. **Subpart 19. Treatment.** Some comments asked for clarification as to whether a license holder must provide all of the elements contained in this definition.

76. In its Final Response to Comments, DHS declined to modify the definition, maintaining treatment is properly defined to include all of the listed elements.

77. The Administrative Law Judge finds the proposed definition of “treatment” to be needed and reasonable as written.

9530.6410 – Applicability

78. This rule part identifies the types of services that are governed by these rules.

79. Minnesota Rules chapter 2960, known as the “Umbrella Rule,” was adopted by DHS and the Department of Corrections in September 2003 to establish licensing standards for all out-of-home placement options for children. The portion of chapter 2960 governing residential treatment for children will be effective July 1, 2005. The rules proposed in chapter 9530 make no reference to chapter 2960, although part 9530.6485, subp. 1, makes reference to additional requirements for programs serving children in out-of-home placement and certifications for those programs.

80. In its Second Response to Comments, DHS proposed adding the following subpart 4:

Subp. 4. Licensing requirements of Minnesota Rules, Chapter 2960.
Beginning July 1, 2005, residential programs providing treatment services to adolescents must be licensed as follows:

- A. A residential program licensed under parts 2960.0010 to 2960.0220 to provide services that address chemical use problems of persons who are under 21 years of age must be certified under parts 2960.0430 to 2960.0490.
- B. A residential program that addresses the chemical use problems of a person older than 15 years of age, and under 21 years of age must either be licensed under parts 2960.0010 to 2960.0220 and certified under parts 2960.0430 to 2960.0490 or be licensed under parts 9530.6405 to 9530.6495.

81. The Department maintains that this proposed addition to the rule is needed and reasonable. In its Second Response to Comments, the Department gave the following explanation:

The above language parallels the language found at part 2960.0440 and clarifies the applicability of each rule to residential programs addressing chemical use problems in children. The provision is necessary to clarify the applicability of both rules and the language is reasonable because it has been duly promulgated in Chapter 2960. Since the language here is based on existing standards and is merely a reiteration of chapter 2960, it is neither a policy change nor a substantial change to the proposed rules.

82. The Administrative Law Judge notes first that the Department has incorrectly quoted item A of 2960.0440, which applies to programs serving persons under 19, not persons under 21 as proposed in subp. 4A.

83. Even if the age were cited correctly, however, the issue is whether the insertion of this section of chapter 2960 into chapter 9530 is appropriate. Chapter 2960 was jointly adopted by the commissioners of corrections and human services pursuant to Laws of Minnesota 1995, Chapter 226, Article 3, Section 60. Laws of Minnesota 1995, Chapter 226, Article 3, Section 50 required the commissioners to jointly amend licensing rules to allow residential facilities to admit 18- and 19-year old extended jurisdiction juveniles (EJJ). Accordingly, chapter 2960 provides that it applies to programs providing services “on a 24-hour basis to a resident,”^[46] and a resident is defined as “a person under 18 years old, or under 19 years old and under juvenile court jurisdiction.”^[47]

84. The Commissioner’s authority is not so broad under Minn. Stat. § 245A.02, subd. 4, which, as noted above, limits the definition of children to a person who has not reached age 18. The fact that chapter 2960 provides for authority to regulate residential programs for children age 18 or older does not mean that such authority is extended to DHS when it makes rules on its own authority. The Department has properly defined an adolescent consistently with chapter 245A, but its proposed insertion of this portion of 2960 into chapter 9530 impermissibly extends the Commissioner’s authority in violation of the statute. This constitutes a defect in the proposed rule, which could be cured by the removal of proposed subpart 4.

9530.6417 – Capacity Management and Waiting List System Compliance.

85. This rule part requires license holders to notify the Department when they have reached 90 percent capacity and to notify the placing county or tribal government when they have reached 100 percent capacity and are no longer able to accept a referral. In its SONAR, DHS maintained that this rule was needed to enable the Commissioner to meet his obligation to coordinate services under Minn. Stat. § 254B.03 and to ensure compliance with federal regulation 45 CFR 96.126, concerning programs for IV drug users. DHS stated that it was necessary to monitor and manage capacity to ensure that services are available and that clients are placed in appropriate treatment as quickly as possible. DHS also said that it was reasonable to require notification of

capacity by license holders to aid the Commissioner in evaluating the need for additional programs.

86. The Department received many comments on this rule part complaining that the notification requirement was unclear and unduly burdensome. For example, one commenter from the New Ulm Medical Center^[48] questioned how often a program that frequently runs at or near capacity would have to contact DHS – every day the program is at 90 percent capacity or only once during the time frame that it is at 90 percent capacity? The Director of Health Policy for the Minnesota Hospital Association asked whether a program would have to notify the multiple counties it serves in advance of a referral.

87. In its First Response to Comments, DHS proposed to delete rule part 9530.6417. According to DHS, it has determined that, given the flexibility of federal regulations governing monitoring programs that serve pregnant women and the limited populations involved, the potential burden imposed on providers by this rule part is not necessary. The Department states that it will develop an alternative mechanism for gathering the information necessary to monitor the availability of these services.

88. The Administrative Law Judge concludes that the deletion of Minnesota Rule part 9530.6417 does not render the rule substantially different from the rule as originally proposed. The proposed rule is needed and reasonable.

9530.6422 – Comprehensive Assessment.

89. **Subpart 1.** This subpart requires license holders to complete a comprehensive assessment of a client's chemical use problem within three calendar days after service initiation for a residential program or three sessions for all other programs. The Department states that the requirement of three days or three treatment sessions was determined to be a reasonable length of time based upon consultation with the its advisory council. The Department maintains that it is necessary to require comprehensive assessments be completed in this allotted time to ensure that the provision of treatment services is not unreasonably delayed.

90. Directors of programs in the Meridan Behavioral Health Network recommended adding the phrase “or other qualified licensed professional” after the phrase “alcohol and drug counselor” in lines three and five of subpart 1, because licensed psychologists, social workers and registered nurses with specific training in substance abuse are qualified to coordinate the assessment process.

91. In its Final Response to Comments, DHS declined to make this change. The Department maintains that the proposed rules already include those professionals and consider them to be “alcohol and drug counselors” if they meet the staff qualifications set forth in part 9530.6450. According to DHS, the definition of “alcohol and drug counselor” found at 9530.6405, subpart 3, encompasses individuals licensed in other fields but who meet staff requirements.

92. The Administrative Law Judge concludes the rule is needed and reasonable as proposed.

93. **Subpart 2. Plan contents.** This subpart requires alcohol and drug counselors to prepare an assessment summary within three calendar days for a residential program or within three treatment sessions of service initiation. An assessment summary supports the treatment plan and serves as the basis for treating the client. DHS maintains that it is necessary to require that the assessment information be summarized to support the determination of treatment service needs.

94 The Department received several comments recommending that the three-day time period be enlarged. One commenter also objected to the requirement that assessment summaries contain information regarding acute intoxication and withdrawal potential and biomedical conditions and complications. The commenter contends that these are medical conditions that need to be addressed by medical professionals and are beyond the training and licensure of alcohol and drug counselors.^[49]

95. In its Second Response to Comments, DHS restated its belief that three days to complete the assessment summary is reasonable. DHS points out that subpart 1 of the rule part allows license holders to delay completion of the summary as long as the basis for the delay is documented. In addition, DHS contends that, contrary to the comments received, subpart 2 does not require licensed counselors to diagnose medical conditions in completing the summary. According to DHS, the rule language allows LADCs to rely on information provided by other sources and to incorporate that information when available into the summary.

96. The Administrative Law Judge finds the rule as proposed to be needed and reasonable.

9530.6425 – Individual Treatment Plans.

97 This rule part establishes minimum standards for development of individual treatment plans for clients receiving treatment services. The Department states that this rule part is authorized by Minn. Stat. § 245A.09, subd. 2(c)(3), which requires the Commissioner to adopt rules establishing “standards for program services,” and is consistent with Minn. Stat. § 254A.01, which provides that “treatment shall be based on an individual treatment plan for each person undergoing treatment.”

98. In its Second Response to Comments, DHS proposed deleting the word “discharged” in subpart 1 and replacing it with the word “terminated” to consistently use the word “terminated” throughout the rules. In addition, DHS proposed to correct a citation to a rule part in subpart 2A to read “9530.6422, subpart 2, item B.”

99. To clarify the language, the ALJ recommends that the wording of the fourth sentence in subpart 1 be modified to read as follows: “The plan must be developed after completion of the comprehensive assessment and is subject to amendment until services to the client are terminated.” In addition, the ALJ recommends that the wording in subpart 2A be modified to read as follows: “treatment goals relating to problems identified in the assessment summary prepared pursuant to 9530.6422, subpart 2, item B.” This modification will clarify that the goals themselves are not listed in subpart 2B. These recommendations are not defects in the rule as written.

100. The Administrative Law Judge finds the proposed changes to subparts 1 and 2, and any changes made in response to the recommendations above, are needed and reasonable and do not substantially change the rule. Both changes clarify the rule.

101 **Subpart 3. Progress notes and plan review.** This subpart requires license holders to enter progress notes in a client's file weekly or after each treatment session, whichever is less frequent. Among other requirements, the progress notes must include monitoring of "any physical and mental health problems." The Department maintains that it is necessary to identify the minimum content of progress notes and treatment plan reviews to enable the Commissioner to objectively determine if the treatment services complied with the rule provisions. The Department contends that it is reasonable to require progress notes be recorded at least weekly or after each session, because it assures that pertinent information about the client's progress is accessible to program staff. The Department also states that it is reasonable to require progress notes include monitoring of physical and mental health problems because it enables program staff to "see the exact time during treatment that such problems occur and allows them to treat such problems accordingly."

102. One commenter objected that the requirement that staff monitor "physical and mental health problems and the participation of others in the treatment plan" was unclear. The commenter objects to this subpart if it means that counselors will be required to take blood pressure or screen for mental health issues.^[50]

103. The Department did not specifically respond to this comment. The Administrative Law Judge notes, however, that LADCs are not required to provide medical treatment or to be mental health professionals. The rule requiring them to monitor known physical and mental health problems is reasonable and necessary as proposed by the Department.

104. In its Second Response to Comments, DHS proposed amending subpart 3B to read as follows:

Subp. 3. Progress notes and plan review.

B. Treatment plan review must:

- (1) Occur weekly or after each treatment service, whichever is less frequent, and
- (2) Address weekly each goal in the treatment plan that has been worked on since the last review, and
- (3) Address whether the strategies to address the goals are effective, and if not, must include changes to the treatment plan.

105. DHS maintains that the above change clarifies that this provision relates to treatment plan review rather than progress notes. And DHS believes that, in response to written comments received, the change clarifies that if treatment services are less frequent than one per week, reviews may also be less frequent. Further, according to DHS, the change clarifies that plan review should focus on those goals that have been addressed in treatment. DHS states that it is reasonable to require the client's individual treatment plan goals to be updated when programming is scheduled

less frequently than once per week because the intention of the provision is to be flexible enough to address an individual client's treatment needs. The intensity of the client's treatment needs should dictate how often treatment plan goals are addressed and updated. DHS maintains that the new language is not a substantial change to what was originally proposed because it simply clarifies the original intent and is consistent with the language in the SONAR.

106. The Administrative Law Judge finds the rule as proposed is needed and reasonable and the changes do not make the rule substantially different from the rule as published.

9530.6430 – Treatment Services.

107. **Subpart 1.** This subpart requires license holders to provide the following treatment services: individual and group counseling, client education strategies, transition services, and services to address co-occurring mental illness. The Department maintains that it is reasonable to require that license holders provide a standardized list of treatment services so that the Commissioner may ensure that clients receive a minimum level of care. Subpart 2 defines additional services that license holders may provide, but which are not mandatory.

108. One commenter recommended that the word "group" in the second sentence of subpart 1A(4) be changed to "session", so that the sentence would read: "At least one session per week must address co-occurring mental illness issues, as needed." He maintains that the word "session" would allow the license holder to determine whether an individual, group or family session would be most appropriate for the client's unique need. He also points out that some times there are not a sufficient number of persons with like mental illnesses that would benefit from a group session.

109. In its Second Response to Comments, DHS proposed deleting "At least one group per week", which is at the beginning of the second sentence in subpart 1(A)(4), and replacing it with the word "Groups". Subpart 1A(4) would read as follows:

(4) services to address issues related to co-occurring mental illness, including education for clients on basic symptoms of mental illness, the possibility of comorbidity, and the need for continued medication compliance while working on recovery from chemical abuse or dependency. ~~At least one group per week~~ Groups must address co-occurring mental illness issues, as needed. When treatment for mental health problems is indicated, it is integrated into the client's treatment plan.

110. DHS maintains that the phrase "at least one group per week" conflicted with the intent of this provision to provide services as needed by the client. Thus, if a client would not benefit from a co-occurring therapy group and would be better served by a one-to-one treatment session, this language change allows the provider the flexibility to meet the client's needs. DHS contends that the change to this part does not amount to a substantial change in rule or policy.

111. The Administrative Law Judge finds the proposed rule to be needed and reasonable and the changes do not make the rule substantially different from the rule as published.

112. **Subpart 4.** In its Second Response to Comments, DHS proposed the following changes to subpart 4:

Subp. 4. **Location of service provision.** Except for services under subparts 2(a), 2(c), and 2(f), a A client of a license holder ~~having multiple facility locations~~ may only receive services at any of the license holder's licensed locations or at the client's home.

113. DHS maintains that the changes clarify the provision's intent to allow flexibility in the location of treatment services for those providers who do not have multiple facility locations. This flexibility is especially important for rural providers. It allows treatment to take place in a client's home if it is consistent with the individual's treatment plan. DHS contends that these changes are not a substantial change to the rule, but merely a clarification.

114. The Administrative Law Judge concludes that the rule as modified is needed and reasonable, and it is not substantially different from the rule as published. The Administrative Law Judge recommends, however, that for consistency in numbering the Department change the references to subparts "2(a), 2(c), and 2(f)" to "2A, 2C, and 2F."

9530.6435 – Medical Services.

115. The Minnesota Board of Nursing recommended that the Department change the heading of this provision from "Medical Services" to "Health Care Services" and make a similar change throughout subpart 1 to more accurately reflect the type of services provided.

116. In its Second Response to Comments, DHS proposed replacing the word "medical" with "health care" throughout the rule part as recommended by the Board of Nursing. In addition, the Department proposed making the following changes to subpart 1:

Subp.1. **Medical Health care services description.** An applicant or license holder must maintain a complete description of the ~~medical~~ health care services, ~~offered by the license holder including nursing services, dietary services, and emergency physician services~~ offered by the license holder. ~~An applicant must include a written copy of a medical services description with the license application.~~

117. DHS states that the above changes are made for clarification and do not amount to a substantial change to the rule.

118. The ALJ finds the proposed rule to be needed and reasonable, and the changes make it more accurate without rendering it substantially different from what was originally proposed.

119. **Subpart 2. Consultation services.** This subpart requires the applicant or license holder to have a written procedure approved by “the medical director” for obtaining medical interventions when needed for any client. The license holder must have access to and document the availability of a mental health professional to provide diagnostic assessment and treatment planning assistance.

120. In its SONAR, the Department maintained that to ensure the health and safety of clients, it is necessary for license holders to develop written medical intervention procedures so that staff know the appropriate actions to take in medical emergencies. The Department also stated that it is reasonable to have these procedures reviewed by the medical director in order to ensure that the procedures adequately address medical needs and reflect current medical standards. And the Department maintained that it is necessary to require the availability of a mental health professional to evaluate mental health problems because many clients receiving treatment services have psychological problems that complicate or are complicated by the client’s chemical use. The Department stated that it is reasonable to require license holders to ensure that clients have access to mental health services.

121. One commenter objected to the requirement that all programs have a medical director and she pointed out that in rural Minnesota it may be difficult to find mental health professionals with whom to contract.^[51]

122. In its Second Response to Comments, DHS proposed deleting the phrase “the medical director” in subpart 2 and replacing it with the phrase “a physician licensed under chapter 147.” DHS explained that this was the only provision in the rule that indicated the need for a medical director. DHS determined that it is unnecessary to require treatment programs to engage the services of a medical director for this single function. DHS maintains that this language change will allow providers to meet the intervention procedure approval requirement through the review and approval of a licensed physician. DHS contends that this is not a substantial change to the rule since in both versions a physician must approve the intervention procedures.

123. The Administrative Law Judge finds the proposed rule to be needed and reasonable, and the changes do not render it substantially different from the rule as published. In addition, because part 9530.6430, subpart 1A(4) requires license holders to provide treatment services to address issues related to co-occurring mental illness, the ALJ finds the requirement that license holders “have access to and document the availability of a mental health professional to provide diagnostic assessment and treatment planning assistance” to be reasonable and needed. The Administrative Law Judge suggests, however, that the Department add the word “licensed” before the term “mental health professional” in this subpart, in subpart 9530.6495 item C, and throughout the rule to indicate that mental health professionals are subject to licensure by other boards or agencies and to exclude the use of unlicensed mental health professionals, if that is the Department’s intent.

124. **Subpart 3. Administration of prescriptive medications.** This subpart requires persons who administer medications to clients to either be appropriately licensed, certified or trained and requires a registered nurse to review the administration of medications at least monthly. The Department maintains that it is reasonable to allow

employees other than licensed medical personnel to provide medication assistance, because licensed medical personnel will not always be available. In addition, the Department states that it is necessary to require training for unlicensed personnel to ensure that staff members are prepared and do not make errors when assisting clients with medication administration.

125. The Minnesota Board of Nursing recommended that the Department change the heading of this subpart to "Administration of medications and assistance with self-administration of medications." The Board recommended additional language to clarify that the administration of medications is a delegated medical function that can only be delegated by a licensed practitioner or registered nurse. The Board recommended further that the Department substitute the word "document" for the word "certificate" in subpart 3A(1) as persons who complete medication administration programs are not certified or credentialed.

126. The Minnesota Board of Nursing also recommended language detailing the process by which a consulting registered nurse will develop the policies and procedures for delegating the administration of medications. The Board also suggested requiring weekly onsite supervision by the registered nurse as opposed to just a monthly review of the license holder's procedures.

127. Other commenters objected on the basis that the proposed rule did not permit clients to self-administer medications if they are properly trained to do so.

128. In its Second Response to Comments, DHS proposed adopting many of the changes recommended by the Minnesota Board of Nursing so that subpart 3 would read as follows:

Subp. 3. **Administration of prescription medication and assistance with self-medication.** A license holder must meet the following requirements if services include medication administration:

A. a staff member, other than a physician, licensed practitioner, registered nurse, or licensed practical nurse, who is responsible delegated by a licensed practitioner or a registered nurse the task of administration of medication or medication assistance with self medication must:

- (1) certificate that document the staff member's completion of a trained medication aide medication administration training program for unlicensed personnel through a Minnesota post-secondary educational institution; or
- (2) be trained according to a formalized training program which is taught and supervised by a registered nurse and offered by the license holder. Completion of the course must be documented in writing and placed in the staff member's personnel records; or
- (3) demonstrate to a registered nurse competency to perform the delegated activity.

B. A registered nurse must provide consultation and review the license holder's procedures for administration of medication at least monthly. be

employed or contracted to develop the policies and procedures for medication administration and or assistance with self-administration of medication. A registered nurse must provide supervision as defined in Minnesota Rules part 6321.0100. The registered nurse supervision must include onsite supervision at least monthly or more often as warranted by the health needs of the clients. The policies and procedures must include:

- (1) delegations of administration of medication is limited to administration of those medications which are oral, suppository, eye drops, ear drops, inhalant, or topical;
- (2) a requirement that each client's file must include documentation indicating whether staff will be administering medication or the client will be doing self-administration or a combination of both;
- (3) a provision that clients may carry emergency medication such as nitroglycerin as instructed by their physician;
- (4) a provision for medication to be self-administered when a client is scheduled not to be at the facility;
- (5) a provision that if medication is to be self-administered at a time when the client is present in the facility, medication will be self-administered under observation of a trained staff person;
- (6) a provision that if the license holder serves clients who are parents with children, the parent must administer medication to the child under staff supervision;
- (7) requirements for recording the client's use of medication, including staff signatures with date and time;
- (8) guidelines regarding when to inform a registered nurse of problems with self-administration and medication administration, including failure to administer, client refusal of a medication, adverse reactions, or errors; and
- (9) procedures for acceptance, documentation, and implementation of prescriptions, whether written, verbal, telephonic, or electronic.

129. DHS maintains that the above changes and additions to subpart 3 are needed to provide more guidance to the license holder and staff to develop medication administration procedures that are consistent with national and state standards for client care. DHS states that the changes are necessary to ensure that the license holder and staff understand that medication administration is a delegated medical function that may only be delegated by a licensed practitioner or registered nurse. Without such delegation, unlicensed staff have no authority to administer medications to clients. DHS maintains that the procedures are consistent with standards taught in medication administration courses and standards used by the Minnesota Health Department in rules governing the provision of health care in settings comparable to chemical dependency and detoxification programs.^[52] DHS contends that the proposed changes are not a substantial change to the rule.

130. The Administrative Law Judge finds the rule to be needed and reasonable. The changes clarify the requirements and make the rule more consistent with other state laws without rendering the rule substantially different from that which was published.

131. **Subpart 4.** The Minnesota Board of Nursing recommended deleting some of the language in subpart 4 regarding storage and control of medications and creating a new subpart with the heading “Control of drugs.” This subpart would require license holders to have written policies and procedures in place regarding the secure handling and storage of drugs. The Board states that the proposed language is consistent with the Department of Health’s regulations for facilities that administer medications and store scheduled drugs. The Board maintains that it is reasonable to require chemical dependency treatment and detoxification programs to have control and storage provisions to lessen the risk of drug theft.

132. In its Second Response to Comments, DHS proposed deleting subpart 4 Medication monitoring because, given the proposed changes to subpart 3, it is no longer needed. DHS further proposes replacing subpart 4 with the following provision governing the control of drugs:

Subp. 4. **Control of Drugs.** A license holder must have in place and implement written policies and procedures developed by a registered nurse that contains the following provisions:

- A. a requirement that all drugs must be stored in a locked compartment. Schedule II drugs, as defined by Minnesota Statutes, section 152.02, must be stored in a separately locked compartment, permanently affixed to the physical plant or medication cart;
- B. a system which accounts for all scheduled drugs each shift;
- C. a procedure for recording the client’s use of medication, including the signatures of the administrator of the medication with time and date;
- D. a procedure for destruction of discontinued, outdated or deteriorated medications;
- E. a statement that only authorized personnel are permitted to have access to the keys to the locked drug compartments; and
- F. a statement that no legend drug supply for one client will be given to another client.

133. DHS maintains that the proposed new subpart 4 is needed to provide license holders with procedures on controlling access and securely storing drugs in environments with a heightened risk of drug theft. DHS states that the above language is reasonable because it is consistent with the Department of Health’s regulations for facilities where medications are administered and scheduled drugs are stored. DHS also maintains that the proposed language does not represent a substantial change because the rule, as published, contained a requirement for locked storage of drugs.

134. The Administrative Law Judge concludes that the proposed rule part is needed and reasonable and the new language is not substantially different from that which was originally proposed. The modifications are within the scope of the rule and are a logical outgrowth of the rulemaking proceeding.

9530.6440 – Client Records.

135. This rule part establishes the minimum standard for client records. The Department maintains that it is necessary to establish minimum standards for client records to ensure that each client receives treatment services appropriate to his or her needs.

136. **Subpart 3. Client records, contents.** This subpart identifies the information that must be included in client records. The Department maintains that it is necessary to require that this information be maintained in all client records because it enables the Commissioner to carry out his responsibilities to conduct inspections and evaluate treatment services as required by Minn. Stat. § 245A.04, subdivisions 4 and 6.

137. The Minnesota Board of Nursing recommended that the Department add the following to the items that must be contained in client records: “current prescriptions signed by a licensed practitioner for each delegated medical function, including legend and nonlegend drugs to be self administered.”

138. In its Second Response to Comments, DHS maintained that no modification to Subpart 3 was necessary as Rule 9530.6435 adequately addressed the concern raised. Specifically, the proposed modifications to part 9530.6435, subp. 3 governs procedures for medication administration, including documentation of prescriptions.

139. The Administrative Law Judge concludes that the rule is reasonable and necessary as proposed and other rule parts adequately address the concerns raised by the Board.

140. **Subpart 4.** In its Final Response to Comments, DHS proposed adding the following subpart to 9530.6440 to address the use of electronic record keeping, including the use of electronic signatures on individual treatment plans under 9530.6425, subpart 1:

Subpart 4. **Electronic Records.** A license holder who intends to use electronic recordkeeping or electronic signatures to comply with parts 9530.6405 to 9530.6505 must first obtain written permission from the commissioner. The commissioner shall grant permission after the license holder provides documentation demonstrating the license holder’s use of a system for ensuring security of electronic records. Use of electronic recordkeeping or electronic signatures does not alter the license holder’s obligations under state or federal law, regulations, or rule.

141. DHS maintains that the above language is needed to recognize advances in technology and anticipated use of electronic record keeping. Because of the unique security and integrity issues inherent in the use of electronic records, DHS believes it is reasonable and necessary to require a license holder make a showing of security

measures before the commissioner agrees that such records satisfy the requirements of the rule. DHS contends that this addition is not a substantial change to the rule as the proposed rules address record keeping requirements in several provisions.

142. The Administrative Law Judge finds the proposed subpart to be needed and reasonable. It responds to criticisms of several commenters that client signature requirements did not keep pace with the technology behind electronic recordkeeping. It is needed, reasonable, and does not amount to a substantial change to the rule as published.

9530.6445 – Staffing Requirements.

143. This rule part establishes requirements for the type of employees that a license holder must employ in order to receive a chemical dependency services license. Minnesota Statute § 245A.09, subd. 2(c)(1) authorizes the Commissioner to adopt rules that include basic licensing standards, including “standards for adequate staff.” DHS maintains that this rule part is necessary to ensure that responsibility for the health and safety of clients is appropriately designated and accountability is clear and to ensure that the license holder has sufficient staff members to provide treatment services in compliance with the rules. Subpart 5 of this rule part requires a license holder to have a least one staff person on the premises who has a current American Red Cross standard first aid certificate and at least one staff person on the premises who has a current American Red Cross community CPR certificate. A single staff person with both certifications satisfies this requirement.

144. One commenter questioned the need for staff CPR and first aid competence in outpatient settings. He also objected to limiting demonstration of competence to Red Cross certification. He suggested allowing staff members more flexibility in documenting competence in CPR and first aid training.^[53] Another commenter, on behalf of the Minnesota Hospital Association, also questioned the need for staff with CPR and first aid certification in outpatient settings. She recommended re-titling this subdivision as “Medical Emergencies.” The Minnesota Board of Nursing also recommended that the Department include a requirement that license holders employ or contract with a registered nurse, as it is required for detoxification programs, to ensure professional delegation and supervision of medical and nursing functions

145. In its Second Response to Comments, DHS stated that CPR certification was necessary in an outpatient program because outpatient staff may be required to perform CPR on a client the same way residential staff may need to perform CPR on a residential client. DHS also proposed making the following changes to Subpart 5 to reflect the availability of qualified CPR certifications from sources other than the American Red Cross:

Subp. 5. **Unusual occurrences.** When clients are present, a license holder must have at least one staff person on the premises who has a current American Red Cross standard first aid certificate or equivalent certification and at least one staff person on the premises who has a current American Red Cross community CPR, American Heart

Association or equivalent CPR certification. certificate. A single staff person with both certifications satisfies this requirement.

146. DHS declined to modify this rule part to include a requirement that license holders employ or contract with a registered nurse. DHS stated that it intends to allow license holders the flexibility to determine whether or not they need a registered nurse on staff.

147. The Administrative Law Judge finds the above changes to be needed and reasonable and they do not amount to a substantial change in the rule. The Administrative Law Judge recommends that the Department consider changing the title of subpart 5 to “Medical emergencies” to better reflect the subject of the subpart. This is a recommendation only, and not a defect in the rule as written.

9530.6450 – Staff Qualifications

148 This rule part establishes the qualifications for staff that have a direct influence on the quality of treatment services. Minn. Stat. § 245A.09, subd. 2(c)(1), authorizes the Commissioner to adopt rules that include standards for adequate staff. The Department maintains that this rule part is necessary to ensure that qualified individuals are performing the services, using methods that are appropriate to the client’s needs and in compliance with governing rules and laws.

149. One commenter questioned why there are different standards in subpart 1 regarding the length of time that paraprofessionals and other staff members should be free from chemical use problems. He suggested that if one year free of chemical use problems was sufficient for some employees, it should be the standard for all. Other commenters also questioned the rationale behind the differing standards.

150. In its Second Response to Comments, DHS defended the different chemical free standards for professionals and paraprofessionals in this rule part. DHS maintains that since professionals have a greater responsibility for helping clients overcome abuse and dependency it is reasonable to require them to demonstrate a higher degree and longer term of freedom from chemical use problems than paraprofessionals. In addition, the Department recognizes that there may be a shortage of licensed professionals in some areas of the state and the use of paraprofessionals is necessary. Since paraprofessionals do not have as much responsibility as professionals, DHS contends that a different and less stringent standard is appropriate for paraprofessionals. DHS proposed, however, adding the phrase “and other professionals” after the word “counselors” in subpart 1A to clarify that all professional staff must have two years free of chemical use problems. Subpart 1A would read as follows:

A. Treatment directors, supervisors, nurses, and counselors and other professionals must be free of chemical use problems for at least the two years immediately preceding their hiring and must sign a statement attesting to that fact.

151. The Administrative Law Judge finds that the differing requirements for professionals and paraprofessionals in this rule part are needed and reasonable. Directors, supervisors, nurses, counselors, and other professional persons have greater

responsibilities and hold a greater position of trust with the clients served in these programs. It is reasonable to require professionals working in the facilities to be free of chemical use problems for at least two years and to require that paraprofessionals with direct client contact be free of such problems for at least one year. The proposed modification to subpart 1A clarifies the language and is not a substantial change to the rule.

152. **Subp. 2. Continuing freedom from chemical use problems employment requirement.** Several comments indicated that this provision was vague because the term “chemical use problem” was not defined and it was not clear what response was required if a staff member experienced a “chemical use problem.”

153. In its Final Response to Comments, DHS proposed modifying this subpart to read as follows:

Subp. 2. Continuing freedom from chemical use problems employment requirement. Staff members with direct client contact must be free from chemical use problems as a condition of employment, but are not required to sign additional statements. Staff members with direct client contact who are not free from chemical use problems must be removed from any responsibilities that include direct client contact for the time period specified in subpart 1. The time period begins to run on the date of the last incident as described in part 9530.6405, subpart 7a, items B, C, or D, or on the date the staff member begins receiving treatment services under item A.

154. DHS states that the above language is needed to clarify that staff members must be free of chemical use problems for the time period required in the staff qualifications part of the proposed rules. If a chemical use problem occurs after a staff member is hired, the license holder must reestablish the requisite period of freedom from chemical use before having direct client contact.

155. The Administrative Law Judge finds the proposed rule part to be needed and reasonable. The proposed modification clarifies the calculation of the time period and is not a substantial change.

156. In its Second Response to Comments, DHS proposed deleting the phrase “with documented competency according to subpart 6 or 7” at the end of Subpart 4A. DHS maintains that this is merely an editorial change to delete an inaccurate reference to subparts 6 and 7.

157. The Administrative Law Judge finds the proposed change to subpart 4A to be needed and reasonable and not a substantial change to the rule.

158. **Subpart 6. Paraprofessional qualifications and duties.** One commenter maintained that this subpart fails to protect the safety of clients by making clear that a licensed chemical dependency counselor is required to directly supervise paraprofessionals. The commenter recommended that a sentence to this effect be added at the end of this subpart.

159. In its Final Response to Comments, DHS declined to modify subpart 6. DHS maintains that subpart 6 provided sufficient express limitations on the duties of

paraprofessionals. DHS further contends that limitations are implied because the rule requires that specific treatment services and assessment tasks be performed by licensed alcohol and drug counselors. As long as paraprofessionals do not perform services that they are not qualified to perform or that they are specifically excluded from performing, DHS intends to allow license holders flexibility to assign the appropriate level of supervision to paraprofessionals.

160. The Administrative Law Judge finds subpart 6 of this rule part to be needed and reasonable as written.

9530.6460 – Personnel Policies and Procedures.

161. This rule part establishes minimum standards for personnel policies and procedures, minimum staff qualifications, minimum staff to client ratios, and minimum standards for maintaining personnel files.

162. **Subpart 1. Policy requirements.** This subpart requires a license holder to establish a written personnel policy. Items E(1) through E(4) list behaviors or incidents considered “chemical use problems.” DHS received comments recommending that the term “chemical use problem” be more specifically defined.

163. In its Second Response to Comments, DHS maintained that because chemical use problems will not be uniformly manifested, it is necessary to define the term broadly to encompass a variety of scenarios.

164. As noted in Finding 54 above, this definition differs from that proposed in the general definitions section in terms of whether it is intended to be an inclusive list. See the discussion at Finding 54 for the Administrative Law Judge’s recommendation to resolve this issue.

165. **Subpart 2. Staff development.** This subpart requires that all staff be trained every two years in client confidentiality rules and regulations, client ethical boundaries, emergency procedures, and client rights. Staff with direct client contact must also be trained every two years on mandatory reporting and HIV standards. And treatment directors, supervisors, nurses and counselors must obtain 12 hours of training in co-occurring mental health problems within 12 months of the date the rule is adopted.

166. One commenter objected to this requirement, maintaining that it conflicts with the Minnesota LADC licensure rule that requires training every third reporting period or six years.^[54]

167. In its Second Response to Comments, DHS stated that the proposed rules have no reporting requirement. The proposed rule only requires that the training be obtained every two years for staff employed in a program licensed under these rules.

168. The Administrative Law Judge finds the rule part to be needed and reasonable and not inconsistent with the Department of Health’s reporting requirements.

9530.6480 Evaluation

169. **Subpart 1. Participation in drug and alcohol normative evaluation.** The Department maintains that it is necessary to clarify that programs must participate

in Drug and Alcohol Abuse Normative Evaluation System (DAANES) and are required to use forms specified by the Commissioner to provide information concerning each client admitted for treatment services.

170. One commenter suggested that submission of clients' personal medical information (PMI) numbers pursuant to DAANES would violate federal law.

171. In its Final Response to Comments, the Department maintains that participation in DAANES does not conflict with federal law requirements. Part 9530.6480 requires a license holder, not a client, to submit data to the Commissioner. While federal law prohibits disclosure of patient identifying information, 42 CFR 2.11 specifically excludes unique patient identifier numbers from the definition of "patient identifying information." The proposed rules only require that license holders provide non-identifying information under a unique patient number. DHS states that in practice, it may require license holders to use a client's PMI number as the unique patient number. And, while the PMI number is linked to identifying information within the Department, DHS points out that the PMI numbers are not available to the public and therefore comply with federal law that prohibits disclosure of patient identifying information, which is defined as "... information by which the identity of a patient can be determined with reasonable accuracy and speed either directly or by reference to *other publicly available information*."^[55]

172. The Administrative Law Judge finds the proposed rule to be needed and reasonable and not in conflict with federal regulations regarding confidentiality of alcohol and drug abuse patient records. Because the subpart does not specifically state that the information is to be provided under a unique patient number, however, the Administrative Law Judge recommends that the Department clarify that the "forms specified by the Commissioner" will require the submission of non-identifying information under a unique patient number. This is not a defect in the rule, but a recommendation made to eliminate a potential conflict with the federal regulation.

9530.6485 – Additional Requirements for License Holders Serving Adolescents.

173. This proposed rule part establishes additional requirements for residential programs that provide treatment services to adolescents. The Department maintains that the need for special requirements is supported by research in current treatment outcomes. The Department states that it is necessary to inform license holders of the additional requirements they must meet in order to provide both treatment and residential services to adolescents. In its SONAR, the Department stated that it was in the process of developing standards to govern the care provided to all children in out-of-home placement, and that it anticipated that new standards for children's residential services would be promulgated at Chapter 2960, in advance of these treatment rules. As noted above in Finding 79, Chapter 2960 was adopted in October 2003.

174. After making the proposed change concerning the age of adolescents, the rule as proposed by DHS reads as follows:

Subp. 1. **License holders serving adolescents.** A residential treatment program that ~~provides treatment services to~~ serves persons under 19 18 years of age must be licensed as a residential program for children in out-

of-home placement by the department unless the license holder is exempt under Minnesota Statutes, section 245A.03, subdivision 2. License holders providing residential treatment services must also obtain any additional certifications required by the department for those programs.

175. Many commenters and others who testified at the public hearing expressed surprise that the Department intended through this section to incorporate the relevant provisions of chapter 2960, because the rule itself makes no reference to that chapter or even to the proposed rules. Those persons who did not have the SONAR were not aware of the Department's reference to chapter 2960, and they contended this subpart was unreasonably vague in failing to define "out of home placement" and "additional certifications required."

176. As noted above, the Department may incorporate only those portions of chapter 2960 that are consistent with its authority under the Human Services Licensing Act, Minnesota Statutes Chapter 245A. Under chapter 245A, the Department has the authority to require additional licensure under chapter 2960, but only with regard to programs serving persons under age 18. The Administrative Law Judge finds the requirement that a program have a particular licensure, and "any additional certifications required by the department," to be impermissibly vague and a defect in the rule. Language that refers to required licenses and certificates, in this circumstance, without citation to the appropriate authority, is vague and confusing. If the Department is referring to licensing and certification that may be required under chapter 2960 it should state this specifically to cure the defect. Correction to the defect as noted would not be a substantial change.

9530.6500 – Additional Requirements for Methadone Programs Serving IV Drug Abusers.

177. This rule part establishes additional requirements for those programs that serve clients who are intravenous drug abusers.

178. **Subpart 3. Waiting list.** The Department maintains that it is necessary to require programs serving intravenous drug abusers to place those who cannot be admitted within 14 days of the date of application on a waiting list so that they can be identified and placed in treatment as openings become available. The Department states that this is also required by federal regulations.^[56] Under this subpart, applicants on a waiting list who receive no services other than "interim services" under part 9530.6430, subp. 1, must *not* be considered a "client" as defined in part 9530.6405, subp. 8. In addition, license holders must assign a unique patient identifier for each intravenous drug abuser seeking treatment, including those receiving "interim services".

179. One commenter expressed concern that persons placed on the waiting list and not considered "clients" would be denied data privacy safeguards afforded to "patients" under federal law. He also pointed out that there is no definition of "interim services" under part 9530.6430, so it is unclear which applicants would not be considered clients. In addition, he maintained that the unique patient identifier numbers will not provide adequate safeguards as required by federal law.

180. The term “client” is defined at 9530.6405, subp. 8 as an individual “accepted by a license holder for assessment or treatment of chemical use problems.” Under federal regulations^[57] disclosure of patient identifying information is prohibited. The term “patient” is defined as “any individual who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a federally assisted program.” The federal regulation definition of “patient” is broader than the Department’s proposed definition of “client” because it does not exclude those who have applied for but have not yet received services.

181 In its Final Response to Comments, DHS states that the definition of client under 9530.6405, subp. 8, is not intended to be used for purposes of information disclosure. In general, the proposed rules do not contain express directives on information disclosure and instead refer programs to federal information disclosure standards. The Department maintains that the proposed rule does not conflict with the federal requirements and instead can be read together to provide information disclosure protections. In addition, DHS contends that federal standards expressly allow a program to assign numbers to its patients if those numbers cannot be used to “identify a patient with reasonable accuracy and speed from sources external to the program,” such as drivers’ license numbers. DHS believes that its proposed “unique patient identifiers” provide adequate safeguards and comply with federal law.

182. Except for the last two sentences of subpart 3, the Administrative Law Judge finds this part to be needed and reasonable and in compliance with federal regulations. The Administrative Law Judge finds, however, that the Department’s failure to define the term “interim services”, which is used in the last two sentences of subpart 3, to be a defect. According to this subpart, applicants on a waiting list who receive only “interim services” under 9530.6430, subp. 1, must not be considered “clients” under 9530.6405, subp. 8. The term “interim services,” however, is not defined or mentioned in 9530.6430, subp. 1. Instead, 9530.6430, subp. 1 lists the treatment services that all license holders are required to provide. Consequently, it is unclear in this subpart which services if received would render an applicant a “client” and which would not. The lack of a definition for the term “interim services” renders the last two sentences in subpart 3 impermissibly vague.

183. If it is the intent of the Department to limit the definition of “client” to only those who have been accepted for assessment or treatment, as opposed to those who have applied for services, the Department may correct the defect in subpart 3 by deleting the references to interim services. That is, the Department may correct the defect by deleting the phrase “including those receiving interim services” in the third sentence and by modifying the last sentence to read: “An applicant on a waiting list who has received no services under part 9530.6430, subpart 1, must not be considered a “client” as defined by part 9530.6405, subpart 8.” In the alternative, the Department could correct the defect by broadening the definition of “client” to include applicants as well as those who have been accepted or received services.

184. **Subpart 6. Central registry.** The Department maintains that it is necessary to require programs serving intravenous drug abusers to comply with State Central Registry requirements in order to prevent client abuse of agonist medications caused by clients obtaining medications through multiple program enrollments. The

Department states that the use of a central registry is contemplated by federal regulations governing confidentiality of client records at 42 CFR 2.34. Requiring clients to submit detailed identifying information is important because it gives program staff multiple ways to identify clients and to prevent multiple enrollments.

185. The Department received a written comment expressing concern that the central registry may violate federal regulations regarding disclosure of patient information.

186. In its Final Response to Comments, DHS proposed the following modifications to subpart 6:

Subp. 6. **Central registry.** Programs serving intravenous drug abusers must comply with requirements to submit information to the state central registry for each client admitted, as specified by the commissioner. The client's failure to provide the information and necessary consents will prohibit involvement in an opiate treatment program. ~~Submissions must be sent in on a weekly basis in a format prescribed by the commissioner with the original kept in the client's chart.~~ The information submitted must include the client's:

- A. full name and all aliases;
- B. date of admission;
- C. date of birth;
- D. social security number or INS number;
- E. enrollment status in other current or last known opiate treatment programs;
- F. government-issued photo-identification card number; and
- G. driver's license number, if any.

This information must be submitted in a format prescribed by the commissioner, with the original kept in the client's chart, whenever a client is accepted for treatment, the client's type or dosage of the drug is changed, or the client's treatment is interrupted, resumed or terminated.

187. The proposed language originally required programs to submit information to the commissioner on a weekly basis. Federal standards allow disclosure of relevant information only if the disclosure is made when (1) the patient is accepted for treatment, (2) the type or dosage of the drug is changed; (3) the treatment is interrupted, resumed or terminated. DHS maintains that the proposed modification will clarify the Department's intent and result in full compliance with federal law. DHS contends that the modification is not a substantial change to the proposed rule because the creation of central registries is included in the rule as proposed and the federal standards were referenced in the SONAR.

188. The Administrative Law Judge finds the rule and the proposed modifications to be needed and reasonable. The modifications are necessary to clarify

the rule and comply with federal regulations, and they do not represent a substantial change to the rule as published.

9530.6505 – Additional Requirements for License Holders Providing Supervised Room and Board.

189. DHS maintains in its SONAR that this provision is needed to clarify the meaning of a residential program in the proposed rule. According to DHS, it is necessary to define residential programs pursuant to Minnesota Statutes chapter 245A because it describes what expectations the Commissioner has for those who provide supervised room and board with treatment services at the licensed program site. In addition, DHS states that it is necessary to include additional requirements for license holders who provide supervised room and board with treatment services because these programs raise additional issues regarding basic client rights and protections.

190. DHS received comments that this rule part lacks oversight requirements for the housing component of programs that provide residential services; lacks coordination with other relevant rules; and reflects a lack of interdepartmental coordination. Specifically, with respect to the lack of interdepartmental coordination, one comment pointed out that subdivision 4 requires license holders who provide room and board and treatment services in the same facility to have “the appropriate license from the Department of Health.” But the relevant Department of Health rule part, 4665.0700, references repealed DHS rule parts (9530.2500 to 9530.4000).

191. In its Final Response to Comments, DHS states that it will request the Revisor of Statutes Office to change the reference to 9530.2500- .4000 in part 4665.0700 to the appropriate citations. DHS also proposes adding the following subpart as subpart 7:

Subp. 7. Health services. License holders must have written procedures for assessing and monitoring client health, including a standardized data collection tool for collecting health related information about each client. The policies and procedures must be approved and signed by a registered nurse.

192. DHS maintains that the added language recognizes that clients in treatment programs may have specific medical needs. DHS contends that a license holder should be prepared to recognize and address those needs, by having some basic health monitoring procedures in place. DHS states that the proposed subpart 7 is not a substantial change to the rule as proposed because the rule already contained similar standards at 9530.4320.

193. The Administrative Law Judge finds the proposed rule and the additional proposed subpart 7 to be needed and reasonable and not a substantial change from the rule as originally published.

Detoxification Facilities

9530.6510 Definitions.

194. **Subpart 1a. Administration of medications.** In its Second Response to Comments, DHS proposed adding the same definition of “Administration of medications” as subpart 1a to the section concerning detox facilities that it proposed for chemical dependency treatment licenses in 9530.6405, subp. 1a. For all of the reasons discussed in Findings 42 to 45, the ALJ finds this modification to be necessary and reasonable and not a substantial change.

195. **Subpart 3a. Chemical dependency assessor.** The Minnesota Board of Nursing recommended that the Department add a definition for the phrase “Chemical dependency assessor,” because rule part 9530.6560, subp. 6, requires detoxification programs to employ “assessors.”

196. In its Final Response to Comments, DHS declined to add a definition for “chemical dependency assessor.” DHS maintains that the term is sufficiently defined at part 9530.6615.

197. The Department’s response does not address the substance of the Board’s comment. Although the term “chemical dependency assessor” is adequately defined at part 9530.6615, this section concerns public assistance recipients and the definitions are expressly limited to 9530.6600 to .6655.^[58] The Administrative Law Judge finds the lack of a definition for “chemical dependency assessor” is a defect in the rule because it is impermissibly vague given the requirement that detoxification programs provide one full-time assessor for every 15 clients served under part 9530.6560, subp.6. The Administrative Law Judge recommends that DHS add a definition of “chemical dependency assessor” similar to that provided in part 9530.6615. Such a modification would cure the defect and not render the rule substantially different.

198. In its Second Response to Comments, DHS proposed to define “chemical use problem” in the same way it proposed defining the phrase in the treatment rules.^[59] Although this addition would be needed and reasonable and would not be a substantial change, it should be done consistently with the revision to 9530.6405, subp. 7a.^[60] It should also be given a different subpart number (possibly 3b).

199. **Subpart 8a. Licensed practitioner.** In its Second Response to Comments, DHS proposed adding at subpart 8a the same definition of “Licensed practitioner” that was proposed for the chemical dependency treatment definitions. For all of the reasons discussed in Findings 62 to 65, the Administrative Law Judge finds this modification to be needed, reasonable, and not a substantial change in the rule.

200. **Subparts 9 and 10. Medical Director, Nurse.** The Minnesota Board of Nursing also recommends correcting the citation in subpart 9’s definition of “Medical director” to Minnesota Statutes, chapter 147, and correcting the citation in subpart 10’s definition of “Nurse” to Minnesota Statutes § 148.171, subdivisions 14 and 15.

201. In its Second Response to Comments, DHS proposed correcting the citation in subpart 9’s definition of “Medical director” to Minnesota Statutes, chapter 147, and correcting the citation in subpart 10’s definition of “Nurse” to Minnesota Statutes § 148.171, subdivisions 14 and 15.

202. The Administrative Law Judge finds these corrections to subparts 9 and 10 to be needed and reasonable. The changes to not make the rule substantially different.

203. **Subpart 13. Responsible staff person.** The Minnesota Board of Nursing recommended that in the definition of “Responsible staff person” in subpart 13 the word “physician” be deleted and replaced by the phrase “practitioner or nurse.”

204. In its Final Response to Comments, DHS declined to change the word “physician” to “practitioner or nurse.” DHS maintains that because the definition says “such as a licensed physician,” it is merely an example of a person who has express authority to make certain decisions regarding client care.

205. The Administrative Law Judge finds the definition of “responsible staff person” as proposed is needed and reasonable, and the modification requested by the Minnesota Board of Nursing is not needed to clarify the term’s meaning.

206. **Subpart 14. Technician.** The Minnesota Board of Nursing also recommended substituting the word “paraprofessional” for “technician” in subpart 14 to be consistent with the definition found at rule part 9530.6405, subpart 16.

207. In its Final Response to Comments, DHS declined to replace the term “technician” with “paraprofessional” because the terms are not intended to be synonymous. According to DHS, the qualifications of the technician differ from those of the paraprofessional because the nature and scope of their contact with clients is different. For example, technicians are less likely to serve as client role models because of the short-term nature of detoxification.

208. The Administrative Law Judge finds the definition of “technician” to be needed and reasonable as written.

9530.6530 Client Services

209. **Subpart 2. Chemical Use Assessment.** This subpart establishes minimum standards for chemical use assessments that must be provided to all clients seeking chemical dependency treatment services that require expenditure of public funds. Minn. Stat. § 254A.03, subd. 3, requires the Commissioner to “establish by rule criteria to be used in determining the appropriate level of chemical dependency care.” DHS maintains that it is reasonable to require detoxification programs to provide chemical use assessments that are consistent with these guidelines so that uniform standards are applied in determining appropriate treatment services for all clients, regardless of payment source.

210. As originally proposed, this subpart required license holders to provide chemical use assessments for each client at the time the client is identified and “at least every year thereafter.” DHS received a comment questioning the reasonableness of requiring a yearly assessment.

211. In its Final Response to Comments, DHS proposed to modify subpart 2 as follows:

Subp. 2. **Chemical use assessment.** A license holder must provide or arrange for the provision of a chemical use assessment, according to parts 9530.6600 to 9530.6660, for each client who suffers from chemical abuse or chemical dependency at the time the client is identified and ~~at least every year thereafter.~~ If the client is readmitted within one year of the most recent assessment, then an update to the assessment must be completed. If more than a year has passed since the most recent full assessment, then a full assessment must be completed. ~~The assessment must be updated each time the client is admitted.~~ The chemical use assessment must include documentation of the appropriateness of an involuntary referral through the civil commitment process.

212. DHS maintains that the proposed modification clarifies the frequency with which new assessments must be done and correlates the timing with the client admissions.

213. The Administrative Law Judge finds that the proposed modifications to subpart 2 are needed and reasonable and do not make the rule substantially different. For purposes of clarity, however, the Administrative Law Judge recommends changing the suggested modification of the second and third sentences to read as follows: "If the client is readmitted within one year of the most recent assessment, an update to the assessment must be completed. If a client is readmitted and it has been more than a year since the last assessment, a new assessment must be completed." This wording avoids the need to define a "full" assessment. This is not a defect in the rule but is a recommendation only. If implemented, it would not be a substantial change.

9530.6535 Protective Procedures

214. The Department maintains that it is necessary to provide procedures that restrict or restrain the movements of clients on certain occasions in order to protect the safety and well being of the entire group of clients. Clients have the right to be protected from physical harm and not be injured by the actions of other clients who are functioning at an impaired level. It may be necessary for license holders to limit clients' actions to protect them from harming themselves, staff members, or other clients. The Department states, however, that it is reasonable to limit the use of protective procedures to situations where they are absolutely necessary and end their use when the client is no longer considered dangerous.

215. The Minnesota Board of Nursing recommended that throughout this rule and rule part the word "physician" be deleted and replaced by the phrase "licensed practitioner or registered nurse." The Board points out that other licensed practitioners, including advanced practice registered nurses, are authorized to prescribe. And the Board maintains that it is within a registered nurse's legal scope of practice to assess the client's condition and determine whether protective measures are required.

216. In its Final Response to Comments, DHS stated that the Board's proposed changes would alter the meaning and intent of these provisions. DHS maintains that its proposed language is clear and appropriate.

217. The Administrative Law Judge finds the Department's use of the word "physician" throughout this rule part to be needed and reasonable.

218. **Subpart 3. Records.** The Department maintains that it is necessary to record use of protective procedures in the client file to facilitate review by the physician, program director or Commissioner.

219. The Administrative Law Judge finds this rule part to be needed and reasonable. The ALJ recommends, however, that DHS add the following to the list of information that must be included in a client's record whenever a protective procedure is used: "the physician's order authorizing use of restraints as required by subpart 6." This modification is a recommendation only and if implemented would not be a substantial change.

9530.6555 Medications.

220. This subpart requires persons who administer medications to either be appropriately licensed, certified, or trained and requires a registered nurse review the administration of medications at least weekly. The Department maintains that because employees other than a physician, registered nurse, or licensed practical nurse may be responsible for medication assistance, it is necessary to require standards governing the administration of medications to protect the health of clients. In addition, it is necessary to require training through an accredited post-secondary institution or by a registered nurse to assure the training is adequate and done by qualified personnel. The Department states that it is reasonable to require these standards because training to administer medications is readily available and it is reasonable to allow training to be provided in more than one way to allow programs flexibility while assuring a minimal training standard.

221. The Minnesota Board of Nursing recommended that the Department change the heading of this subpart to "Administration of Medications." The Board recommended additional language to clarify that the administration of medications is a delegated medical function that can only be delegated by a licensed practitioner or registered nurse. The Board recommended further that the Department substitute the word "document" for the word "certificate" in item A(1) as persons who complete medication administration programs are not certified or credentialed.

222. The Minnesota Board of Nursing also recommended language detailing the process by which a consulting registered nurse will develop the policies and procedures for delegating the administration of medications. The Board also suggested requiring weekly onsite supervision by the registered nurse as opposed to just a weekly review of the license holder's procedures.

223. In its Second Response to Comments, DHS proposed adopting many of the changes recommended by the Minnesota Board of Nursing so that this rule part would read as follows:

9530.6555 Medications

~~In addition to the medication administration procedure in chapter 4665, a license holder must meet the requirements in items A and B. A license~~

holder must meet the following requirements if services include medication administration:

A. A staff member, other than a physician, licensed practitioner, registered nurse, or licensed practical nurse, who is responsible delegated by a licensed practitioner or a registered nurse the tasks of administration of medications or for assistance with self medications medication administration must either:

- (1) provide a certificate document which must be placed in the staff member's personnel records verifying successful completion of a trained medication aide medication administration training program through an accredited, Minnesota post-secondary educational institution; Completion of the course must be documented and placed in the staff member's personnel records; or
- (2) be trained according to a formalized training offered by the license holder that is taught and supervised by a registered nurse. Completion of the course must be documented and placed in the staff member's personnel records; or
- (3) demonstrate to a registered nurse competency to perform the delegated activity.

B. A registered nurse must provide consultation and review the license holder's procedures for administration of medication at least weekly. be employed or contracted to develop the policies and procedures for medication administration. A registered nurse must provide supervision as defined in Minnesota Rules part 6321.0100. The registered nurse supervision must include onsite supervision at least monthly or more often as warranted by the health needs of the clients. The policies and procedures must include:

- (1) a requirement that delegations of administration of medication is limited to administration of those medications which are oral, suppository, eye drops, ear drops, inhalant, or topical;
- (2) a provision that clients may carry emergency medication such as nitroglycerin as instructed by their physician;
- (3) requirements for recording the client's use of medication, including staff signatures with date and time;
- (4) guidelines regarding when to inform a registered nurse of problems with medication administration, including failure to administer, client refusal of a medication, adverse reactions or errors; and
- (5) procedures for acceptance, documentation, and implementation of prescriptions, whether written, verbal, telephonic, or electronic.

224. DHS stated that the above changes were added to provide consistency between the licensing of treatment programs and detoxification facilities. DHS

maintains that it is necessary to provide more specific guidelines regarding the use of unlicensed staff in the administration of medications. DHS states further that it is reasonable to make these provisions consistent with standards applied by the Minnesota Department of Health and standards established by the Board of Nursing.

225. The Administrative Law Judge finds that the Department's proposed changes to 9530.6555 are needed and reasonable and do not amount to a substantial change in the rule. The changes provide greater specificity to an area already addressed in the published rule. However, because the Department is proposing an additional subpart on the control of drugs (below), the ALJ recommends that the Department create a subpart 1 for this provision and title it "Administration of medication." In addition, the ALJ notes that similar language contained in proposed part 9530.6435, subp. 3, does not require an accredited Minnesota post-secondary educational institution at A(1). The ALJ recommends that DHS be consistent and either require accredited educational institutions in both parts or delete it from both.

226. The Minnesota Board of Nursing also recommended creating a new item or subpart governing the control and handling of drugs. This subpart would require license holders to have written policies and procedures in place regarding the secure handling and storage of drugs. The Board states that the proposed language is consistent with the Department of Health's regulations for facilities that administer medications and store scheduled drugs. The Board maintains that it is reasonable to require detoxification programs to have control and storage provisions to lessen the risk of drug theft.

227. In its Second Response to Comments, DHS proposed adding the following provision governing the control of drugs:

Subp. 4. **Control of Drugs.** A license holder must have in place and implement written policies and procedures developed by a registered nurse that contains the following provisions:

- A. a requirement that all drugs must be stored in a locked compartment. Schedule II drugs, as defined by Minnesota Statutes, section 152.02, must be stored in a separately locked compartment, permanently affixed to the physical plant or medication cart;
- B. a system for accounting for all scheduled drugs each shift;
- C. a procedure for recording the client's use of medication, including staff signatures with time and date;
- D. a procedure for destruction of discontinued, outdated or deteriorated medications;
- E. a statement that only authorized personnel are permitted to have access to the keys to the locked drug compartments; and
- F. a statement that no legend drug supply for one client will be given to another client.

228. DHS maintains that the proposed new subpart is needed to provide adequate procedures governing secure storage for drugs, especially in a setting where scheduled drugs are likely to be misappropriated. DHS states that the above language is reasonable because it is consistent with the Department of Health's regulations for facilities where medications are administered and scheduled drugs are stored.

229. The Administrative Law Judge finds that the proposed subpart is needed and reasonable and does not represent a substantial change. However, it is inaccurate to name this provision "subpart 4." The ALJ recommends that DHS create a subpart 2 for this provision and title it "Control of drugs."

9530.6560 Staffing Requirements

230. This part establishes the requirements for the number and type of employees that a license holder must employ in order to receive a license to provide detoxification services. The Department maintains that it is necessary to establish minimum staffing levels in order to assure that the license holder has sufficient staff to protect client health and safety and to provide appropriate detoxification services.

231. The Minnesota Board of Nursing stated that the program director and responsible staff person are not qualified to direct staff regarding delegated medical and nursing functions. The Board recommended that the Department exclude medical and nursing services from the services that the program director and responsible staff person's responsibilities and clarify that these services must be directed by a licensed practitioner or registered nurse.

232. In its Final Response to Comments, DHS contends that the changes proposed by the Board of Nursing are not necessary. DHS points out that the definition of "responsible staff person" at 9530.6510, subp. 13, specifically excludes decisions that are expressly assigned to other staff.

233. The Administrative Law Judge finds subpart 2 as proposed to be needed and reasonable and the Minnesota Board of Nursing's recommendation to be unnecessary.

234. **Subpart 4. Registered nurse required.** The Department maintains that it is necessary to require license holders to employ a licensed registered nurse because medical issues often arise that only a licensed physician or nurse are qualified to handle. And the Department states that this requirement is reasonable because it is consistent with current staffing requirements.

235. The Minnesota Board of Nursing recommended adding the following to the list of responsibilities contained in subpart 4A: "basic health screening, including development of a data collection tool, as required in part 9530.6550;" and "a medication control plan".

236. The Administrative Law Judge finds these changes are not necessary because the rule as proposed already requires the establishment and implementation of a health monitoring plan and a medication control plan. The ALJ finds the rule as proposed to be reasonable and needed. For grammatical reasons, the ALJ recommends changing "that includes" to "including" in subpart 4A.

9530.6565 Staff Qualifications

237. This part establishes the qualifications for staff that have a direct influence on the quality of detoxification services. The Department maintains that it is necessary to establish standards to ensure that qualified individuals perform the services, that methods appropriate to clients' needs are employed, and that this rule part is in compliance with governing rules and statutes.

238. **Subpart 6. Personal relationships.** The Minnesota Board of Nursing recommended that the policy in subpart 6 regarding personal relationships between clients and staff apply to all staff and not just unlicensed staff members. In addition, the Board suggested adding a reporting requirement in subpart 6 item C.

239. In its Second Response to Comments, DHS proposed deleting the word "unlicensed" throughout subpart 6 and adding the phrase "prior to" before the phrase "the client's admission" in items B and C. In addition, DHS proposed adding the following sentence at the end of item C: "If a personal relationship exists, the employee must report the relationship to their supervisor and recuse themselves from the clinical relationship with that client."

240. DHS states that the changes are reasonable to ensure that all staff, regardless of licensure, report personal relationships with clients to supervisors to ensure the safety of clients.

241. The Administrative Law Judge finds the proposed changes to be needed and reasonable. The changes do not amount to a substantial change to the rule as the issue of personal relationships with clients was addressed in the rule as published.

9530.6605 Definitions

242. The only changes that DHS proposes to the chemical dependency rules for persons receiving public assistance are in the definitions section, 9530.6605. In subpart 10a, the Department has deleted references to existing rules that will be repealed; subpart 15 deletes references to rehabilitation programs (previously defined as Categories I through IV); subpart 15a deletes references to existing rules; subpart 17 modifies the definition of halfway house; subpart 22 deletes references to programs in a free standing facility; and subpart 24 deletes the reference to rehabilitation programs that are "residential."

243. One commenter expressed concern that in defining "combination inpatient/outpatient treatment" in subpart 10a the Department was limiting inpatient treatment to 7 to 14 days duration. The Department responded that subpart 10a, by its own terms, permits the duration requirements to be altered if specified in a host county agreement.

244. Other commenters expressed their fears that these changes were inadequate to address how the public assistance rules and consolidated fund rules would be interpreted, absent definition of Categories I through IV. These concerns were addressed earlier in the section containing general comments.

245. The only definition that the Department proposed to change in its post-hearing responses is subpart 10a, in which it proposed deletion of the reference to

“Category II” licensure and the insertion of “tribal” in the phrase “host county or tribal agreement.” The subpart would read as follows:

Subp. 10a. **Combination inpatient/outpatient treatment.** “Combination inpatient/outpatient treatment” means inpatient chemical dependency primary rehabilitation licensed as ~~Category II under parts 9530.4100 to 9530.4450~~ of seven to 14 days duration followed by licensed outpatient chemical dependency treatment licensed ~~under parts 9530.5000 to 9530.6500~~ of three or more weeks duration. The duration requirements may be altered if specified in a host county or tribal agreement conforming to part 9550.0040.

246. The Administrative Law Judge finds that these definitions, and the modifications proposed to subpart 10a, are needed and reasonable and do not constitute a substantially different rule.

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

CONCLUSIONS

1. The Department of Human Services gave proper notice of the hearings in this matter.

2. The Department has fulfilled the procedural requirements of Minn. Stat. §§ 14.14 and all other procedural requirements of law or rule.

3. With the exceptions noted in Findings 84, 176, 182, and 197, the Department has demonstrated its statutory authority to adopt the proposed rules and has fulfilled all other substantive requirements of law or rule within the meaning of Minn. Stat. §§ 14.05, subd. 1, 14.15, subd. 3 and 14.50 (i) and (ii).

4. With the exceptions noted in Findings 84, 176, 182, and 197, DHS has documented the need for and reasonableness of its proposed rules with an affirmative presentation of facts in the record within the meaning of Minn. Stat. §§ 14.14, subd. 2 and 14.50 (iii).

5. The modifications to the proposed rules that were offered by the Department after publication in the State Register do not make the rules substantially different from the proposed rule within the meaning of Minn. Stat. §§ 14.05, subd. 2 and 14.15, subd. 3.

6. The Administrative Law Judge has suggested action to correct the defects cited in Conclusions 3 and 4, as noted at Findings 84, 176, 183, and 197.

7. Due to Conclusions 3 and 4, this Report has been referred to the Acting Chief Administrative Law Judge for his approval pursuant to Minn. Stat. § 14.15, subd. 3.

8. Any Findings that might properly be termed Conclusions and any Conclusions that might properly be termed Findings are hereby adopted as such.

9. A finding or conclusion of need and reasonableness in regard to any particular rule subsection does not preclude and should not discourage the DHS from further modification of the proposed rules based upon an examination of the public comments, provided that the rule finally adopted is based upon facts appearing in this rule hearing record.

Based upon the foregoing Conclusions, the Administrative Law Judge makes the following:

RECOMMENDATION

IT IS HEREBY RECOMMENDED that the proposed rules be adopted except as otherwise noted above.

Dated this 12th day of January 2004.

/s/ Kathleen D. Sheehy
KATHLEEN D. SHEEHY
Administrative Law Judge

NOTICE

The Department must wait at least five working days before taking any final action on the rules. During that period, this Report must be made available to all interested persons upon request.

Pursuant to the provisions of Minnesota Rules, part 1400.2100, and Minnesota Statutes, section 14.15, subdivisions 3 and 4, this Report has been submitted to the Chief Administrative Law Judge for his approval. If the Chief Administrative Law Judge approves the adverse findings of this Report, he will advise the Commissioner of actions that will correct the defects. If the Department elects to make any changes to the rule, it must resubmit the rule to the Chief Administrative Law Judge for a review of those changes before adopting the rule.

However, in those instances where the Chief Administrative Law Judge identifies defects which relate to the issues of need or reasonableness, the Department may either follow the Chief Administrative Law Judge's suggested actions to cure the defects or, if the Department does not elect to follow the suggested actions, it must submit the proposed rule to the Legislative Coordinating Commission, and the House of Representatives and Senate Policy Committees with primary jurisdiction over state governmental operations for the advice of the Commission and Committees.

When the rule is filed with the Secretary of State by the Office of Administrative Hearings, the Department must give notice to all persons who requested that they be informed of the filing.

- [1] Minn. Stat. §§ 14.131 through 14.20.
- [2] Minn. R. 9530.4100 - .4450.
- [3] Minn. R. 9530.5000 - .6400.
- [4] Minn. R. 9530.6600 - .6660.
- [5] Minn. R. 9530.6800 - .7031.
- [6] Minn. R. 9530.4100 to 9530.4450.
- [7] SONAR at 6.
- [8] Ex. 1; Minn. Stat. § 14.101.
- [9] Ex. 5.
- [10] Ex. 8.
- [11] Ex. 9.
- [12] Ex. 7.
- [13] Minn. Stat. § 245A.02, subd. 14.
- [14] Minn. Stat. § 245A.02, subd. 10.
- [15] Minn. Stat. § 245A.02, subds. 2, 4 and 11.
- [16] SONAR at 5.
- [17] SONAR at 5.
- [18] SONAR at 5.
- [19] SONAR at 7.
- [20] SONAR at 7.
- [21] Minn. Stat. § 14.131.
- [22] Minn. Stat. § 14.002.
- [23] *Mammenga v. Department of Human Services*, 442 N.W.2d 786 (Minn. 1989); *Manufactured Housing Institute v. Petterson*, 347 N.W.2d 238, 244 (Minn. 1984).
- [24] *In re Hanson*, 275 N.W.2d 790 (Minn. 1978); *Hurley v. Chaffee*, 231 Minn. 362, 367, 43 N.W.2d 281, 284 (1950).
- [25] *Greenhill v. Bailey*, 519 F.2d 5, 19 (8th Cir. 1975).
- [26] *Mammenga*, 442 N.W.2d at 789-90; *Broen Memorial Home v. Department of Human Services*, 364 N.W.2d 436, 444 (Minn. Ct. App. 1985).
- [27] *Manufactured Housing Institute*, 347 N.W.2d at 244.
- [28] *Federal Security Administrator v. Quaker Oats Co.*, 318 U.S. 218, 233, 63 S. Ct. 589, 598 (1943).
- [29] Minn. R. 1400.2100.
- [30] Minn. Stat. § 14.15, subd. 3.
- [31] Minn. Stat. § 14.05, subd. 2.
- [32] Minn. R. 9530.6640 - .6641.
- [33] Minn. R. 9530.7000, subp. 18.
- [34] Minn. R. 9530.7012.
- [35] Minn. R. 9530.7015, subp. 2; 9530.7020, subp. 1a.
- [36] Minn. R. 9530.7024.
- [37] Minn. R. 9530.7031.
- [38] A Request for Comments for parts 9530.6600 to 9530.6655 was published in the State Register in October 2003.
- [39] Department's First Response to Comments and Hearing Testimony, November 26, 2003.
- [40] Minn. R. 9530.4100, subp. 2.
- [41] Minn. Stat. § 245A.02, subd. 2.
- [42] Minn. R. 9530.6405, subp. 7.
- [43] Minn. R. 9530.4100, subps. 5 & 6.
- [44] There is also reference to this list of behaviors in 9530.6450, subp. 2.
- [45] Minn. R. 9530.4100, subp. 8.
- [46] Minn. R. 2960.0010, subp. 2.
- [47] Minn. R. 2960.0020, subp. 59. In addition, Minn. Stat. § 260B.193, subd. 5, allows court jurisdiction of an extended jurisdiction juvenile up to age 21.
- [48] Ex. 45.
- [49] Ex. 48.
- [50] Ex. 48.
- [51] Ex. 48.

[\[52\]](#) See Minn. R. 4668.0855 (home care licensure).

[\[53\]](#) Ex. 45.

[\[54\]](#) Ex. 48.

[\[55\]](#) 42 CFR 2.11 (emphasis added).

[\[56\]](#) See, 45 CFR 96.126.

[\[57\]](#) 42 CFR 2.11.

[\[58\]](#) Minn. R. 9530.6605, subp. 1.

[\[59\]](#) See Finding No. 52. In the detoxification section, however, the Department suggested by use of the word “and” in item C that it intended to require all four behaviors to indicate a chemical use problem, as opposed to one. If the Department uses this definition, it should change the word “and” to “or” at the end of item C.

[\[60\]](#) See Finding No. 54.