

Minnesota Attorney General: Administrative Rules Proceedings

Copyright Notice:

This material may be protected by copyright law (U.S. Code, Title 17). Researchers are liable for any infringement. For more information, visit www.mnhs.org/copyright.

Version 3
August 20, 2018

Our File No. 826

RULE REVIEW CHECKLIST

DATE RULE RECEIVED 6-29-82
DATE FOR REVIEW 7-9-82
DATE DUE 7-19-82

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

Approved 7-19-82 Disapproved _____ Returned to Agency 7-19-82

Resubmitted _____ Due _____
Approved _____ Disapproved _____ Returned to Agency _____

Date filed w/Secretary of State 7-19-82 Revisor approved 7/1/82
disapproved

✓ Rule as Adopted

✓ Rule as Proposed See SR.

✓ Order Adopting 6.2.82 Date - combined with F&F

✓ Supplemental Order 6.17.82

✓ Notice of Intent to Solicit Outside Opinion + comments

✓ Order for rulemaking
12.15.81 date of Hearing

N/A Certificate of Board's Authorizing Resolution

✓ Notice of rulemaking
✓ Sufficiency

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

✓ Mailing list Certificate

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

✓ Hearing Examiner's Report 2.2.82

Chief Hearing Examiner's Report(s)
N/A Approving H.E.'s Report
✓ DIS — Approving agency action 6.7.82

✓ Agency's Findings of Fact combined with Order Adopting

N/A LCRAR Report or agency Affidavit

Certificate of Board's Resolution Adopting Rules

Order Approving Incorporation by Reference

✓ Statement of Need and Reasonableness + Posthearing Comments

N/A Petition for Adoption of a Rule

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

✓ Certificate of Compliance w/Rulemaking Procedures
not submitted

✓ Affidavit of Mailing Notice of Submission to Attorney General

✓ Notice of Submission to the Attorney General
Incorrect address of Atty. Gen.

SF-00006-02

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL

Office Memorandum

TO: ARTHUR E. NOOT
Commissioner of Public Welfare

DATE: 7/19/82

ATTN: BEVERLY JONES HEYDINGER, Spec. Ass't. Atty. Gen.

FROM: LARRY D. STARNS
Special Assistant
Attorney General

PHONE: 297-3493

SUBJECT: In the Matter of the Proposed Adotpion of 12 MCAR § 2.065 of the Department of Public Welfare Governing the Administration of the Pre-admission Screening and Alternative Care Grant Program

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

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

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

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

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

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

LDS:drw
Encs.

cc: Ms. Kathy Burek
Mr. Duane Harves

TO Judith Wehrwein
Attorney General // 204 Admin

FROM BJL Hamper

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

SUBJECT: Rule 65 (12 MCAR 2.065) DATE: 6-29-82

The file for Rule 65 is being submitted according to the requirements of 1 MCAR 1.202.

This rule is also being submitted for the Revisor's endorsement today.

SIGNED BJL Hamper

AN EQUAL OPPORTUNITY EMPLOYER

DPW-696b
(4-77)

6-2794

HE copy.

Department of Public Welfare

Income Maintenance Bureau

Adopted Rule Governing the Administration and Provision of Preadmission Screening and Long term Care and Alternative Care Grants (12 MCAR S 2.065)

Rule as Adopted

12 MCAR S 2.065 Preadmission screening for persons entering long term care facilities and alternative care grant services.

A. Responsibility for the program. The county agency responsible for administering the medical assistance program in each participating county shall be responsible for complying with requirements of the preadmission screening program.

B. Program scope. In counties participating in the program, screening teams shall review and make recommendations for nursing home applicants who are eligible for medical assistance and those who will be eligible within 90 days of admission to a nursing home. If an applicant or recipient's county of financial responsibility is included in the screening program, such applicant or recipient must be screened by the county of financial responsibility for admission to any nursing home. The procedures and criteria used by the screening team shall be in accordance with D.-H. Participating counties shall be eligible for the alternative care grant program described in H.

HE 10

C. Notification about program.

1. Notice to eligible persons. The county agency responsible for the screening program shall refer to a screening team all persons eligible for the screening as described in B. When possible, ~~these persons~~ medical assistance recipients shall be notified of the screening requirement ~~by~~ through a direct ~~mail~~ mailing by the local welfare agency. At the time of the referral, with the consent of the applicant, the local welfare agency shall notify a responsible party or appropriate relative that the person has been referred, and the pre-admission screening is a condition of medical assistance coverage.

HE 11

2. Public notice. The county agency responsible for the screening program shall provide public notification of the screening requirement. The methods of public notification shall include publication in available appropriate newsletters, display and dissemination of information leaflets in a readable form and in ~~an~~ accessible ~~location~~ locations, and promotion through other local media sources. The public notification shall include information on how to contact the screening team, implications of the screening team's recommendations, and the individuals' rights to appeal the screening team's recommendations.

3. Notice to officials and health care professionals. The Department of Public Welfare shall provide formal notification about the screening program to county commissioners, local health and welfare agencies, state hospitals, nursing homes, and physicians. The department shall assist participating counties in providing information sessions and materials to further explain the program.

D. Resource material for screening programs.

1. Screening tool. The department shall recommend a screening tool to be used as a guide in conducting the screening interview. The screening tool recommended by the department shall obtain consistent categories of information and ensure that persons are receiving uniform screening. The assessment tool used by the county screening teams shall require information related to the following criteria:

a. present medical conditions;

b. present unmet needs;

c. informal and formal service available or being provided to the person;

d. the recipient's preferences;

e. persons consulted in the screening process;

f. observations of the screening team during the onsite visit;

g. assessment of functional capacity; and

h. a preliminary service care plan.

The state agency shall allow counties flexibility in using the recommended tool or a comparable one which includes the information related to the criteria in a.-h. and has been approved by the state agency. HE 14

2. Technical assistance. Department staff shall be available to provide technical assistance in conducting the screenings, including special training sessions.

3. Directory of services. The county agency shall develop a resource directory of available institutional and noninstitutional services to be used by the screening team in determining how well an applicant's needs can be met by existing community services. HE 16

E. Screening ~~procedures~~ requirements.

1. Screening team. Minn. Stat. S 256B.091, subd. 2, shall govern the composition of the screening team. The screening team must include a public health nurse from the local public health nursing service, a social worker from the local community welfare agency, a physician available for consultation when necessary, and the individual's physician if the physician chooses to participate. The screening team shall utilize the individual's attending physicians' assessment forms if available. HE 17

2. Screening procedures. The screening team shall notify the individual's attending physician that the screening is a condition of medical assistance and that the physician has the right to participate in the screening procedure. The screening team shall begin the screening process within five working days after receiving the request, and it shall issue a recommendation within ten working days after receiving the request. The screening team shall notify the applicant or appropriate relative or responsible party of the decision. The team shall also notify the referring physician, the referring local welfare department if the applicant is a medical assistance recipient, and the nursing home if placement is recommended. HE 18 reinstated per CHE 6/7

3. Rescreening procedures. Reconsideration of a previously denied application shall be given when there has been a change in circumstances. The application shall be resubmitted

to the screening team with a written explanation of the change in circumstances. Time requirements for initial applications shall apply. HE 18

F. Criteria for screening team recommendations.

1. Nursing home admission. The screening team shall recommend admission to a nursing home when it is determined that the individual requires care or services which are not available to the recipient outside of the nursing home and cannot be provided through the alternative care grants program. In assessing the individual's need for service, the screening team may use reliable information gathered by others. HE 19

2. Use of community services. The screening team shall not recommend admission to a nursing home when it is determined that the individual can remain in the community and that care and services are available ~~and accessible~~ to the individual in his or her own community. HE 20

3. Choice of care. The recipient or his or her representative shall be informed of all feasible alternatives and allowed to choose among them where the cost of home and community-based services are not expected to exceed the cost of the appropriate level of nursing home care. This choice shall be recorded and maintained in the individual's plan of care. per FofF p. 10

G. Plan of care required. A recommendation for the applicant to remain in the community shall be accompanied by a plan of care including referral to service providers and assignment of responsibility for implementing the plan.

1. Development of the plan. The plan of care shall be developed by the screening team in consultation with the individual, the treating physician, and appropriate family members or responsible parties. The resource directory described in D.3. shall be used in determining what services are available.

2. ~~Availability of~~ Services provided in the plan of care. Where the plan of care includes services that are not available at that time through other public assistance sources, the services shall be provided through an alternative care grant FofF p. 11 and HE 23

described in H.

3. Responsibility for the plan of care. The plan of care shall include the name of the person responsible for ensuring compliance, the method of monitoring the recipient's acceptance of and adjustment to the services provided under the plan, the date for reevaluation, and any temporary measures that might be required immediately in order to ensure the safety of the person. When needed services become unavailable, the assigned person shall be responsible for recommending a reevaluation by the screening team.

HE 21

4. Cost-effective alternatives. The plan of care shall include documentation that the most cost-effective alternatives available have been offered to the individual.

FoF p. 12

H. Alternative care grant.

1. Use of grant. The grant shall be used to provide services to ~~these persons~~ medical assistance recipients who have been screened and found appropriate for home or community care. Services that may be provided through this grant are day care, case management, homemaker, home health aide, personal care, respite care, foster care, and others for which federal participation is provided under the Social Security Act, section 1915, as added by Public Law 97-35, as amended through December 31, 1981. The grant shall supplement but not supplant services available through other public assistance or service programs. The grant shall not be used to establish new programs for which public money is available through other sources.

FoF p. 12

FoF p. 12, 13

2. Service provision. The services shall be provided by a licensed health care provider; a home health service eligible for reimbursement under 42 United States Code, Subchapters XVIII or XIX, as amended through December 31, 1981, and Code of Federal Regulations, title 42, sections 405.1201-405.1230 (1981); or by persons employed by, or under contract to, the county board or the local welfare agency.

no indication of why this was added.

3. Reimbursement of services. Services shall be reimbursed at a level no greater than that which is allowed under 42 United States Code, Subchapters XIX and XX, as amended

through December 31, 1981, and Code of Federal Regulations, title 42, sections 405.201-405.252 (1981), unless lower rates are negotiated with providers at a level sufficient to insure the availability of such services in the community.

4. Assurances. The county shall provide the Commissioner of Public Welfare with assurances that the alternative care grant is used for purposes specified in Minn. Stat. S 256B.091, subd. 8 and in Public Law 97-35, Section 2176 relating to community-based services.

I. Reimbursement of nursing home costs.

~~1. Nonemergencies, unscreened applicants. When an individual covered by the mandatory screening requirement is admitted to a nursing home on a nonemergency basis and has not obtained the required pre-admission screening, the nursing home shall notify the screening team within two working days. The screening team shall make a decision on the case within five working days of being contacted by the nursing home. If the screening team fails to review the case within five working days or recommends that institutionalization is necessary, medical assistance shall cover the cost of the care. If the screening team determines that the individual does not require institutionalization, the admitting facility shall not be reimbursed for any costs incurred, and patient days resulting from that stay must be counted in the facility's patient day statistics for the purposes of rate calculation under 12 MCAR S 2.049.~~

~~2. Emergencies, unscreened applicants. When an individual covered by the mandatory screening requirement is admitted to a nursing home on an emergency basis and has not obtained the required pre-admission screening, the nursing home shall notify the screening team within two working days. The screening team shall make a decision on the case within five working days of being contacted by the nursing home. If the screening team fails to review the case within five working days or recommends that institutionalization is necessary, the costs of nursing home care shall be covered by medical assistance. If~~

~~the screening team reviews the admission within the five working days and determines that the individual does not require institutionalization, medical assistance shall cover the costs only for the period through the date the screening team notified the nursing home of its decision, and until a plan for alternative care can be implemented. If the admitting facility fails to contact the screening team within the prescribed period, the facility shall not be reimbursed for any costs incurred, and patient days resulting from that stay must be counted in the facility's patient day statistics for the purposes of rate calculation under 12 MCAR S 2.049. Reimbursement for emergencies of unscreened persons shall be allowed for medical emergencies only, as certified by the attending physician.~~

~~3. Screened applicants. Medical assistance shall not be available to reimburse the nursing home in instances when an individual is admitted to a nursing home after the screening team has determined that institutionalization is not necessary. The individual has the right to notification and a fair hearing on such denial of payment in accordance with K.~~

1. Notification of admission of unscreened applicants. When an individual covered by the mandatory screening requirement is admitted to a nursing home on an emergency or nonemergency basis and has not obtained the required preadmission screening, the nursing home shall notify the screening team within two working days. If the admitting facility fails to contact the screening team within the prescribed period, the facility shall not be reimbursed for any costs incurred until the decision is made and the recipient and the nursing home are notified. Patient days resulting from that stay must be counted in the facility's patient day statistics for the purposes of rate calculation under 12 MCAR S 2.049.

2. Screening team review. When an unscreened applicant has been admitted to the nursing home, the screening team shall make a decision on the case within five working days of being contacted by the nursing home. If the person prefers to return

F.F. p. 14, 15

to the community, medical assistance shall cover the costs only for the period through the date the screening team notified the nursing home of this decision and until a plan for alternative care can be implemented. F&F p. 15

~~4.~~ 3. Persons not screened. Nursing home applicants who have not been screened and are not medical assistance recipients shall be asked by the nursing home if they have sufficient funds to cover 90 days of nursing home care or whether they will be applying for medical assistance within that time period. If, based on the information given and recorded, the nursing home determines that the person is not subject to the screening requirement the applicant may be admitted without screening. The nursing home shall maintain documentation of the basis for this decision in the patient's file. If the patient's statement concerning proposed eligibility is inaccurate, the health care facility shall not be denied reimbursement because of the inaccuracy of this statement. HE 30

J. Reimbursement for screening costs.

1. Persons eligible for medical assistance. The Department of Public Welfare shall reimburse the county agency for the preadmission screening required for persons who are eligible for medical assistance and those who will be eligible for medical assistance within 90 days of admission to a nursing home. Reimbursement shall be in a manner agreed upon by both parties.

2. Persons not receiving assistance. The Department of Public Welfare shall reimburse the county agency for all or a portion of the cost of screening for a person whose costs are not reimbursed under 1. The percentage rate of reimbursement by the department shall be determined according to the schedule in Exhibit 12 MCAR S 2.065 J.2.-1., except that the maximum amount of reimbursement from the department for a screening shall not exceed the maximum reimbursement available to a county agency for the cost of a screening reimbursed under 1. The county agency may assess the person who is screened for the part of the screening cost not reimbursed by the department.

Exhibit 12 MCAR S 2.065 J.2.-1.

Annual Gross Income per Individual	Screening Fee Reimbursement for Applicants not Eligible for Medical Assistance
under - 13,000	100 %
13,001 - 13,500	90
13,501 - 14,000	80
14,001 - 14,500	70
14,501 - 15,000	60
15,001 - 15,500	50
15,501 - 16,000	40
16,001 - 16,500	30
16,501 - 17,000	20
17,001 - 17,500	10
17,501 - and over	0

K. Right to appeal.

1. Appeal procedures. Persons who are recipients of or applying for medical assistance have the right to a fair hearing pursuant to Minn. Stat. S 256.045 ~~to challenge the decision of the screening team~~ if they are not informed of and allowed to choose among alternatives available to them as set forth in F.3., or if the plan of care is not satisfactory. The hearing shall be conducted in accordance with appeal procedures set forth in Minn. Stat. S 256.045. ~~An appeal must be made within 30 days after receiving written notice of the screening team's recommendation.~~ If it appears at the hearing that circumstances are different than they were at the time the ~~initial recommendation was made~~ plan of care was established, the referee may refer the case back to the screening team for ~~reevaluation~~ reconsideration.

FoF p.17

2. Appeal by the physician. When the treating physician disagrees with the outcome of the screening ~~team's decision~~, the physician shall notify the screening team ~~and request~~ in order to initiate an appeal on behalf of the individual. The appeal may be withdrawn with the consent of the individual and the treating physician.

HE 32

~~3. Persons not receiving assistance. Persons who are not applying for or receiving medical assistance shall consider the recommendation by the screening team to be advisory, unless the person applies for medical assistance within 90 days following~~

FoF p.17

~~admission to a nursing home.~~

L. County reports. The county agency shall submit a report to the Department of Public Welfare according to a schedule agreed upon by the department and the county agency. The report shall be submitted on forms provided by the commissioner and include the number of persons screened, results of each screening, and the rationale for each screening recommendation. The county agency shall retain the plan of care for persons who are to remain in the community and shall make it available to the department on request. The county agency shall also provide information as requested by the commissioner for ongoing evaluation of the program.

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
JUL 19 1982
Joan Anderson Growe
Secretary of State

11:15 AM

APPROVED AS TO LEGALITY
July 19, 1982
WARREN SPANNAUS, ATTORNEY GENERAL
BY Jerry D. Jones
SPECIAL ASSISTANT ATTORNEY GENERAL

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE ARTHUR E. NOOT

COMMISSIONER OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of 12 MCAR 2.065 of the Department of Public Welfare Governing the Administration of the Pre-admission Screening and Alternative Care Grant Program

SUPPLEMENTAL ORDER ADOPTING RULE 12 MCAR 2.065

Docket No. 82-021-GB

The Commissioner's Order Adopting Rule 12 MCAR 2.065 was submitted to the Chief Hearing Examiner on June 2, 1982 for review. The response was received by the Department of Public Welfare June 7, 1982. The Chief Hearing Examiner determined that there had been a substantial change in the rule as proposed by deleting language establishing a deadline for the screening team's recommendation. This change results in a rule substantially different from that contained in the Notice of Hearing. Based on this finding, the Chief Hearing Examiner ordered the Department of Public Welfare to either reinstate the language, or to withdraw the rules as proposed. The Department will reinstate the language which had been deleted (found at page 3, lines 27-29 of the Revisor of Statutes draft of the rules, dated May 17, 1982) and submit the completed hearing record and rules as authorized by the Chief Hearing Examiner.

Now, therefore, it is ordered that 12 MCAR § 2.065 is hereby adopted as submitted.

It is further ordered, that the rule as adopted shall be submitted to the Attorney General and such subsequent action as necessary to fully comply with Minn. Stat. § 15.0412 (Supplement 1981).

State of Minnesota
Department of Public Welfare

Arthur E. Noot
Commissioner of Public Welfare

June 17, 1982
Date

Exh. No. I
File No. 82-021-JL
Date 12/15/JL

RECEIVED
OCT 19 1981
ADMINISTRATIVE HEARINGS

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

IN THE MATTER OF THE PROPOSED ADOPTION OF THE DEPARTMENT OF PUBLIC WELFARE RULE GOVERNING THE ADMINISTRATION AND PROVISION OF PRE-ADMISSION SCREENING AND LONG TERM CARE AND ALTERNATIVE CARE GRANTS (12 MCAR 2.065)

ORDER OF HEARING

IT IS ORDERED this 15 day of October, 1981, that a public hearing on the proposed rules captioned above be held in Room A, 4th Floor, Centennial Office Building, St. Paul, Minnesota 55155 on December 15, 1981, commencing at 9:00 a.m., and continuing until all representatives of associations or other interested groups or persons have had an opportunity to be heard.

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

STATE OF MINNESOTA

Arthur E. Noot

ARTHUR E. NOOT
COMMISSIONER OF PUBLIC WELFARE

BT/abd

Exh. No. J
File No. 82-021-JL
Date 12/15/82

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

RECEIVED
NOV 20 1981
ADMINISTRATIVE HEARINGS

IN THE MATTER OF THE PROPOSED ADOPTION OF THE DEPARTMENT OF PUBLIC WELFARE RULE GOVERNING THE ADMINISTRATION AND PROVISION OF PRE-ADMISSION SCREENING AND LONG TERM CARE AND ALTERNATIVE CARE GRANTS (12 MCAR 2.065)

NOTICE OF HEARING

A public hearing concerning the above-entitled matter will be held in Room A, 4th Floor, Centennial Office Building, St. Paul, Minnesota, 55155 on December 15, 1981 commencing at 9:00 a.m. and continuing until all interested persons have an opportunity to be heard. The proposed rule may be modified as a result of the hearing process. Therefore, if you are affected in any manner by the proposed rule, you are urged to participate in the rule hearing process.

Following the agency's presentation at the hearing, all interested or affected persons will have an opportunity to ask questions and make comments. Statements may be made orally and written material may be submitted. In addition, whether or not an appearance is made at the hearing, written statements or material may be submitted to Jon Lunde, Hearing Examiner, Office of Administrative Hearings, 1745 University Avenue, Room 300, St. Paul, Minnesota 55104, 612/296-5938, either before the hearing or within five working days after the public hearing ends. The hearing examiner may, at the hearing, order that the record be kept open for a longer period not to exceed 20 calendar days. The rule hearing procedure is governed by Minn. Stat. §§ 15.0411-15.0417 and 15.052, and by 9 MCAR §§ 2.101-2.112 (Minnesota Code of Agency Rules). If you have any questions about the procedure, call or write the hearing examiner.

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

The purpose of 12 MCAR 2.065 is to set forth procedures and standards for establishing county based pre-admission screening programs and alternative care services as required in Minn. Stat. 256B.091. The screenings are mandatory for nursing home applicants who are eligible for Medical Assistance or who will be eligible within 90 days of admission, and is also available to others on a sliding fee schedule.

The screening team of a public health nurse, social worker and consulting physician determine whether the applicant requires institutionalization, or can be maintained in the community with home-based services. Services specified in a plan of care are provided through existing community programs and the supplementary alternative care grant programs. The plan of care must include provisions for follow-up to assure that services provided meet applicable standards.

The intent of the program is to establish a mechanism so that nursing home applicants are directed to appropriate care, and to ensure that public funding for long-term care are spent in a cost effective manner. Statewide implementation of the program will also provide basic information for assessing future service needs.

The rule addresses the following concerns:

(a) Assigns responsibility for the program;
(b) Defines program scope including eligible persons;
(c) Specifies notification about the program to potential recipients, providers and others affected by the requirement;
(d) Describes resources material to be used by the screening team;
(e) Sets forth screening procedures to be used by the county;
(f) Defines when nursing home admission should be approved, and when to recommend alternative care services;
(g) Specifies that the plan of care assign responsibilities, list services, and include a component for follow-up care;
(h) Provides instructions on uses of the alternative care grants, including providers, reimbursement, and assurances of how the funds are to be used;
(i) Sets guidelines for reimbursement of nursing homes for admissions in the folowing instances: emergency and non-emergencies, screened and non-screened applicants; and medical assistance eligible and ineligible persons;
(j) Sets guidelines for reimbursement of screening costs for the following categories: applicants who are eligible for Medical Assistance, applicants who will be eligible for Medical Assistance in 90 days, and applicants who volunteer for the screening who will be assessed on a sliding fee schedule;
(k) Assures persons being screened of their right to appeals; and
(l) Requires that the county submit reports on specific items, and other information as determined necessary by the Commissioner of Public Welfare.

The agency's authority to adopt the proposed rule is contained in Minn. Stat. §256B.091.

Cost to the county agencies for the pre-admission and alternative care grant program will be $62,456.00 for F.Y. 1981-1982 and $12,981.00 for F.Y. 1982-1983. This estimate is based on 4.5 percent match for reimbursement of the screening teams and 10 percent match on the alternative care grants. These amounts can be separated out as follows: F.Y. 1981-1982 Pre-admission screening $2,456.00 and alternative care grants $60,000.00; F.Y. 1982-1983 Pre-admission screening $9,812 and alternative care grants $120,000.00.

Copies of the proposed rule are now available and at least one free copy may be obtained by writing to Marie Scheer, Department of Public Welfare, 444 Lafayette Road, Box #43170, St. Paul, Minnesota 55164, telephone 612/296-2274. Additional copies will be available at the hearing. If you have any questions on the content of the proposed rule, contact Marie Scheer at 612/296-2274.

Any person may request notification of the date on which the hearing examiner's report will be available, after which date the agency may not take any final action on the rules for a period of five working days. Any

person may request notification of the date on which the hearing record has been submitted or resubmitted to the Attorney General by the agency. If you desire to be so notified, you may so indicate at the hearing. After the hearing, you may request notification by sending a written request to the hearing examiner, in the case of the hearing examiner's report, or to the agency, in the case of the agency's submission or resubmission to the Attorney General.

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

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

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

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

Dated: 10.23.81

Arthur E. Noot

ARTHUR E. NOOT
COMMISSIONER OF PUBLIC WELFARE

BS/g1a

Exh. No. 6
File No. 82-021-JL
Date

RECEIVED
NOV 20 1981
ADMINISTRATIVE HEARINGS

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

IN THE MATTER OF THE PROPOSED ADOPTION OF THE DEPARTMENT OF PUBLIC WELFARE RULE GOVERNING THE ADMINISTRATION AND PROVISION OF PRE-ADMISSION SCREENING AND LONG TERM CARE AND ALTERNATIVE CARE GRANTS (12 MCAR 2.065)

AFFIDAVIT OF ADDITIONAL MAILING

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

That on the 12 day of November, 1981, at the City of St. Paul, County of Ramsey, State of Minnesota, in addition to serving the attached Notice of Hearing to all persons and associations who have requested that their names be placed on file for the purpose of receiving notice of the proposed adoption of rules by this Department, she also served the attached Notice by depositing in the State of Minnesota Central Mail System for first class mailing at said City of St. Paul, a copy thereof, properly enveloped, with postage prepaid to the following agencies:

47 Community Health Serv. Agencies
3 Public Health Serv. Nurses
Health Care Facilities
MN Hospital Assn.
State Medical Assn.
Wilder Health Care Center
MN Senior Federation
Board on Aging
MN Social Services Assn.
MN Nurses Assn.
St. Louis County
Blue Earth County
Commissioner, Dept. of Health
Association of MN Counties

Wendy Johnson

Subscribed and sworn to before me

this 12 day of November, 1981.

Margaret Holt

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

Rule No. F
File No. 82-021-JL
Date 12/15/81

RECEIVED
NOV 20 1981
ADMINISTRATIVE HEARINGS

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

IN THE MATTER OF THE PROPOSED ADOPTION OF THE DEPARTMENT OF PUBLIC WELFARE RULE GOVERNING THE ADMINISTRATION AND PROVISION OF PRE-ADMISSION SCREENING AND LONG TERM CARE AND ALTERNATIVE CARE GRANTS (12 MCAR 2.065)

AFFIDAVIT OF MAILING

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

That on the 12 day of November, 1981, at the City of St. Paul, County of Ramsey, State of Minnesota, she served the attached Notice of Hearing by depositing in the State of Minnesota Central Mail System for first class mailing, a copy thereof, properly enveloped, with postage prepaid, on all persons and associations who have requested that their names be placed on file with the Department of Public Welfare for the purpose of receiving notice of the proposed adoption of rules by this Department.

Wendy Johnson

Subscribed and sworn to before me

this 12 day of November, 1981.

Margaret Holt

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

Exh. No. 14
File No. 82-021-JL
12/15/81 Date 12/15/81

RECEIVED
NOV 20 1981
ADMINISTRATIVE HEARINGS

STATE OF MINNESOTA

COUNTY OF RAMSEY

CERTIFICATE

IN THE MATTER OF THE PROPOSED ADOPTION OF THE DEPARTMENT OF PUBLIC WELFARE RULE GOVERNING THE ADMINISTRATION AND PROVISION OF PRE-ADMISSION SCREENING AND LONG TERM CARE AND ALTERNATIVE CARE GRANTS (12 MCAR 2.065)

I hereby certify that the list of persons, associations, and other interested groups who have requested, pursuant to Minn. Stat. §15.0412, subd. 4, that their names be placed on file with and maintained by the State Department of Public Welfare for the purpose of receiving notice of the proposed adoption of rules by this Department is accurate and complete as of 12:00 P.M., this 12 day of November, 1981.



Exh. No. C
File No. 82-[redacted]1-JL
Date 12/15/81

RECEIVED
NOV 2[illegible]
ADMINISTRATIVE HEARINGS

1. Explain why a variance is sought;

2. Explain how the applicant meets the criteria for a variance set forth in C.;

3. Specify the desired alternative standard to the rule and demonstrate that under the alternative standard the scale or device will conform to good commercial practices;

4. Provide a detailed plan showing the following:

a. The dimensions for all parts of the scale or device;

b. The materials from which those parts are made; and

c. The construction of the scale or device, including its foundation and location.

C. Approval criteria. No request for a variance shall be granted unless all the following criteria are met:

1. The rule for which a variance is sought works an undue hardship on the applicant, or it is impossible for the applicant to comply with the rule;

2. The variance sought will not work a harm to the public interest;

3. The director is able to determine, after investigation, that under normal operating conditions the scale or device for which a variance is sought will:

a. Maintain the applicable accuracy standards;

b. Maintain the permanence of adjustments required; and

c. Contain operating parts which function as intended.

D. Denial. No variance will be granted if it is a variance of a tolerance or would apply to the value of the minimum graduated interval of a device.

E. Response by the division to request. All requests will be answered by the division in writing, setting forth the reasons for granting or denying the variance.

Department of Public Welfare
Income Maintenance Bureau

Proposed Rule Governing the Administration and Provision of Pre-admission Screening and Long-term Care and Alternative Care Grants (12 MCAR § 2.065)

Notice of Hearing

A public hearing concerning the above-entitled matter will be held in Room A, 4th Floor, Centennial Office Building, St. Paul, Minnesota, 55155 on December 15, 1981 commencing at 9:00 a.m. and continuing until all interested persons have an opportunity to be heard. The proposed rule may be modified as a result of the hearing process. Therefore, if you are affected in any manner by the proposed rule, you are urged to participate in the rule hearing process.

Following the agency's presentation at the hearing, all interested or affected persons will have an opportunity to ask questions and make comments. Statements may be made orally and written material may be submitted. In addition, whether or not an appearance is made at the hearing, written statements or material may be submitted to Jon Lunde, Hearing Examiner, Office of Administrative Hearings, 1745 University Avenue, Room 300, St. Paul, Minnesota 55104, (612) 296-5938, either before the hearing or within five working days after the public hearing ends. The hearing examiner may, at the hearing, order that the record be kept open for a longer period not to exceed 20 calendar days. The rule hearing procedure is governed by Minn. Stat. §§ 15.0411-15.0417 and 15.052, and by 9 MCAR §§ 2.101-2.112 (Minnesota Code of Agency Rules). If you have any questions about the procedure, call or write the hearing examiner.

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

The purpose of 12 MCAR § 2.065 is to set forth procedures and standards for establishing county based pre-admission screening programs and alternative care services as required in Minn. Stat. § 256B.091. The screenings are mandatory for nursing home applicants who are eligible for Medical Assistance or who will be eligible within 90 days of admission, and is also available to others on a sliding fee schedule.

The screening team of a public health nurse, social worker and consulting physician determine whether the applicant requires institutionalization, or can be maintained in the community with home-based services. Services specified in a plan of care are provided through existing community programs and the supplementary alternative care grant programs. The plan of care must include provisions for follow-up to assure that services provided meet applicable standards.

The intent of the program is to establish a mechanism so that nursing home applicants are directed to appropriate care, and to ensure that public funding for long-term care are spent in a cost effective manner. Statewide implementation of the program will also provide basic information for assessing future service needs.

The rule addresses the following concerns:

(a) Assigns responsibility for the program;

(b) Defines program scope including eligible persons;

(c) Specifies notification about the program to potential recipients, providers and others affected by the requirement;

(d) Describes resources material to be used by the screening team;

(e) Sets forth screening procedures to be used by the county;

(f) Defines when nursing home admission should be approved, and when to recommend alternative care services;

(g) Specifies that the plan of care assign responsibilities, list services, and include a component for follow-up care;

(h) Provides instructions on uses of the alternative care grants, including providers, reimbursement, and assurances of how the funds are to be used;

(i) Sets guidelines for reimbursement of nursing homes for admissions in the following instances: emergency and non-emergencies, screened and non-screened applicants; and medical assistance eligible and ineligible persons;

(j) Sets guidelines for reimbursement of screening costs for the following categories: applicants who are eligible for Medical Assistance, applicants who will be eligible for Medical Assistance in 90 days, and applicants who volunteer for the screening who will be assessed on a sliding fee schedule;

(k) Assures persons being screened of their right to appeals; and

(l) Requires that the county submit reports on specific items, and other information as determined necessary by the Commissioner of Public Welfare.

The agency's authority to adopt the proposed rule is contained in Minn. Stat. § 256B.091.

Cost to the county agencies for the pre-admission and alternative care grant program will be $62,456.00 for F.Y. 1981-1982 and $12,981.00 for F.Y. 1982-1983. This estimate is based on 4.5 percent match for reimbursement of the screening teams and 10 percent match on the alternative care grants. These amounts can be separated out as follows: F.Y. 1981-1982 Pre-admission screening $2,456.00 and alternative care grants $60,000.00; F.Y. 1982-1983 Pre-admission screening $9,812 and alternative care grants $120,000.00.

Copies of the proposed rule are now available and at least one free copy may be obtained by writing to Marie Scheer, Department of Public Welfare, 444 Lafayette Road, Box #43170, St. Paul, Minnesota 55164, telephone 612/296-2274. Additional copies will be available at the hearing. If you have any questions on the content of the proposed rule, contact Marie Scheer at 612/296-2274.

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

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

(a) Engaged for pay or other consideration, or authorized by another individual or association to spend money, who spends

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

more than five hours in any month or more than $250, not including his own travel expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials; or

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

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

October 23, 1981

Arthur E. Noot
Commissioner of Public Welfare

Rule as Proposed (all new material)

12 MCAR § 2.065 Pre-admission screening for persons entering long term care facilities and alternative care grant services.

A. Responsibility for the program. The county agency responsible for administering the medical assistance program in each participating county shall be responsible for complying with requirements of the pre-admission screening program.

B. Program scope. In counties participating in the program, screening teams shall review and make recommendations for nursing home applicants who are eligible for medical assistance and those who will be eligible within 90 days of admission to a nursing home. The procedures and criteria used by the screening team shall be in accordance with D.-H. Participating counties shall be eligible for the alternative care grant program described in H.

C. Notification about program.

1. Notice to eligible persons. The county agency responsible for the screening program shall refer to a screening team all persons eligible for the screening as described in B. When possible, these persons shall be notified of the screening requirement by direct mail.

2. Public notice. The county agency responsible for the screening program shall provide public notification of the screening requirement. The methods of public notification shall include publication in available appropriate newsletters, display and dissemination of information leaflets in a readable form and in an accessible location, and promotion through other local media sources. The public notification shall include information on how to contact the screening team, implications of the screening team's recommendations, and the individuals' rights to appeal the screening team's recommendations.

3. Notice to officials and health care professionals. The Department of Public Welfare shall provide formal notification about the screening program to county commissioners, local health and welfare agencies, state hospitals, nursing homes, and physicians. The department shall assist participating counties in providing information sessions and materials to further explain the program.

D. Resource material for screening programs.

1. Screening tool. The department shall recommend a screening tool to be used as a guide in conducting the screening interview. The screening tool recommended by the department shall obtain consistent categories of information and ensure that persons are receiving uniform screening. The state agency shall allow counties flexibility in using the recommended tool or a comparable one approved by the state agency.

2. Technical assistance. Department staff shall be available to provide technical assistance in conducting the screenings, including special training sessions.

3. Directory of services. The county agency shall develop a resource directory of available non-institutional services to be used by the screening team in determining how well an applicant's needs can be met by existing community services.

E. Screening procedures. The screening team shall begin the screening process within five working days after receiving the request, and it shall issue a recommendation within ten working days after receiving the request. The screening team shall notify the applicant or appropriate relative or responsible party of the decision. The team shall also notify the referring physician, the referring local welfare department if the applicant is a medical assistance recipient, and the nursing home if placement is recommended. Reconsideration of a previously denied application shall be given when there has been a change in circumstances. The application shall be resubmitted with a written explanation of the change in circumstances.

F. Criteria for screening team recommendations.

1. Nursing home admission. The screening team shall recommend admission to a nursing home when it is determined that the individual requires care or services which are not available to the recipient outside of the nursing home.

2. Use of community services. The screening team shall not recommend admission to a nursing home when it is determined that the individual can remain in the community and that care and services are available and accessible.

G. Plan of care required. A recommendation for the applicant to remain in the community shall be accompanied by a plan of care including referral to service providers and assignment of responsibility for implementing the plan.

1. Development of the plan. The plan of care shall be developed by the screening team in consultation with the individual, the treating physician, and appropriate family members or responsible parties. The resource directory described in D.3. shall be used in determining what services are available.

2. Availability of services. Where the plan of care includes services that are not available at that time through other public assistance sources, the services shall be provided through an alternative care grant described in H.

H. Alternative care grant.

1. Use of grant. The grant shall be used to provide services to those persons who have been screened and found appropriate for home or community care. The grant shall supplement but not supplant services available through other public assistance or service programs. The grant shall not be used to establish new programs for which public money is available through other sources.

2. Service provision. The services shall be provided by a licensed health care provider; a home health service eligible for reimbursement under 42 United States Code, Subchapters XVIII or XIX, as amended through December 31, 1981; or by persons employed by, or under contract to, the county board or the local welfare agency.

3. Reimbursement of services. Services shall be reimbursed at a level no greater than that which is allowed under 42 United States Code, Subchapters XIX and XX, as amended through December 31, 1981, unless lower rates are negotiated with providers at a level sufficient to insure the availability of such services in the community.

4. Assurances. The county shall provide the Commissioner of Public Welfare with assurances that the alternative care grant is used for purposes specified in Minn. Stat. § 256B.091, subd. 8 and in Public Law 97-35, Section 2176 relating to community-based services.

I. Reimbursement of nursing home costs.

1. Nonemergencies; unscreened applicants. When an individual covered by the mandatory screening requirement is admitted to a nursing home on a nonemergency basis and has not obtained the required pre-admission screening, the nursing home shall notify the screening team within two working days. The screening team shall make a decision on the case within five working days of being contacted by the nursing home. If the screening team fails to review the case within five working days or recommends that institutionalization is necessary, medical assistance shall cover the cost of the care. If the screening team determines that the individual does not require institutionalization, the admitting facility shall not be reimbursed for any costs incurred, and patient days resulting from that stay must be counted in the facility's patient day statistics for the purposes of rate calculation under 12 MCAR § 2.049.

2. Emergencies; unscreened applicants. When an individual covered by the mandatory screening requirement is admitted to a nursing home on an emergency basis and has not obtained the required pre-admission screening, the nursing home shall notify the screening team within two working days. The screening team shall make a decision on the case within five working days of being contacted by the nursing home. If the screening team fails to review the case within five working days or recommends that institutionalization is necessary, the costs of nursing home care shall be covered by medical assistance. If the screening team reviews the admission within the five working days and determines that the individual does not require institutionalization, medical assistance shall cover the costs only for the period through the date the screening team notified the nursing home of its decision, and until a plan for alternative care can be implemented. If the admitting facility fails to contact the screening team within the prescribed period, the facility shall not be reimbursed for any costs incurred, and patient days resulting from that stay must be counted in the facility's patient day statistics for the purposes of rate calculation under 12 MCAR § 2.049. Reimbursement for emergencies of unscreened persons shall be allowed for medical emergencies only, as certified by the attending physician.

3. Screened applicants. Medical assistance shall not be available to reimburse the nursing home in instances when an individual is admitted to a nursing home after the screening team has determined that institutionalization is not necessary. The individual has the right to notification and a fair hearing on such denial of payment in accordance with K.

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

4. Persons not screened. Nursing home applicants who have not been screened and are not medical assistance recipients shall be asked by the nursing home if they have sufficient funds to cover 90 days of nursing home care or whether they will be applying for medical assistance within that time period. If, based on the information given and recorded, the nursing home determines that the person is not subject to the screening requirement the applicant may be admitted. The nursing home shall maintain documentation of the basis for this decision in the patient's file.

J. Reimbursement for screening costs.

1. Persons eligible for medical assistance. The Department of Public Welfare shall reimburse the county agency for the pre-admission screening required for persons who are eligible for medical assistance and those who will be eligible for medical assistance within 90 days of admission to a nursing home. Reimbursement shall be in a manner agreed upon by both parties.

2. Persons not receiving assistance. The Department of Public Welfare shall reimburse the county agency for all or a portion of the cost of screening for a person whose costs are not reimbursed under 1. The percentage rate of reimbursement by the department shall be determined according to the schedule in Exhibit 12 MCAR § 2.065 J.-1., except that the maximum amount of reimbursement from the department for a screening shall not exceed the maximum reimbursement available to a county agency for the cost of a screening reimbursed under 1. The county agency may assess the person who is screened for the part of the screening cost not reimbursed by the department.

Exhibit 12 MCAR § 2.065 J.-1.

Annual Gross Income per Individual	Screening Fee Reimbursement for Applicants not Eligible for Medical Assistance
under-13,000	100%
13,001-13,500	90
13,501-14,000	80
14,001-14,500	70
14,501-15,000	60
15,001-15,500	50
15,501-16,000	40
16,001-16,500	30
16,501-17,000	20
17,001-17,500	10
17,501-and over	0

K. Right to appeal.

1. Appeal procedures. Persons who are recipients of or applying for medical assistance have the right to a fair hearing pursuant to Minn. Stat. § 256.045 to challenge the decision of the screening team. The hearing shall be conducted in accordance with appeal procedures set forth in Minn. Stat. § 256.045. An appeal must be made within 30 days after receiving written notice of the screening team's recommendation. If it appears at the hearing that circumstances are different than they were at the time the initial recommendation was made, the referee may refer the case back to the screening team for reevaluation.

2. Appeal by the physician. When the treating physician disagrees with the screening team's decision, the physician shall notify the screening team and request an appeal on behalf of the individual. The appeal may be withdrawn with the consent of the individual and the treating physician.

3. Persons not receiving assistance. Persons who are not applying for or receiving medical assistance shall consider the recommendation by the screening team to be advisory, unless the person applies for medical assistance within 90 days following admission to a nursing home.

L. County reports. The county agency shall submit a report to the Department of Public Welfare according to a schedule agreed upon by the department and the county agency. The report shall be submitted on forms provided by the commissioner and include the number of persons screened, results of each screening, and the rationale for each screening recommendation. The county agency shall retain the plan of care for persons who are to remain in the community and shall make it available to the department on request. The county agency shall also provide information as requested by the commissioner for ongoing evaluation of the program.

DPW-82-021-GB

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of the Department of Public Welfare Rule Governing the Administration and Provision of Preadmission Screening and Long Term Care and Alternative Care Grants (12 MCAR § 2.065).

REPORT OF THE HEARING EXAMINER

The above-entitled matter came on for hearing before State Hearing Examiner George A. Beck on Tuesday, December 15, 1981, at 9:00 a.m. in Room A, Fourth Floor, Centennial Office Building, Saint Paul, Minnesota.

This Report is a part of a rule hearing procedure pursuant to Minn. Stat. §§ 15.0411 through 15.0417 and 15.052 to determine whether the proposed rule should be adopted by the Department of Public Welfare.

Members of the Agency panel appearing at the hearing included: Marie Scheer, Coordinator, Preadmission Screening Program, Department of Public Welfare; Nancy Feldman, Supervisor of Health Care Policy, Department of Public Welfare; and Beverly Jones Heydinger, Special Assistant Attorney General, representing the Department of Public Welfare.

Fifty people signed the hearing register. Twenty public witnesses appeared and spoke at the hearing. The Department submitted 18 written exhibits. Twenty-five written exhibits were received from the public.

Pursuant to Minn. Stat. § 15.0412, subd. 4d and 4e (1980), this Report shall be available for review to all affected individuals upon request for at least five working days. Thereafter, the Commissioner of Public Welfare shall, if he proposes to adopt the rule as recommended herein, submit the rule, together with the complete hearing record to the Attorney General and shall be responsible for notifying persons who have indicated that they wish to be notified of such filing. If the Commissioner makes changes in the rule other than those recommended herein, he shall submit the rule with the complete hearing record to the Chief Hearing Examiner for a review of the changes prior to submitting it to the Attorney General for review.

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

FINDINGS OF FACT

Procedural Requirements

1. On October 19 and 20, 1981, the Department of Public Welfare filed the following documents with the Chief Hearing Examiner:

(a) A copy of the proposed rules.
(b) The Order for Hearing.
(c) The Notice of Hearing proposed to be issued.
(d) A Statement of the number of persons expected to attend the hearing and estimated length of the Agency's presentation.

2. On November 9, 1981, a Notice of Hearing and a copy of the proposed rules were published at 6 State Register 884.

3. On November 12, 1981, the Department of Public Welfare mailed the Notice of Hearing to all persons and associations who had registered their names with the Department for the purpose of receiving such notice.

4. On November 20, 1981, the Department of Public Welfare filed the following documents with the Hearing Examiner:

(a) The Notice of Hearing as mailed.
(b) The Agency's certification that its mailing list was accurate and complete.
(c) The Affidavit of Mailing the Notice to all persons on the Agency's list.
(d) The Statement of Need and Reasonableness.
(e) The names of Department personnel who will represent the Agency at the hearing together with the names of any other witnesses solicited by the Agency to appear on its behalf.
(f) A copy of the State Register containing the proposed rules.
(g) An Affidavit of Additional Notice.
(h) All materials received following a Notice of Intent to Solicit Outside Opinion published at 5 State Register 1617 (April 13, 1981).

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

5. The record remained open through January 4, 1982, for the receipt of written comments and statements, the period having been extended by order of the Hearing Examiner to 20 calendar days following the hearing.

Statutory Authority

6. The nursing home preadmission screening program was established by the 1980 legislature and the legislation was codified at Minn. Stat. § 256B.091. Subdivision 1 of that section provides that "the commissioner of public welfare shall promulgate temporary rules in order to implement this section by September 1, 1980". The Department did promulgate a temporary rule which was in effect from January 1 through June 30 of 1981. The alternative care grant program was enacted by the 1981 legislature and was codified as subdivision 8 of § 256B.091. It provided, in part: "The commissioner shall promulgate temporary rules in accordance with section 15.0412, subdivision 5 to establish required documentation and reporting of care delivered". The Department states that authority to promulgate permanent rules is implied in order to continue these two programs which are mandated by statute. The Department also points to Minn. Stat. § 256B.04, subd. 2, which provides as follows:

> Make uniform rules and regulations, not inconsistent with law, for caring out and enforcing the provisions hereof in an efficient, economical, and impartial manner, and to the end that the medical assistance system may be administered uniformly throughout the state, having regard for varying costs of medical care in different parts of the state and the conditions in each case, and in all things to carry out the spirit and purpose of this program, which rules and regulations shall be made with the approval of the attorney general on form and legality, shall be furnished immediately to all county agencies, and shall be binding on such county agencies.

There was no challenge to the Agency's statutory authority in this proceeding. The Department has demonstrated its statutory authority to adopt the proposed rule.

Nature of the Rule

7. Minn. Stat. § 256B.091 requires each county to establish a screening team composed of a public health nurse and a social worker. The team is given the responsibility of screening medical assistance recipients prior to admission to a nursing home to determine if there is alternative care available to the individual in the community which would allow a person to remain outside of a nursing home. The program excludes patients transferred from hospitals to nursing homes or residents transferred from other nursing homes. The alternative care grant program is designed to assist counties in providing health and social services to screened persons who are able to remain at home. The objective of the program is to postpone institutional care if the individual's care can be supplemented with alternative services so that he or she can continue to live independently in a less-restrictive setting. A pilot program was conducted in Blue Earth and St. Louis Counties during the first half of 1981. Approximately 25% of the persons screened were found able to remain in the community. The Department expects medical assistance costs to be contained by implementation of the program. Counties will participate in the program on a voluntary basis. (Exs. M, R).

General Support

8. General support for the preadmission screening program was voiced by most participants in the rule proceeding. Those expressing strong support for the program included Senator Linda Berglin, Representative Karen Clark, Maria Gomez, Nursing Home Residents Advocates, the Minnesota Board on Aging, the Metropolitan Senior Federation, the Metropolitan Health Board, Joy Sansal, a home care advocate, Blue Earth County Human Services, St. Louis County Social Service Department, Ramsey County Home Care Demonstration Project, Wilder Foundation Community Services, Catholic Charities Programs for Aging, Helen Yates, and the Minnesota Public Health Nursing Directors Association. The statutory mandate, together with these comments, establish the general need for the program.

Section 2.065A - Responsibility for the Program

9. This section assigns responsibility for the program to the county welfare agency. The Minnesota Public Health Nursing Directors Association (Nursing Directors) asked that the county commissioners be specified as the responsible persons in this subsection. (Ex. 21). The Minnesota Association of Health Care Facilities (MAHCF) requested that the rule state that the nursing home should notify the county of financial responsibility. (Ex. 25, pp. 2-3). The Department may consider these suggestions. The rule subsection is needed and reasonable as proposed. no change

Section 2.065B - Program Scope

10. This section directs the screening teams to review and make recommendations for nursing home applicants eligible for medical assistance or those who would be eligible within 90 days of admission to the nursing home. The

MAHCF had two suggestions. First, that the statutory language excluding hospital patients and nursing home transfers from the program be inserted in the rule. It also requested that language encouraging counties to include a long-term care professional on the screening team be inserted in the rule. (Ex. 24, p. 3). The subsection is needed and reasonable as proposed. In its post-hearing comments, DPW agreed that the question of financial responsibility raised by MAHCF in connection with section 2.065 A. should be clarified in the rule. The Department suggested that the following language be added after the first sentence in section B.

> If an applicant or recipient's county of financial responsibility is included in the screening program, such applicant or recipient must be screened by the county of financial responsibility for admission to any nursing home.

(Ex. R, p. 1). The language could also be inserted at the end of subsection A. It does not represent a substantial change and so amended, either subsection would be needed and reasonable.

Section 2.065 C. - Notification About Program

11. Subsection C.1. requires the local welfare agency to refer eligible persons to the screening team. The Legal Aid Society suggested that a responsible party or appropriate relative be notified when an eligible person is referred and that notice be given that prescreening is a condition of medical assistance. (Ex. 13, pp. 1, 2,). MAHCF suggested that this subsection should also direct the nursing homes to advise the screening team of a prospective resident who is likely to become eligible for medical assistance within 90 days. (Ex. 24, p. 3). The Department of Health suggested that the words "these persons" be clarified as well as who must do the mailing. In response to this last suggestion, DPW agreed to modify the second sentence to read: "When possible, medical assistance recipients should be notified of the screening requirement through a direct mailing by the local welfare agency." (Ex. R, p. 2). The amendment does not result in a substantially different rule and so amended, the proposed subsection is needed and reasonable. The Department should consider the other suggestions to determine if they would result in a more useful rule.

12. Subsection C.2. provides for public notice of the screening program. The Nursing Home Residents Advocates (NHRA) suggested that notice of the program be included with all medical assistance applications and in nursing home brochures. The Department noted that there is no statutory authority to require a notice in nursing home literature, but since nursing homes have a financial incentive to notify recipients, they very likely will do so. (Ex. R, p. 2). MAHCF suggested that the word "location" in this subsection be made plural. (Ex. 24, p. 3). The subsection is needed and reasonable as proposed.

13. Subsection C.3. requires DPW to provide notice to local officials and health care professionals. The Legal Aid Society suggested that hospitals and nursing homes be required to post information on the screening program. (Ex. 13, p. 1). MAHCF suggested that notice also be given to providers of alternative care services. (Ex. 24, p. 3). The Department should consider whether

or not these suggestions will strengthen the rule. The subsection is needed and reasonable as proposed.

Section 2.065 D. - Resource Material for Screening Programs

14. Subsection D.1. provides that DPW shall recommend a screening tool to the counties to be used as a guide in conducting the screening interview. The subsection provides that "the state agency shall allow counties flexibility in using the recommended tool or a comparable one approved by the state agency". A number of commentors, including Blue Earth County (Ex. 4), Ebeneezer Community Services (Ex. 20, p. 1), the Public Health Nurses (Ex. 21) supported the concept of a flexible screening tool. Other commentors, however, felt that it would be difficult to collect uniform information unless the Department established uniform standards for categories and a uniform data base for the screening tool. (Ex. 15, p. 1; Ex. 17, p. 2; Ex. 21; Ex. 23, p. 3). The MAHCF suggested deleting the last sentence, which is the language quoted above, to ensure a standardized screening tool. (Ex. 24, p. 4).

In its post-hearing comments, the Department suggested that specific criteria for the screening tool be included in the proposed rule subsection by adding the following language after the second sentence:

> The assessment tool shall include the following criteria: (a) information on present medical condition; (b) present unmet needs; (c) information on informal and formal services available or being provided to the person; (d) the recipient's preferences; (e) persons consulted in the screening process; (f) observations of the screening team during the onsite visit; (g) assessment of functional capacity; (h) preliminary service-care plan.

(Ex. R, p. 2). The suggested amendment meets the concerns of some of the commentors and, so amended, the proposed rule subsection is needed and reasonable. The amendment does not constitute a substantial change, but is merely an elaboration. The Department should consider, however, deleting the last sentence of the rule as proposed since it seems to imply that the counties could use a comparable screening tool which might not include the criteria contained in the amendment suggested by the Department. This would seem to defeat the purpose of the amendment. That sentence might be replaced by language which makes it clear that the counties would be free to use additional criteria other than that listed in this rule subsection.

15. Subsection D.2. directs the Department staff to provide technical assistance in conducting screenings. The State Health Department suggested the use of its employees for this purpose. (Ex. 15, p. 1). The Nursing Directors (Ex. 19, p. 3) asked that a public health nurse be included among the state's staff. The rule subsection is needed and reasonable as proposed.

16. Subsection D.3. directs the county to develop a resource directory of community services. The Health Department (Ex. 15, p. 2) and the Nursing Directors (Ex. 19, p. 3) suggested that local public health agency directories now exist which could be utilized. MAHCF questioned why only noninstitutional services were listed. (Ex. 24, p. 4). DPW may consider the suggestions; however, the subsection is needed and reasonable as proposed.

Section 2.065 E. - Screening Procedures

17. This subsection sets out the time guidelines and notification procedures for the screening team, together with a procedure for reconsideration. Two commentors stated that the rule should set out the members of the screening team as specified by the statute. (Ex. 20, p. 1). DPW stated that it was not included in order to avoid duplication. In its post-hearing comments, the Department proposed addition of the following language: "The statute shall govern the composition of the screening team as set forth in Minn. Stat. § 256B.091, subd. 2." (Ex. R, p. 3). The proposed amendment, although a bit redundant, would not constitute a substantial change and would result in language which is needed and reasonable. It may be clearer, however, to simply to repeat the members of the team as set out in the statute since it would appear to be crucial to the ability of a person affected by the rule to comprehend its meaning and effect as contemplated by Minn. Stat. § 15.0412, subd. 1.

Similar to statutory language added. p.3

18. Southern Minnesota Regional Legal Services ("Legal Services") (Ex. 22, p. 3) and the Minnesota Medical Association (MMA) (Ex. 23, p. 2) stated that the rule should require consultation with the treating physician or at least notice to the treating physician of his right to participate on the screening team. DPW agreed. It suggested that the following language be added to the rule: "The individual's attending physician shall be notified of his or her right to participate in the screening process." (Ex. R, p. 3). The suggested amendment does not result in a substantially different rule. Legal Services also requested that written notice be given to the treating physician when nursing home placement is not recommended. (Ex. 22, p. 6). The MAHCF also requested that the nursing home be given notice when placement is not recommended. (Ex. 24, p. 4). DPW should carefully consider whether or not including these suggestions would provide a more workable rule. The Health Department stated that the rule should define when a change in circumstances occurred and specify to whom a resubmission should be made. (Ex. 15, p. 2). Legal Services asked that the rule require a reconsideration to be issued within 10 working days after the request. (Ex. 22, p. 5). DPW stated that further definition of a change in circumstances would limit flexibility. (Ex. R, p. 3). The Department should determine whether identifying to whom the resubmission must be made and set a deadline for action on that request would result in a better rule. With the amendments proposed by DPW, the subsection as a whole is needed and reasonable.

added p.3

so specified p.4.

time limit added p.4

Section 2.065 F. - Criteria for Screening Team Recommendations

19. Section F.1. directs the screening team to recommend admission to a nursing home when an individual requires care which is not available outside of the nursing home. The Legal Aid Society suggested that this subsection should reference subsection G.2. of the rule, which requires unavailable services to be provided through care grants. (Ex. 13, p. 1). The subsection is needed and reasonable as proposed. It does appear, however, that there is some ambiguity in the use of the word "available" in this subsection as compared to its use in the following subsection, and in G.2. Subsection G.2. appears to actually refer to funding of services, while subsection F. appears

to refer to whether or not the services exist. In its post-hearing comments, DPW suggested that a sentence be added to subsection F.1. in order to indicate that existing information concerning the person to be screened which had been collected by providers should be utilized. DPW suggested that the following sentence be added: "Information used in the determination shall be gathered by or verified by the screening team". (Ex. R, p. 4). Although the amendment would not create a substantial change in the subsection, it does not appear to accomplish a great deal since it does not in fact direct the screening team to utilize existing information, but merely states the obvious; namely, that the team shall gather the information to be used. The proposed amendment also creates some confusion by the use of the word "verified" which in the legal sense may require information submitted to be under oath. The use of the word "or" in the proposed amendment creates further confusion.

20. Subsection F.2. directs the screening team to recommend against admission to a nursing home when an individual can remain in the community and "care and services are available and accessible". The Nursing Home Residents Advocates and the Legal Aid Society requested a definition of availability and accessibility. (Ex. 13, p. 2). The Legal Advocacy for Older Americans Project ("Legal Advocacy") suggested that the rule specify that the services be accessible "to the individual in his or her own community". (Ex. 25, p. 1). In its written comments, DPW acknowledged that the words "available" and "accessible" are vague, but stated that they were intended to allow maximum flexibility so that local standards might apply to each decision. The Department suggested that the following language be added to the subsection:

> Availability and accessibility will depend on the type of community in which the person lives, the availability of transportation appropriate for the person's condition, and other such factors.

(Ex. R, p. 4). The amendment does not clarify the meaning of accessibilty, however. If the word "accessibility" adds nothing beyond the word "availability", then it should be deleted. Although the amendment proposed by the Department is not a substantial change, it is somewhat confusing. Availability would not seem to depend upon the type of community since a service would either be available or not in any individual community. If it is the Department's intent to make it clear that it is the services which are available in the surrounding community which will be considered, then the language suggested by Legal Advocacy would be appropriate. Although the subsection is needed and reasonable, the Department should consider the above suggestions.

Section 2.065 G. - Plan of Care Required

21. The first paragraph of Section G. requires a plan of care to be developed when it is recommended that the applicant remain in the community. The Health Department (Ex. 15, p. 2), the Nursing Home Residents Advocates and MAHCF (Ex. 24, p. 4) all asked that the procedure for referral to providers and the responsibility for implementation of the plan be clarified in the rule. In its written comments, the Department suggested adding the following language as a new subsection G.3.:

> 3. Responsibility for the plan of care. The plan of care shall include the name of the person responsible for ensuring

compliance, the method of monitoring the recipient's acceptance of and adjustment to the services provided under the plan, the date for reevaluation, and any temporary measures that might be required immediately in order to ensure the safety of the person. When needed services become unavailable, the assigned person shall be responsible for recommending a reevaluation by the screening team.

added p.5

(Ex. R, p. 5). The proposed amendment is not a substantial change and addresses the concerns of the commentors. The first paragraph of subsection G. is needed and reasonable as proposed.

22. Subsection G.1. directs the screening team to develop the plan of care in consultation with the applicant, the treating physician and family members or responsible parties. The Courage Center and the Wilder Services to the Elderly emphasized that individuals should make these decisions rather than the team. (Ex. 2; Ex. 17, p. 2). The Nursing Directors (Ex. 19, p. 3) stated that either the health or welfare agency in the county should be named as the responsible party for the plan of care. The Ebeneezer Community Services (Ex. 20, p. 2) asked that a procedure for amendments to the plan be specified. The last two comments appear to be addressed by the proposed amendment quoted in the preceding Finding. Legal Advocacy asked that a 30-day time limit for the plan to be implemented be stated in the rule and that an applicant be allowed to stay in a nursing home until the plan is implemented. Although this subsection is needed and reasonable as proposed, the Department should consider addressing at some point in the rule what is to happen to an applicant who is not recommended to a nursing home before the plan of care can be implemented.

23. Subsection G.2. permits alternative care grant funds to be used for services not already funded. The Health Department commented that the phrase "other public assistance sources" seems to limit services to traditional public assistance programs. (Ex. 15, p. 2). The Nursing Directors asked that the party responsible for providing and reimbursing alternative services be identified. (Ex. 19, p. 4). DPW stated that the "public assistance" language is contained in the statute. (Ex. R, p. 5). The sense of the statute, however, is to preclude payment of alternative care grant funds for services that are already publicly funded. The Health Department's concern, however, is that the phrasing in the rule would limit all services to just public assistance programs. The rule might be reworded to avoid this implication. Legal Services suggested addition of language to the rule requiring the plan of care to be implemented within 30 calendar days and permitting nursing home placement if this is not accomplished. (Ex. 22, p. 4). Additionally, as indicated earlier, the use of the word "available" creates some ambiguity. Although this word is used in the statute, the use of a synonym consistent with the meaning of the statutory language would be permissible and might result in a clearer rule. A change in the title of subsection G.2. would be advisable. The subsection is needed and reasonable as proposed.

changed p.4

Section 2.065 H. - Alternative Care Grant

24. Subsection H.1. authorizes the use of alternative care grant funds for applicants found to be appropriate for non-institutional care as long as

other public money is not available. The Nursing Home Residents Advocates questioned what would happen to an applicant when the care grant funds are exhausted. DPW replied that counties would be cautioned only to enroll the number of persons for which it has funds for the biennium. (Ex. R, p. 10). The Health Department asked whether the phrase "public money" referred to money which was actually or potentially available. (Ex. 15, p. 2). The subsection is needed and reasonable as proposed.

25. Subsection H.2. specifies who may provide the alternative services. The Health Department suggested that the narrowness of the definition might cause a person to be assigned to a nursing home even though alternative care was available if it was not available from a provider as defined in the rule. (Ex. 15, p. 2). Ebeneezer Community Services stated that adult day care, respite care and homemaking are licensed programs, but should be permitted services under the rule. (Ex. 20, p. 2). DPW commented that it believes the rule will allow quality care to recipients since the county has authority to contract with providers and choose the best available service among competing providers. It noted that the individual, the treating physician and family members consult in developing the plan of care to ensure quality. (Ex. R, p. 5). The subsection is needed and reasonable as proposed.

26. Subsection H.3. sets the level of reimbursement for services at no greater than the federal law. Ebeneezer Community Services commented that it believes that this level of reimbursement is inadequate. (Ex. 20, p. 2). The subsection has been shown to be needed and reasonable as proposed.

Section 2.065 I. - Reimbursement of Nursing Home Costs

27. Subsection I.1. requires a nursing home to notify the screening team if it admits an unscreened eligible person. If the team determines that the individual is not eligible for admission, the nursing home will not be reimbursed but the patient days from the stay are counted in the facility's statistics for the purpose of rate calculation. Both the MAHA (Ex. 18, pp. 2-15) and the MAHCF (Ex. 24, pp. 5-6) objected to this subsection basically on two grounds. First they believe that the division of the rule into emergency and nonemergency situations renders it unworkable. They suggest that if an emergency situation is interpreted to be a medical emergency, then the patient would be receiving hospital care. Since a physician must find medical necessity before recommending a nursing home admission, MAHA concludes that there is no nonemergency admission situation. The two groups also object to the penalty imposed on nursing homes by denying reimbursement and additionally counting the unreimbursable days in the patient day statistics. They suggest that this will provide a very strong disincentive for facilities to accept unscreened nonemergency admissions. The Wilder Foundation Services to the Elderly also expressed concern that the rule would encourage nursing homes to discriminate against medicaid recipients. (Ex. 17, p. 3). DPW replied that this was not a problem in the two counties where the pilot program existed. The Department believes that the screening team could actively be involved in ensuring nursing home admission when it is recommended. (Ex. R, p. 9). Both the Legal Aid Society (Ex. 13, p. 2) and Legal Advocacy (Ex. 25, p. 2) stated that the rule should specifically prohibit nursing homes from

billing a resident when medical assistance reimbursement is denied. As to this last concern, DPW replied that billing the recipient in this manner is prevented by 12 MCAR § 2.047 F.1. (Ex. R, p. 6). MAHA and MAHCF have suggested a revision of section I. which would meet their concerns. (Ex. 24, p. 6). They would delete I.1. in its entirety and amend I.2. and I.3. as follows:

> 1. Unscreened applicants. When an individual covered by the mandatory screening requirement is admitted to a nursing home and has not obtained the required pre-admission screening, the nursing home shall notify the screening team within two working days. The screening team shall make a decision on the case within five working days of being contacted by the nursing home. If the screening team fails to review the case within five working days or recommends that institutionalization is necessary, the costs of nursing home care shall be covered by medical assistance. If the screening team reviews the admission within the five working days and determines that the individual does not require institutionalization, medical assistance shall cover the costs only for the period through the date the screening team notified the nursing home of its decision, and until a plan for alternative care can be implemented, whichever is later. If the admitting facility fails to contact the screening team within the prescribed period, and if the screening team determines that the individual does not require institutionalization, the facility shall not be reimbursed for any costs incurred, and the patient days resulting from that stay must be counted in the facility's patient day statistics for the purposes of rate calculation under 12 MCAR Section 2.049.
>
> 3. Screened applicants. Medical assistance shall not be available to reimburse the nursing home in instances when an individual is admitted to a nursing home after the screening team has determined that institutionalization is not necessary and the nursing home is aware of such determination. The individual has the right to notification and a fair hearing on such denial of payment in accordance with K.

The language suggested would allow a nursing home to be reimbursed through the date the screening team notifies the nursing home that an individual does not require institutionalization. DPW responded that this suggestion is inconsistent with the statute. Minn. Stat. § 256B.091, subd. 4, specifically provides that the screening be done prior to nursing home admission. Section 256B.091, subd. 6, prohibits reimbursement for any recipient placed in a nursing home in opposition to the screening team's recommendation with three exceptions. (Ex. R, p. 6). Subdivision 6(3) requires an exception to the non-reimbursement rule to be made where an individual is placed in the nursing home in an emergency situation. DPW argues in the Statement of Need and Reasonableness that there must be definite financial consequences to non-compliance with the screening procedures. It is also necessary that responsibility for compliance be clearly fixed. DPW's interpretation of the statute is correct and its rule is a needed and reasonable response to the statutory mandate.

28. Subsection I.2. sets out a separate procedure for unscreened applicants in the case of emergencies. The distinction is required by the statute. Under this subsection, medical assistance will cover the costs of nursing home care through the date the screening team notified the nursing home of its decision or until a plan for alternative care can be implemented. In response to a suggestion by MAHCF, the Department suggested a clarification

of the reimbursement policy under the rule by adding the following sentence to the subsection:

> Reimbursement will be allowed only through the day the screening team notifies the nursing home of the decision or until the plan for alternative care can be implemented, whichever is later.

(Ex. R, p. 7). The addition of this language is not a substantial change and does serve to clarify the rule. It might be somewhat clearer to accomplish this change by amending the fourth sentence of the subsection, such as by changing the word "and" to "or" and adding the phrase "whichever is later". Legal Services stated that language should be added to this subdivision which requires a 10-day notice to individuals before assistance is terminated along with the reasons for termination and a right to appeal. (Ex. 22, p. 5). It would appear that such an appeal would be permissible under section 2.065 K.1. The agency should consider whether or not this should be explicitly stated in this subsection. With the amendment made by DPW, this subsection is needed and reasonable as proposed.

29. Subsection I.3. states the general rule in regard to reimbursement for screened applicants, namely that medical assistance is not available if the screening team determines that institutionalization is not necessary. The Legal Aid Society pointed out that the statute requires medical assistance to be paid pending appeal. DPW acknowledged this to be the law despite a seemingly contrary statement in the Statement of Need. (Ex. R, p. 6). Legal Services requested that a specific statement be included in the rule saying that individuals were eligible for reimbursement pending appeal. (Ex. 22, p. 3). DPW should consider whether the rule would be clearer and more complete by adding such a statement. The subsection is needed and reasonable as proposed.

30. Subsection I.4. requires the nursing home to inquire of an applicant whether or not they have sufficient funds to cover 90 days of nursing home care. If the person is determined by a nursing home not to be subject to screening, he or she may be admitted. MAHCF states that the provision is vague as to what level of documentation and inquiry will be considered sufficient. It suggests that the following sentence be added at the end of the subsection: "Should the patient's statement concerning proposed eligibility be inaccurate, the health care facility shall not be denied reimbursement because of the inaccuracy of this statement." (Ex. 24, p. 7). Along the same lines, Legal Services stated that the rule should provide that a nursing home will be reimbursed if it makes a good faith attempt to document the person's resources and that they appear to be sufficient for more than 90 days. (Ex. 22, p. 6). Although the subsection is needed and reasonable as proposed, the Department should seriously consider adding language similar to that suggested so as to give the nursing home a more definite guideline or safe harbor within which to operate.

added P. 8

12 MCAR § 2.065 K. - Right To Appeal

31. Subsection K.1. gives recipients or applicants for medical assistance the right to a hearing to challenge the decision of the screening team. A number of commentors, including the Nursing Home Residents Advocates, the

Health Department (Ex. 15, p. 3), the MAHCF (Ex. 24, p. 7) and Legal Advocacy (Ex. 25, p. 2) asked what services a person can receive while an appeal is pending. They suggested that the rule make it clear that DPW will pay for care during the pendency of an appeal as required by statute. They also emphasized that a prompt hearing is necessary including a hearing decision within 10 days of the appeal period. (Ex. 25, p. 2). Legal Services pointed out that where serious questions of health are at stake, the screening team's decision should be subject to expedited review. They suggested that the following language be inserted after the second sentence of this subsection:

> Upon a showing of good cause, the commissioner shall grant an expedited hearing, in which case the hearing decision shall be rendered not later than 10 calendar days after the receipt of the appeal notice. (Ex. 22, p. 5).

Although the rule subsection as proposed cannot be called arbitrary and is, therefore, needed and reasonable, the Department should seriously consider clarifying an applicant's status during the appeal and providing for the possibility of an expedited hearing procedure along the lines suggested.

32. Subsection K.2. provides that the treating physician shall notify the screening team when he disagrees with their decision and request an appeal. Legal Services (Ex. 22, p. 6) and the Minnesota Medical Association (Ex. 23, p. 4) both argued that this rule conflicts with Minn. Stat. § 256B.091, subd. 5, which makes the appeal automatic. The statute states that "an appeal shall be automatic if the individual's physician does not agree with the recommendation of the screening team". The Department suggests in the Statement of Need that the rule requires the physician to notify the screening team and request an appeal for the purposes of administration. The proposed rule has the appearance of inconsistency with the statute due to the use of the word "request". Since the statute and the Department's intent is that the appeal be automatic, it is suggested that this word be changed. It is also recommended that the subsection be linked to the notice given to the referring physician under subsection E. so that it is plain that the physician is responding to a notice from the screening team. It is further suggested that a time limit be placed in the rule within which the physician must initiate the automatic appeal. The subsection is needed and reasonable as proposed.

33. Subsection K.3. deals with persons who are screened but are not receiving medical assistance or applying for it. Legal Services commented that people whose money runs out shortly <u>after</u> the 90-day period should also have the right to a hearing since nursing homes will not risk admitting them if there is a possibility that the admission is later called inappropriate. (Ex. 22, p. 4). The Department may consider the suggestion. The Department also commented that the problem of an individual who would be bound by the decision of a screening team when it appeared that he or she would be eligible for medical assistance within 90 days of admission but who then did not become eligible within that time period can be solved by the person appealing with an admission to the nursing home being allowed pending the outcome. (Ex. R, pp. 7-8). The subsection is needed and reasonable.

12 MCAR § 2.065 L. - County Reports

34. This subsection requires the county to submit reports to the state department, including the "results of each screening". The Health Department suggested deletion of the phrase "of each screening" in order to avoid an unnecessarily costly reporting system. (Ex. 15, p. 3). The Department should consider this suggestion as a matter of policy. The subsection is needed and reasonable as proposed.

35. A number of comments in this rule hearing proceeding were directed toward the governing statutes rather than the proposed rule. Two administrators (Exs. 1, 5) commented that the statute was not cost-effective and does not preserve patient choice in regard to alternatives. Legal Services argued that the statute was inconsistent with the comparable federal law. (Ex. 22, p. 1). A number of commentors also suggested that the statute should be changed to apply the screening program to transfers from hospitals and between nursing homes. (Ex. 12, p. 2; Ex. 15, p. 4; Ex. 19, p. 1). MAHA felt that the statute should not be extended to hospitals since there was no evidence of a cost benefit in that instance. (Ex. 18, p. 17).

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

CONCLUSIONS

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

2. That the Department of Public Welfare has fulfilled the procedural requirements of Minn. Stat. § 15.0412, subd. 4-4f (1980) and all other procedural requirements of law or rule.

3. That the Department of Public Welfare has documented 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. §§ 15.0412, subd. 4e and 15.052, subd. 3(4)(i) and (ii) (1980).

4. That the Department of Public Welfare has demonstrated the need for and reasonableness of the proposed rules by an affirmative presentation of facts in the record within the meaning of Minn. Stat. § 15.0412, subd. 4c (1980).

5. That the additions and amendments to the proposed rules which were suggested by the Department of Public Welfare after publication of the proposed rules in the State Register do not result in rules which are substantially different from the proposed rules as published in the State Register within the meaning of Minn. Stat. § 15.0412, subd. 4d (1980) and 9 MCAR §§ 2.110 A. and 2.111 (1980 Ed.).

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

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

rule finally adopted is based upon facts appearing in this rule hearing record.

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

RECOMMENDATION

It is hereby recommended that the proposed rules be adopted consistent with the Findings and Conclusions made above.

Dated: February 2 , 1982.

GEORGE A. BECK
State Hearing Examiner

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
400 SUMMIT BANK BUILDING
310 SOUTH FOURTH AVENUE
MINNEAPOLIS, MINNESOTA 55415
(612) 341-7600

JUN 1982
RECEIVED
MEDICAL ASSISTANCE
PROGRAM

June 7, 1982

Ms. Marie Scheer, Director
Pre-admission Screening and
Alternative Care Grants Program
P. O. Box 43170
444 Lafayette Road
St. Paul, Minnesota 55164

Re: Our File DPW-82-021-GB
Proposed Adoption of 12 MCAR § 2.065, Relating to the Preadmission Screening and Long Term Care and Alternative Care Grants Program

Dear Ms. Scheer:

Enclosed with this letter and herewith served upon you is the original of the Chief Hearing Examiner's Order finding a substantial change in the rules as submitted.

I am also enclosing the original of the Hearing Examiner's Report which you forwarded to me at the time of the review. The other materials sent to me appear to be copies which we are keeping for our file.

Yours very truly,

DUANE R. HARVES
Chief Hearing Examiner

Telephone: 612/341-7640

DRH:sh
Enc.
cc: Kathy Burek, LCRAR
J. Michael Miles, Assistant Attorney General
George A. Beck, Hearing Examiner

DPW-82-021-GB

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF PUBLIC WELFARE

IN THE MATTER OF THE PROPOSED ADOPTION OF THE DEPARTMENT OF PUBLIC WELFARE RULE GOVERNING THE ADMINISTRATION AND PROVISION OF PREADMISSION SCREENING AND LONG TERM CARE AND ALTERNATIVE CARE GRANTS (12 MCAR § 2.065).

ORDER OF THE
CHIEF HEARING EXAMINER

WHEREAS, a hearing was held on December 15, 1981, before George A. Beck, a Hearing Examiner of the State Office of Administrative Hearings, on the above-entitled matter in compliance with Minn. Stat. § 15.0412; and

WHEREAS, the Report of Hearing Examiner made pursuant to Minn. Stat. § 15.052, subd. 3, was issued to the Department of Public Welfare on February 2, 1982; and

WHEREAS, the Department of Public Welfare has now determined to adopt rules pursuant to Minn. Stat. § 15.0412, subd. 4-4f; and

WHEREAS, the Department of Public Welfare has submitted said rules to the Chief Hearing Examiner for review pursuant to Minn. Stat. §§ 15.0412, subd. 4e and 15.052, subd. 4, and 9 MCAR § 2.112; and

WHEREAS, with the exception noted below, the Chief Hearing Examiner finds that the final proposed rules are not substantially different from those proposed at the public hearing; and

WHEREAS, the Chief Hearing Examiner finds that the amendment to Rule 12 MCAR § 2.065 E.2. wherein the agency has deleted the following language: "and it shall issue a recommendation within ten working days after receiving the request" (found at page 3, lines 27 - 29 of the Revisor of Statutes' draft of the rules dated May 17, 1982) does constitute a substantial change in the rules in that the removal of the deadline by which the screening team is to issue a recommendation, a factor of concern to parties at the hearing, makes a major substantive change in the rules as proposed and results in a rule different from that contained in the Notice of Hearing.

reinstated p. 3

NOW, THEREFORE, upon receipt of this Order, the Department of Public Welfare shall either withdraw the rules or it shall reinstate the language quoted above. In the event the agency reinstates the above-quoted language, the department has the responsibility of submitting the complete hearing record and the rules as adopted to the Attorney General and to publish in the State Register, all pursuant to Minn. Stat. § 15.0412, subd. 4e and 4f.

Dated: June 7th, 1982.

DUANE R. HARVES
Chief Hearing Examiner

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE ARTHUR E. NOOT

COMMISSIONER OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of 12 MCAR 2.065 of the Department of Public Welfare Governing the Administration of the Pre-admission Screening and Alternative Care Grant Program

ORDER ADOPTING AND DEPARTMENT'S FINDINGS OF FACT AND CONCLUSIONS

Docket No. 82-021-GB

The above-entitled matter came on for hearing before Hearing Examiner George A. Beck on Tuesday, December 15, 1981, at 9:00 a.m., in Room A, Fourth Floor, Centennial Office Building, Saint Paul, Minnesota. Pursuant to Minn. Stat. §15.0412, Subd. 4 all persons, associations, and other interested groups registered with the Secretary of State for that purpose received notice of the hearing.

The hearing considered proposed Rule 12 MCAR 2.065 as published at State Register on November 9, 1981, (6 S.R. 886-888). Members of the Agency panel appearing at the hearing included: Marie Scheer, Program Director, Pre-admission Screening and Alternative Care Grants, Department of Public Welfare; Nancy Feldman, Supervisor of Health Care Policy, Department of Public Welfare; and Beverly Jones Heydinger, Special Assistant Attorney General, representing the Department of Public Welfare. Fifty people signed the hearing register. Twenty public witnesses appeared and spoke at the hearing. The Department submitted eighteen written exhibits. Twenty-five written exhibits were received from the public.

The hearing continued until all interested groups and persons had an opportunity to be heard. Pursuant to the order of the Hearing Examiner, the record remained open for twenty days to allow the submission of written materials.

Based upon the records and proceedings, the Hearing Examiner made Findings of Fact,

Conclusions, and a Recommendation that are contained in the February 4, 1982, Report of the Hearing Examiner attached hereto as Exhibit A. Pursuant to Minn. Stat. §15.0412, Subd. 4 (Amended, 1977), the Report was available to all affected persons for at least five days.

Minn. Stat. §256B.091 which authorizes 12 MCAR 2.065, also requires the Department to apply for a waiver of certain federal regulations so that federal funding is available for services reimbursed through the alternative care grant program but not otherwise covered by Medical Assistance. The waiver application was written in accordance with §2176 of the Omnibus Budget Reconciliation act, P.L. 97-35, and submitted to the United States Department of Health and Human Services on December 8, 1981. The official response from the Department of Health and Human Services to the Department of Public Welfare regarding the waiver application was received on February 12, 1982 and indicated that two portions of the application were unacceptable to the federal government. The two areas of concern were that: (1) individual choice should prevail over the recommendation of the screening team, and (2) home and community-based services should not have a cap of 75 percent of per diem nursing home costs.

1982 legislation modified the pre-admission screening and alternative care grant statute so that the state program requirements are consistent with those of the federal waiver for home and community-based services. Accordingly, changes must be made in the proposed rule to achieve consistency with the 1982 legislation. The 1982 legislation is attached as Appendix B.

Having considered all of the evidence adduced and upon the records, files and proceedings herein, and applicable statutory standards and criteria, and having confirmed the need for the above captioned rule and reasonableness thereof; and

Having considered the need to make changes in the proposed rule which are in strict accordance with legislative changes required to obtain the federal waiver:

Now, therefore, it is ordered that the Findings of Fact, Conclusions, and Recommendation of the Hearing Examiner are hereby adopted and incorporated herein except as modified or rejected below. In addition, the Commissioner of Public Welfare proposes changes in the rule which are deemed necessary to comply with the federal law, and to obtain the federal waiver, as required by Minn. Stat. §256B.091.

Items addressed in the Commissioner's Order are presented either in response to the Hearing Examiner's Report, or to be consistent with recent changes in the state law. This document will follow the sequence of the rule so that where changes to comply with the recent law have a direct effect on the findings of the Hearing Examiner, the two factors can be considered concurrently.

Section 2.065A - Responsibility for the Program

The Hearing Examiner approved this section as needed and reasonable as proposed.

Section 2.065B - Program Scope

The Hearing Examiner noted that it is not clear whether counties screen applicants to nursing homes in that county, or whether they screen persons in their county who are applying to any nursing home in the state. At the hearing, the Department proposed the following change:

> In counties participating in the program, screening teams shall review and make recommendations for nursing home applicants who are eligible for Medical Assistance and those who will be eligible within 90 days of admission to a nursing home. <u>If an applicant or</u>

recipient's county of financial responsibility is included in the screening program, such applicant or recipient must be screened by the county of financial responsibility for admission to any nursing home. The procedures and criteria used by the screening team shall be in accordance with D-H. Participating counties shall be eligible for the alternative care grant program described in H.

The Hearing Examiner accepted the suggestion, found that it did not constitute a substantial change, and that the section, as amended, was necessary and reasonable.

Section 2.065C - Notification about the Program

Subsection C.1. Notice to eligible persons. The Hearing Examiner noted several comments at the hearing which would make the notification procedure more effective and specific. The Department proposed at the hearing to modify the second sentence, and add a third sentence in response to comments received.

The county agency responsible for the screening program shall refer to a screening team all persons eligible for the screening as described in B. When possible, ~~these persons~~ Medical Assistance recipients shall be notified of the screening ~~by~~ through a direct ~~mail~~ mailing by the local welfare agency. At the time of the referral, with the consent of the applicant, the local welfare agency shall notify a responsible party or appropriate relative that the person has been referred, and that the pre-screening is a condition of Medical Assistance.

The section was approved by the Hearing Examiner as amended and is not substantially different from the proposed rule, and is needed and reasonable to ensure proper notice.

Subsection C. 2. Public Notice. The Hearing Examiner correctly noted that information leaflets are to be displayed in "in an accessible location," and encourages the Department to change this to read "in accessible locations." The Department in in agreement and will make the appropriate change, which is not a substantial change.

> The county agency responsible for the screening program shall provide public notification of the screening requirement. The methods of public notification shall include publication in available appropriate newsletters, display and dissemination of information leaflets in a readable form and in an accessible ~~location~~ locations, and promotion through other local media sources. The public notification shall include information on how to contact the screening team, implications of the screening team's recommendations, and the individuals' rights to appeal the screening team's recommendations.

Subsection C. 3. Notice to officials and health care professionals. The Hearing Examiner approved this subsection as proposed.

Section 2.065D - Resource Material for Screening Program

Subsection D.1. Screening tool. The Hearing Examiner noted that there was considerable controversy regarding the flexibility for counties to use an assessment tool other than the one provided by the state agency, and the need for standard criteria for collecting uniform information. The Department recognize that there is controversy, and proposes the following in order to allow flexibility while at the same time maintaining uniform standards for the assessment tool.

> The department shall recommend a screening tool to be used as a guide in conducting the screening interview. The screening tool recommended by the department shall obtain consistent caregories of information and ensure

that persons are receiving uniform screening. The assessment tool used by the county screening teams shall require information related to the following criteria:

a. present medical conditions;

b. present unmet needs;

c. informal and formal service available or being provided to the person;

d. the recipient's preferences;

e. persons consulted in the screening process;

f. observations of the screening team during the onsite visit;

g. assessment of functional capacity; and

h. a preliminary service care plan.

The state agency shall allow counties flexibility in using the recommended tool or a comparable one which includes the information related to the criteria in a.-h., and has been approved by the state agency.

The Hearing Examiner found that this change was not substantial as it serves to elaborate upon the language in the proposed rule.

Subsection D.2. Technical assistance. The Hearing Examiner approved this subsection as needed and reasonable as proposed.

Subsection D.3. Directory of services. The Hearing Examiner encouraged the Department to consider comments made at the public hearing, although he found the provision acceptable as proposed. In response to a comment received from the Minnesota Association of Health Care Facilities, the Department changes this subsection to read:

> The county agency shall develop a resource directory of available institutional and non-institutional services to be used by the screening team in determining how well an applicants' needs can be met by existing services.

This change is not substantial, but only expands the scope of services included in the service directory.

Section 2.065E - Screening requirements

The Hearing Examiner raised a number of questions regarding screening requirements. One was whether the rule should set out the members of the screening team as specified by the statute in order to clarify this requirement, even though this would duplicate statutory language. A second concern was that the individuals' physician might not be aware that the screening was taking place. The third concern was whether re-screenings would be considered within the same time restrictions as initial screenings. The Department is in agreement that these concerns should be resolved and proposes changes in the section to resolve these concerns.

The title of the section is changed to the heading of "screening requirements" since the amended section applies more generally than to "screening procedures". Section E.1 summarizes the statutory language setting forth requirements of the screening team. This subsection now reads:

> Section E. Screening ~~procedures~~ requirements
>
> Subsection E.1. Screening team. The statute shall govern the composition of the screening team as set forth in Minn. Stat. § 256B.091, Subd. 2, which requires that at a minimum, the screening team must include: (a) a public health nurse from the local public health nursing service, (b) a social worker from the local community welfare agency, (c) the individual's attending physician if the physician chooses to participate, and (d) a physician available for consultation when necessary. The screening team shall utilize the individual's attending physicians' assessment forms if available.

The addition of subsection E.1. is not a substantial change because the qualifications of the screening team members are clearly required by statute and would be a condition of county participation in the program. The Department believes this subsection is necessary to clarify the rule and that it is consistent with statute.

Subsection E.2. includes a sentence ensuring that the applicant's physician will be notified when an individual in his or her care will be screened. The Department agrees that this is the intent of the screening program and proposes this language to clarify that intent.

> Subsection E.2. Screening procedures. The individual's attending physician shall be notified that the screening is a condition of Medical Assistance and informed of his or her right to participate in the screening procedure. The screening team shall begin the screening process within ten days after receiving the request. The screening team shall notify the applicant or appropriate relative or responsible party of the decision. The team shall also notify the referring physician, the referring local welfare department if the applicant is a medical assistance recipient, and the nursing home if placement is recommended.

Subsection E.3. expands on the previous language governing re-screening policy. The Department believes it is important for the program and for federal waiver requirements that the re-screening procedures ensure timely and appropriate handling of second or third applications. It is also important that recipients are aware that the screening team will reconsider the case when there is a change in circumstances.

Subsection E.3. Rescreening procedures. Reconsideration of a previously denied application shall be given when there has been a change in circumstances. The application shall be resubmitted to the screening team with a written explanation of the change in circumstances. Time requirements for initial applications shall apply.

The Department proposes the amended Section E. to clarify the rule guidelines for screening requirements. The amendments expand earlier language found acceptable to the Hearing Examiner and do not constitute substantial change.

Section 2.065F - Criteria for screening team recommendation

The Hearing Examiner noted some ambiguity in the use of the word "available" in subsection 1 and 2, and urged the Department to clarify the term, or to delete it if it adds nothing to the rule and does in fact, raise questions as to its meaning. The Department has chosen to leave the word "available" in the rule, but to add other language to the rule so the meaning is more clear. The change clarifies the rule but does not substantially alter the rule's scope. Amended subsections F.1., and F.2. now read:

Subsection F.1. Nursing home admission. The screening team shall recommend admission to a nursing home when it is determined that the individual requires care or services which are not available to the recipient outside of a nursing home and cannot be provided through the alternative care grants program. In assessing the individual's need for service, the screening team may use reliable information gathered by others.

Subsection F.2. Use of community services. The screening team shall not recommend admission to a nursing home when it is

determined that the individual can remain in the community and that services are available and accessible to the individual in his or her own community.

Also, Minn. Laws 1982, Chapter 455, amending Minn. Stat. §256B.091, requires that persons receiving the pre-admission screening shall be informed of all appropriate alternatives including those that are expected to be less costly than nursing home care, and allowed to choose among them. This change in the law was necessary in order to obtain the federal waiver for home and community-based services required for this program. To accomodate this change, the Department added a new subsection F.3.

Subsection F.3. Choice of care. The recipient or his or her representative shall be informed of all feasible alternatives and allowed to choose among them where the cost of home and community-based services are not expected to exceed the cost of the appropriate level of nursing home care. This choice shall be recorded and maintained in the plan of care.

Although F.3. is new to the rule, it does not significantly alter the scope of the rule. This provision adds greater flexibility for persons who are screened, and the change is required by state law. For these reasons, the new language does not constitute substantial change and is both necessary and reasonable in order to conform with current state law.

Section 2.065G - Plan of care required

The Hearing Examiner noted three requests for clarification of the procedure for referral of alternative care recipients to providers, and the assignment of responsibility

for implementation of the service care plan. Subsection G.1. was approved as proposed. The Hearing Examiner points out that the use of the word "available" in G.2. creates some ambiguity, and he advises replacing this term with one which is less confusing. To resolve this concern, the Department proposes changing the title of Subsection G.2. so that the focus is on services provided in the plan of care rather than on the availability of services. The term "available" in this context refers to financial availability.

> Subsection G.2. ~~Availability of services.~~ Services provided in the plan of care. Where the plan of care includes services that are not available at that time through other public assistance sources, the services shall be provided through an alternative care grant described in H.

Subsection G.3. is a new provision in the rule that will ensure follow-up care for screened persons who are living in the community. This subsection was added in response to comments at the public hearing and also to comply with the federal waiver requirement that the state must assure the health and welfare of recipients. Alternative care grants are distributed to counties, and county screening teams develop the plan of care. Counties have direct control over the services provided through the plan of care and must bear the responsibility for administering the plan of care. The statute clearly requires the screening team to provide follow-up care including monitoring and re-evaluation. Although subsection G.3. is new, it is consistent with statutory language governing this program and should be required of all participating counties.

> Subsection G.3. Responsibility for the plan of care. The plan of care shall include the name of the person responsible for ensuring compliance, the method of monitoring the recipient's acceptance of

and adjustment to the services provided under the plan, the date for re-evaluation, and any temporary measures that might be required immediately in order to ensure the safety of the person. When needed services become unavailable, the assigned person shall be responsible for recommending a re-evaluation by the screening team.

Subsection G.4. is a necessary addition to the rule to bring the administrative rule into compliance with 1982 Minn. Law Chapter 455, and P.L. 97-35. Both the federal law and state statute require that following the screening the applicant must be informed of all viable alternatives under the waiver and allowed to choose among them. The state law provides a choice for the individual only when the cost of alternative care does not exceed the average expenditure for nursing home care.

Subsection G.4. - Cost-effective alternatives. The plan of care shall include documentation that the most cost-effective alternatives available have been offered to the individual.

Subsection G.4. clarifies certain responsibilities inherent in the screening program, and does not alter the scope of the rule as proposed.

Section 2.065H - Alternative care grant

The Hearing Examiner raised no significant questions regarding this section of the rule. The Department suggests a change in H.1. from "those persons" to "Medical Assistance recipients," and the introduction of new language specifying the services that are available for reimbursement through the alternative care grant. The remainder of section H. is unchanged. Authority for including these services is from the alternative care grant legislation, Minn. Stat. §256B.091, Subd. 9, and federal law

set forth in P.L. 97-35, §2176, 95 Stat. 812. The additional language makes more clear which services may be covered by the Alternative Care Grant Program, but does not alter the scope of the rule. It is, therefore, necessary and reasonable to add the specific language, and does not constitute a substantial change.

Subsection H.1. Use of the grant. The grant shall be used to provide services to ~~these persons~~ medical assistance recipients who have been screened and found appropriate for home or community care. Services that may be provided through this grant are day care, case management, homemaker, home health aide, personal care, respite care, foster care, and others for which federal participation is provided under the Social Security Act, section 1915, as added by Public Law 97-35, as amended through December 31, 1981. The grant shall supplement but not supplant services available through other public assistance or service programs. The grant shall not be used to establish new programs for which public money is available through other sources.

P.5

Section 2.065I - Reimbursement of nursing home costs

The Hearing Examiner recognized questions from provider groups regarding the fairness of certain sanctions in the rule. These questions have been resolved through changes made in the state law during the 1982 Legislative Session in order to obtain federal funding. Under the new provisions, there are no situations where the state agency will deny nursing home placement where such placement is the choice of the applicant. The emphasis of the federal law and the amended state law is to provide the screened applicant with information on viable alternatives and allow a choice among the alternatives where services required are not expected to cost more than the appropriate level of nursing home placement. These changes reduce the need to deny reimbursement to facilities who admit

patients in opposition to the recommendation of the screening team. Therefore, the Department proposes deletion of punitive language in the rule that no longer applies. The Department has chosen to rewrite subsections 1 through 3 so they are more consistent with the federal law and the state law. As rewritten, the sections are less restrictive than the provisions approved by the hearing examiner. P. 6, 7, 8

Subsection I.1. includes language to enforce the requirement that nursing homes notify the screening team if they admit an individual who should be screened. This requirement is necessary for the program to work effectively to reduce inappropriate nursing home admissions. Changes in the state and federal laws leave much of the law to voluntary compliance. It is essential that nursing homes notify the screening teams as soon after admission as possible. Two days was set as a reasonable notification period, and approved by the hearing examiner.

> Subsection I.1. Notification of admission of unscreened applicants. When an individual covered by the mandatory screening requirement is admitted to a nursing home on an emergency or nonemergency basis and has not obtained the required preadmission screening, the nursing home shall notify the screening team within two working days. If the admitting facility fails to contact the screening team within the prescribed period, the facility shall not be reimbursed for any costs incurred until the decision is made and the recipient and the nursing home are notified. Patient days resulting from that stay must be counted in the facility's patient day statistics for the purposes of rate calculation under 12 MCAR S 2.049.

Subsection I.2. governs the time requirements for review by the screening team. It is important that where unscreened persons have been admitted to a facility, the

screening team take an action as quickly as possible to avoid disruption to the person's life and unnecessary costs to the Medical Assistance reimbursement system. The time line for notification and screenings is the same as that proposed at the public hearing and was found to be reasonable by the Hearing Examiner.

> Subsection I.2. Screening team review. When an unscreened applicant has been admitted to the nursing home, the screening team shall make a decision on the case within five working days of being contacted by the nursing home. If the person prefers to return to the community, medical assistance shall cover the costs only for the period through the date the screening team notified the nursing home of this decision and until a plan for alternative care can be implemented.

Regarding subsection I.3., the Hearing Examiner encourages the Department to add language to this provision that gives nursing homes a more definite guideline or safe harbor within which to operate. In accordance with this suggestion, subsection I.3. now reads:

> Subsection I.3. Persons not screened. Nursing home applicants who have not been screened and are not medical assistance recipients shall be asked by the nursing home if they have sufficient funds to cover 90 days of nursing home care or whether they will be applying for medical assistance within that time period. If based on the information given and recorded, the nursing home determines that the person is not subject to the screening requirement the applicant may be admitted without screening. The nursing home shall maintain documentation of the basis for this decision in the patient's file. If the patient's statement concerning proposed eligibility is inaccurate, the health care facility shall not be denied reimbursement because of the inaccuracy of this statement.

Section 2.065J - Reimbursement for screening costs

This section of the rule did not receive controversial comment at the public hearing, and the Hearing Examiner made no specific findings. This section sets forth policies for reimbursement to counties for costs of conducting the pre-admission screening. Subsection J.1. allows for reimbursement to counties participating in the screening program as agreed upon by the Department and the county agency. Subsection J.2. establishes the sliding fee schedule required by the statute for persons who are not covered by the screening mandate. This provision is intended to enable persons who are ineligible for Medical Assistance to obtain the screening at a minimal charge. No changes have been made from Section J as proposed. This section is necessary in order to establish a mechanism for payment, and is reasonable.

Section 2.065K - Right to Appeal

Concerns of the Hearing Examiner and comments at the public hearing urged clarification of what services could be provided while an appeal is pending, and what reimbursement would be allowed during that time. Statutory changes brought about by 1982 Minn. Laws Chapter 455 provide sufficient opportunity for applicant choice, thereby reducing the incidence of client appeals expected under the previous statutory language. Subsection K.1. was rewritten to accomodate this statutory change and comply with the federal requirements. Amended subsection K.1. allows for the right to appeal where services provided under the rule are not provided to the recipient, or where the plan of care is not acceptable to the recipient. This change is consistent with the statute and is not substantial.

Subsection K.1. Appeal procedures. Persons who are recipeints of or applying for medical assistance have the right to a fair hearing pursuant to Minn. Stat. § 256.045 ~~to challenge the decision of the screening team~~ if they are not informed of and allowed to choose among alternatives available to them as set forth in F.3., or if the plan of care is not satisfactory. The hearing shall be conducted in accordance with appeal procedures set forth in Minn. Stat. § 256.045. ~~An appeal must be made within 30 days after receiving written notice of the screening team's recommendation.~~ If it appears at the hearing that circumstances are different than they were at the time the ~~initial recommendation was made~~, plan of care was established, the referee may refer the case back to the screening team for ~~reevaluation~~ reconsideration.

Subsection K.2. has been modified so it is consistent with the state law and federal regulations described above. Also, there was concern that the statute grants the physician "automatic appeal," while the proposed rule required that the physician "notify the screening team and request" an appeal when there is disagreement with the outcome of the screening.

Subsection K.2. Appeal by the physician. When the treating physician disagrees with the ~~screening team's decision~~, outcome of the screening, the physician shall notify the screening team ~~and request~~ in order to initiate an appeal on behalf of the individual.

Subsection K.3. was deleted because it is irrelevant given the changes in statute.

Section 2.065L - County Reports. Found by the Hearing Examiner to be needed and reasonable as proposed.

Now, therefore, it is ordered that 12 MCAR §2.065 is hereby adopted as set forth herein, that all provisions of the rule are necessary and reasonable as adopted, and that there has been no substantial change from the rule as proposed, and that all procedural requirements of Minn. Stat. §15.0412 and all other procedural requirements of law or rule have been met.

It is further ordered, that this rule identified as Rule 65 of the Rules of the Minnesota Department of Public Welfare is hereby adopted, and after this day Rule 65 shall read in its entirety as set forth in the attached Exhibit C.

It is further ordered, that the rule as adopted shall be submitted to the Chief Hearing Examiner for approval, and such subsequent action as necessary to fully comply with Minn. Stat §15.0412 (Supplement 1981).

State of Minnesota
Department of Public Welfare

Commissioner of Public Welfare

June 2, 1982
Date

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

IN THE MATTER OF THE PROPOSED RULE OF THE DEPARTMENT OF PUBLIC WELFARE GOVERNING THE PRE-ADMISSION SCREENING AND ALTERNATIVE CARE GRANT PROGRAM FOR LONG TERM CARE, 12 MCAR §2.065 (RULE 65)

STATEMENT OF NEED AND REASONABLENESS

AUTHORITY FOR RULE 65

The rule cited above is proposed by the Department of Public Welfare ("DPW" or the "State Agency") to: (1) replace the temporary rule for the pre-admission screening program effective January 1, 1981, through June 30, 1981; and (2) establish the rule for the alternative care grant program. The pre-admission screening program was enacted during the 1980 Legislative Session, Minn. Stat. §256B.091 (1980). Statutory authority for DPW to promulgate the rule to implement the pre-admission program is §256B.091, Subd. 1. The alternative care grant program was enacted by the 1981 Legislature, Minn. Stat. §256B.091, Subd. 8, (Minn. Laws 1981, ch. 360, §29). This subdivision also authorizes DPW to promulgate a rule to govern the alternative care grant program.

The two pieces of legislation are designed to be implemented as one program with pre-admission screening being the first step, and the alternative care grants being the second. Therefore, it is logical for the two program components to be integrated and included in one rule.

Authority to propose the permanent rule is assumed based on the specific charge to promulgate a temporary rule. In the instance of the pre-admission screening program, the temporary rule was in effect for the six months allowed under the Administrative Procedures Act. Minn. Stat. §15.0412, Subd. 5, (Minn. Laws 1981, ch. 253, §15) prohibits reissuance of the rule beyond 180 days without following the procedure set forth in subdivisions 4 to 4g or 4h of that section, relating to permanent rule promulgation. Therefore, authorization to promulgate a permanent rule is implied in order to continue a program that is required by statute. Similarly, in the instance of the alternative care grant program, the legislation authorizes promulgation of a temporary rule so that implementation of the program would not be delayed by the full rule process. Integrating the alternative care grant rule into Rule 65 has three advantages: (1) it does not delay implementation of the program since the pre-admission screening program must be in place prior to the award and use of the grants; (2) it goes beyond the requirements of the temporary rule and provides public notice and hearing; and (3) it allows for the two program components to be considered together rather than at separate times.

In addition, under Minn. Stat. §256B.04, Subd. 2, (1980), the Commissioner of Public Welfare is charged with the authority to develop rules to carry out provisions of the chapter 256B in order that Medical Assistance is administered in an efficient, economical, and impartial manner throughout the state. In developing these rules, the statute requires that consideration should be given to varying costs for medical care in different parts of the state and the conditions in each case. The rules are to be developed so that the spirit and purpose of the program is protected, and that

the intent of the service is made apparent to all. Such rules are binding on the county agencies which administer Medical Assistance programs.

The need for this rule extends beyond the state statutory citations noted above. Federal Medicaid regulations for utilization control in skilled nursing facilities and intermediate care facilities set forth requirements for a medical, psychiatric and social evaluation prior to admission to a facility. The federal regulations define the scope of the evaluation and reserve for each state the option of implementing a procedure to comply with the regulations. These federal regulations are contained in 42 CFR §§456.260 - et seq., for skilled nursing facilities and 42 CFR §§456.360 - et seq., for intermediate care facilities. In August, 1981, Congress enacted similar provisions for providing services in the community, as part of the Omnibus Budget Reconciliation Act of 1981, Pub.L. §97-35. A copy of the relevant section is attached hereto, and is discussed in greater detail below.

DESCRIPTION OF RULE 65

This rule governs pre-admission screening for persons applying to enter a nursing home directly from their own home or from other living arrangements in the community, and provides for alternative care grants for persons able to remain outside of an institution if supplemental services are provided. The objective of the screening is to postpone institutional care if the individual's care can be supplemented with health and social services so that he/she can continue to live independently in a less restrictive setting. In counties participating in the program, the screening is mandated for persons who are eligible for Medical Assistance or who will be eligible for Medical Assistance within 90 days of admission to a nursing home. The screening is available to others on a sliding fee schedule. Persons transferring from acute care hospitals or other nursing homes are exempt from the screening requirement.

Facilities affected by the screening program are licensed nursing homes receiving applications from persons residing within a county that is participating in the pre-admission screening program pursuant to Minn. Stat. §256B.091, Subd. 2, (1980). Nursing homes included in the program are skilled nursing facilities and intermediate care facilities I. Intermediate care facilities II are licensed as Board and Care Homes and are therefore not covered by this rule. Persons being admitted to ICF-MR facilities are not included in the program at this time. Skilled nursing and intermediate care facilities have 38,169 licensed beds with an average occupancy rate of 95 percent.

Medical Assistance recipients comprise 65 percent of the nursing home residents. The average Medical Assistance reimbursement for both categories of licensed nursing homes is $49.00 per day, or $17,885.00 per year (1980 data, Department of Public Welfare). The pre-admission screening program is intended to prevent unnecessary nursing home placements by identifying those people who are able to remain in the community with health and social services. If institutional costs can be reduced by diverting some nursing home applicants into less expensive non-institutional services, the Medical Assistance program will be able to use its appropriation to provide services to the greatest number of needy persons.

The pre-admission screening program was conducted in two counties from January 1, 1981, through June 30, 1981. The two counties, Blue Earth and St. Louis, reported that 25 percent of persons screened were found able to remain in the community. It is anticipated that over time there will be substantial savings from this program. The 1981 Legislature funded the program to be implemented statewide by June 30, 1983. Priority will be placed on implementation in the metro counties where there is the greatest potential for savings. Although the Medical Assistance Program is ordinarily

administered on a uniform, statewide basis, section 2176 of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), allows the state to request a waiver of the "statewideness" requirement from the Secretary of the U.S. Department of Health and Human Services (HHS) in order to implement home and community-based services on a phased in schedule.

The pre-admission screening legislation represents an initial effort in Minnesota to implement a statewide pre-admission screening program for long term care to comply with the federal regulations. The language in the proposed rule relating to the screening is purposefully chosen to reflect the spirit and intent of the state statute. Basic requirements for the program which are set forth in statute appear in the rule only where there is a need for clarification of procedure. The rule governs procedures for establishing pre-admission screening teams, conducting the screenings to determine the appropriate recommendation, and providing guidelines for legal determinations when the decision of the screening team is in question.

The alternative care grant legislation is to assist counties in providing health and social services to screened persons who are able to remain at home. The rule provides guidelines for use of the grant, provision of services, reimbursement of services, and assurances or agreements for expenditure of the funds. The state legislation is similar in concept to the federal provisions for home and community-based services to certain individuals in section 2176, Omnibus Budget Reconciliation Act of 1981. Language in the rule is compatible with the federal law and its implementing regulations, except in one respect. The federal law does not prohibit funding for nursing home placements which are inappropriate. State law prohibits payment for such placements. Because of the inconsistency, DPW has asked HHS to allow DPW to prohibit payment for inappropriate placements.

A primary objective of the pre-admission screening and alternative care program is to promote cost containment through restrictions on inappropriate and premature nursing home placements. Cost containment is intended to be a coordinated effort between the Minnesota Departments of Health and Public Welfare. The statute requires that: "The commissioners of public welfare and health shall seek to maximize use of available federal and state funds and establish the broadest program possible within the appropriation available". It is essential that standards and requirements set forth in the rule are compatible with existing state and federal regulations and guidelines in order to avoid complications in funding or program implementation. To this extent the Department of Health shares in the responsibility for assuring that the rule promotes maximum coordination between the two agencies. The Department of Public Welfare will seek federal approval as permitted by §2176 of the Omnibus Budget Reconciliation Act of 1981, to maximize federal funding for the program.

The program has several purposes in addition to that of cost containment. The legislation states that an additional purpose is "to prevent inappropriate nursing home placement". Inherent in this is the fact that non-institutional health and social services must be available in the community in order to recommend and maintain alternative living arrangements. Many communities do not have the level of services necessary to achieve this goal and will find it necessary to increase services. Therefore, services expansion is a second purpose of the program. Still another purpose is to provide senior citizens with additional information and assistance in evaluating their present and future need for care. Support for the program comes from those who benefit from the changes because they would prefer to delay nursing home admission if other services were available; those opposing the changes prefer the traditional nursing home referral and admission procedures, free from governmental constraints. However, the cost of most nursing home care in Minnesota is reimbursed through the Medical Assistance Program by the Department of Public Welfare. In F.Y.

1980, its expenditures for nursing home care were $252,750,635.00 with additional ancillary costs of $38,873,162.00. Therefore, the state has a legitimate interest and a responsibility to the taxpayers to limit payments for nursing home care to only those Medical Assistance recipients who truly need medical care in an institutional setting.

This program is intended to be a county-managed program and to encourage local planning and self-determination. The rule provides guidelines for important links between DPW and the counties participating in the screening program through requirements for public notification, screening guidelines, approval for reimbursement, plans of care, and use of the alternative care grants. Also, the State Agency will provide technical assistance, brochures, and report forms.

Minn. Stat. §256B.091, Subd. 2, places responsibility for establishing a statewide screening and alternative care program on the Commissioner of Public Welfare. The rule contains procedures for implementing this program. Efforts have been made to accommodate the special requests of persons affected by the legislation where there would not be an adverse effect on the program.

A. Responsibility for the program. The county welfare agencies are required by statute to administer Medical Assistance in their respective counties under the supervision of the Department of Public Welfare, Minn. Stat. §256B.05, Subd. 1, (1980). Therefore, it is reasonable to assign the county welfare agency the responsibility for assuring compliance with the requirements of the pre-admission screening and alternative care grant program. Funding for both program components derives from the Medical Assistance budget, so that reporting and billing forms would logically flow between the State agency and county welfare agencies.

B. Program Scope. This section provides further instructions that counties participating in the program shall conduct the screening procedure and make a recommendation for persons covered under the mandatory screening requirement. The recommendations to be made and the conditions under which they are made are explained in detail in the rule. This obligation is the basic premise of the screening requirement set forth in statute. Counties are encouraged to implement the pre-admission screening and alternative care grant program on a voluntary basis. Counties must first implement the pre-admission screening program, which entitles them to the alternative care grant. The program is to be implemented statewide by June 30, 1983.

C. Notification about program. The provisions in Section C guarantee, to the extent possible, that all persons for whom the screening is mandated are made aware of the requirement and how to obtain the screening. In addition, it is essential that persons who are in a position to provide information and referral services to elderly persons understand the purpose of the program, who is eligible, and how to apply. Also, nursing homes must be aware of the screening requirement and the financial risk of admitting patients who have not been screened. Study groups in the State (Governor's Blue Ribbon Task Force, Department of Health Long Term Care Plan) have recommended expansion of the program to include screening persons transferring from acute care hospitals or from other nursing homes, presently excluded under the statute. See Minn. Stat. §256B.091, Subd. 4. Until that happens, it would be advantageous to share information on alternative care services with hospital discharge planners to ensure more appropriate placement of their patients, but this is not required under the rule.

C.1. Notice to eligible persons. Section C.1. confirms that the county agency responsible for the screening is to be a primary referral point for this program. In this role, the county agency's responsibility is two-fold: (1) to notify nursing home applicants of their right to obtain alternative care services outside of an institutional

setting; and (2) to prevent nursing home admissions of Medical Assistance recipients who have not been approved by the screening team, and which might result in denial of Medical Assistance reimbursement and the expense of appeal proceedings. The county welfare department determines eligibility for Medical Assistance reimbursement, which is then paid directly to the medical vendor by DPW. Therefore, it is at the county level that compliance with the statute must be enforced to ensure that DPW is notified of violations or exceptions to prescribed procedures.

The optimal notification system would include direct notification of all persons potentially affected by the pre-admission screening requirement. It is possible to notify current recipients by enclosing a notice with the monthly mailing of Medical Assistance cards. However, it is only practical to use the centralized mailing system when the program has been implemented statewide; partial mailings are very expensive. For this reason the rule specifies that: "where possible, persons covered by the mandate should receive direct notification of the screening requirement". The intent of this requirement is for DPW and the counties to work together to develop and utilize the most effective procedure for notifying people affected by the screening requirement. When the program is implemented statewide, the automated mailing system can be used to ensure uniform and timely notification to all Medical Assistance recipients. It is expected that the nursing homes will also inform potential Medical Assistance recipients of the requirement in order to ensure that the nursing home receives payment for services rendered. See Section I.4. of the rule.

C.2. Public notice. The pre-admission screening requirement also applies to: "any individual who would become eligible for Medical Assistance within 90 days of admission to a licensed nursing home", Minn. Stat. §256B.091, Subd. 1. These persons are outside the Medical Assistance Programs, and will not be reached through the methods discussed above. Active efforts should be made to notify persons in this category through the public notification provisions in C.2.

Note that the financial risk of improper nursing home admissions is placed on the nursing home and not the recipient. All nursing homes will receive notice of the screening requirement and the counties participating, and will necessarily absorb the costs if a Medical Assistance recipient, or an individual who will be eligible for Medical Assistance within 90 days of nursing home admission is improperly admitted. (See Section I. of the rule). DPW can insure that each nursing home participating in the program receives notice of the screening requirement and its potential effect. In light of the financial benefits nursing homes realize through the Medical Assistance reimbursement program, it is incumbent upon them to know and understand the screening requirement, and to shoulder the financial effects if the screening requirement is not met. DPW staff have met with representatives of the hospital and nursing home associations to explain the requirement and to seek their input.

Section C.2. makes explicit the statutory requirement that the agency responsible for the screening provide "information and education to the general public regarding availability of the screening program", Minn. Stat. §256B.091, Subd. 3(a) (1980). The rule requires that notification shall be carried out through publication in available newsletters, information leaflets displayed in an accessible form and location, and promotion through other local media sources. A general brochure will be available for statewide use, but, if county agencies prefer to have their own, they will be responsible for costs.

Notification to the public shall be sufficient if the county agencies meet the standards of the rule. The counties will be encouraged to make special attempts to reach persons who are not eligible for Medical Assistance but are subject to the statutory screening requirement. In addition, a well-developed referral system will ensure that persons applying for nursing home admission will be referred to the screening team.

C.3. Notice to officials and health care professionals. Section C.3. sets forth the process for formal notification from the Department of Public Welfare to county government officials and agencies, state hospitals, and to all nursing homes and physicians in the counties participating. The purpose is to strengthen the referral system and to ensure that all points of contact for admission to a nursing home are aware of the screening requirement and knowledgeable about the procedure for screening. Hospitals will be contacted to encourage discharge planning including referral to the screening team and to alternative care services in the community as appropriate for follow-up care.

D. Resource materials for screening program. This portion of the rule governs specific procedures of the screening process including the assessment tool, technical assistance and the directory of community resources. The primary purpose of these sections is to insure uniformity in the screening process, as explained below.

D.1. Screening tool. The state agency shall designate a screening tool to be used in the pre-admission screening procedure, but counties may use a comparable one if it is approved by the state agency. The screening tool is important for three reasons: (1) it is the form that is used by the social worker and the nurse during the assessment; (2) it is the method for obtaining information used in the screening team's determinations; and (3) it provides documentation for the recommendation, which is binding for Medical Assistance recipients. These multiple demands require that the screening tool used by the counties meets established standards of quality, purpose, and design. While it is not essential that a single screening tool is used statewide, it is essential that the screening tools meet standards established by the Department of Public Welfare, with input from persons or groups affected by the screening requirement.

One stated purpose of the pre-admission screening legislation is to gain further information about how to contain costs associated with inappropriate nursing home admissions. The information obtained from the screening tool will be used in aggregate to determine the extent of inappropriate nursing home placement, the need for non-institutional health and social services, and where possible, the cost of maintaining elderly persons in the community. Therefore, it is equally important that the screening tool is designed to obtain information that will be useful for purposes of planning for future state needs of the elderly. If the information is to be useful, there must be a degree of uniformity to the data collection.

The assessment tool is intended to screen nursing home applicants for appropriate placement, and to be used as a resource document for establishing the plan of care for non-institutionalized persons. The federal law, §2176 of the Omnibus Budget Reconciliation Act of 1981, requires that federal criteria for admission to a skilled nursing facility or intermediate care facility must be included in the assessment tool. The federal law and state law requirements for evaluation of the program necessitate consistent data collection. Any statewide program such as this requires that persons screened in various counties must be assessed with equivalent standards. The screening tool is critical because it is used to make a decision directly affecting an individual's future, and because it is a reference point for future planning. Uniform standards are an important link between the federal, state and county programs.

An important objective in the pre-admission screening program is to increase the base of information about: (1) non-institutional services that are available in the counties; (2) which services are most effective and in demand for reducing the current reliance on institutional services; and (3) the cost-effectiveness of changing utilization patterns. Collection and use of the data is governed by the Government Data Practices Act, Minn. Stat. §15.1611 et seq (1980). Information collected on individuals for welfare purposes is specifically protected by Minn. Stat. §15.1691 (1980). Data collected by the screening team is classified as private under this Act. Persons who are screened shall be fully

informed of the purpose and intended use of the data; the individual's right to refuse to give certain information and the consequences of that decision; and the identification of persons or entities authorized to receive the data.

D.2. Technical assistance. Section D.2. requires state agency staff to provide technical assistance including training sessions for members of the screening team. This provision was added to bring about consistency in the approach used to conduct screenings. Training sessions are especially important in counties where screening teams may not have specific expertise or skills for working with the elderly. Sensitivity toward the special needs of the elderly is one important contribution the screening can make to long term care policy in Minnesota.

D.3. Directory of services. Section D.3. requires that the county agency develop a resource directory of available non-institutional services. Counties or communities should conduct a thorough inventory of services that could be helpful to an elderly person remaining at home, or in alternative living arrangements outside of a nursing home. It is intended that the inventory go beyond formally organized public services, and identify others that are non-public, voluntary, or that can be obtained through the informal community support system.

The resource directory shall be used by the screening team to match the applicant's needs with services that are available. This directory should be an important reference in developing the individual plan of care required for all persons who have been screened and referred back to the community. The directory should be organized so that information about eligibility, location, and contacts for service are readily available. The directory can also be the basis for a statewide inventory of services for purposes of planning and resource allocation.

E. Screening Procedures. This section sets forth guidelines for conducting the screening including time constraints, notification requirements, and reconsideration of denied applications. The screening team is required to take action on screening requests within five working days of receiving the request, as specified in this rule governing admissions on an emergency or non-emergency basis. The final decision on whether to approve nursing home admissions or recommend alternative living arrangements must be made by the screening team within ten working days. The time requirements in the proposed permanent rule were part of the previous temporary rule and found by the participating counties to be appropriate.

When the screening team has reached a decision, notification must be given to assure that appropriate follow-up actions are taken. If the applicant is eligible for Medical Assistance or will be within 90 days of admission, and nursing home care is recommended, notification must be given to the applicant or appropriate relative or responsible party, referring local welfare department, referring physician, and nursing home. This is to ensure that Medical Assistance reimbursement will begin and the physician will make the necessary visits, and that the nursing home can be prepared. If the applicant is eligible for Medical Assistance or will be within 90 days of nursing home admission, and nursing home admission is not approved, notification must be given to the applicant or appropriate relative or responsible party, referring local welfare department, and referring physician. This is to ensure that Medical Assistance reimbursement does not begin, and that the physician will work with the screening team on a plan of care for determining what services should be delivered to the individual who will remain in the community. Persons who are not eligible for Medical Assistance, but will be in 90 days are considered "private pay" patients, and any notifications must be given with consideration to the privacy of the private pay individuals.

Persons who have received a recommendation from the screening team can request reconsid-

eration of the decision if there has been a change in circumstances. All that is necessary is to resubmit an application along with the explanation of the change in circumstances.

If the applicant is not eligible for Medical Assistance and will not be within 90 days of admission to a nursing home, the screening team's recommendation is considered to be advisory, and formal notification is required only to the applicant or appropriate relative or responsible party, and referring physician.

F. Criteria for screening team recommendation. This section clarifies the options available to the screening team in making its recommendation for future care.

F.1. Nursing home admission. Section F.1. describes a situation where the individual's condition requires a level of care beyond that which can be provided at home, or where the services required for the individual to remain in the community are not available outside of the nursing home. In these instances, the recommendation shall be for approval of the individual's application for nursing home admission.

F.2. Use of community services. This section describes a situation where the screening team has determined that the individual can be successfully maintained outside of an institution, and where the necessary services are both available and accessible in the community. The resource directory mandated in Section D.3. should be used by the screening team in developing a plan of care that can keep the person at home or in the community, and that is acceptable to the applicant and his/her family and physician.

G. Plan of care required. The screening team may recommend: "Maintenance in the community with specific service plans and referrals, and designation of a lead agency to implement each individuals plan of care". This section clarifies the statutory requirement for a plan of care.

G.1. Development of the plan. The plan of care required for persons who remain in a non-institutional setting must be viewed as a summary of the applicants health and social service needs, what services are available in the community to meet those needs, and how gaps in the service plan can be met.

Consumer groups have expressed concern that the plan of care should be acceptable to the recipients of the services. To insure that recipients personal preferences are considered, the rule requires that the family and the individual shall be consulted when determinations on scheduling, kind and frequency of services delivered, and cost of the services are being made. Also, it is anticipated that individuals will receive a combination of assistance from family and friends, and services from the formal provider network. It is important for purposes of accountability and to ensure quality of care that a formal agreement exists within the plan of care that clearly describes the responsibilities of all involved parties, and how the services will be monitored. Although DPW controls eligibility for Medical Assistance payments, it does not view the county's role in the development of the care plan as an adversary one. A well-trained screening team will work with the recipient to arrange an appropriate plan, mutually acceptable to all concerned, within the framework of community-based care. If all attempts to negotiate a plan fail, the recipient has the right to appeal the agency's decision to deny payment for nursing home services.

G.2. Availability of services. The plan of care is an important component of the pre-admission screening program because it represents the link between the screening team and the follow-up services that the screened individual must have to stay outside of the nursing home. The importance of the plan of care has been increased by two factors. One is the Alternative Care Grant Program enacted by the 1981 State Legislature (Minn. Laws 1981, ch. 360, Section 29), setting aside funding for services

which are required in the plan of care, but are not available in the community. Therefore, the plan of care will be important in documenting the need for the service, and the fact of unavailability.

The second consideration is section 2176 of the Omnibus Budget Reconciliation Act of 1981 recently enacted by the United States Congress. This Act sets forth conditions for a waiver of certain Medicaid regulations necessary to provide certain home and community based services, and requires an individual plan of care based on a comprehensive assessment for persons who are to receive home and community-based services as an alternative to institutionalization.

H. Alternative care grant. The alternative care grant program was enacted in an attempt to redistribute money that has traditionally gone to institutional care, to home and community-based services. This program was intended to meet the specific needs of persons who can remain outside of an institution if required services are available, or can be obtained through supplementary funds such as alternative care grants.

H.1. Use of the grant. Use of the grant is based on the premise that counties have health and social services available that are provided through funding sources such as Titles XX, XVIII, and III of the Social Security Act. The money for alternative care grants is intended to supplement services required to keep individuals at home where tnere is no other source of funds.

H.2. Service provision. This program allows Medical Assistance reimbursement for services traditionally funded through social service programs. There is a critical need for assurance that services provided under this funding meet acceptable quality standards. Where federal and state requirements are in existence they will be considered the acceptable standard. In other instances, the county is the employer or contractor, and will be accountable for the quality of services delivered. This is not intended to be a policing action, but rather to insure that support such as training sessions and special workshops are available so that care givers develop needed skills.

H.3. Reimbursement of services. This allowance for service reimbursement was established so that there is a cap on the amount that can be paid, and so that counties have the flexibility to set reimbursement at a lower level to allow local competition.

H.4. Assurances. The grants program must comply with the state law, and with federal law in order to obtain federal financial funding. Some of the requirements are in the form of agreements to follow certain guidelines in implementing programs and expending funds. These assurances include quality care, assessment practices, limits of reimbursement, financial accountability and reporting.

I. Reimbursement of nursing home costs. This section presents guidelines for reimbursement of nursing home costs through Medical Assistance. The purpose of this section is to clarify the responsibilities of the nursing home, the applicant, and the funding agency and to assign responsibility for reimbursement of emergency and non-emergency admission to nursing homes.

Clear delineation of responsibility is crucial to the success of the pre-admission screening program. If the screening requirement is to be implemented as the statute requires, there must be financial consequences attached to non-compliance. Therefore, the rule defines what procedures are to be followed in admission of persons whose Medical Assistance eligibility is in doubt. It is intended to be very clear in the rule that nursing homes must actively participate in the screening program by referring

applicants, including those on waiting lists, to the screening team, and that they comply with the notification requirements when persons are admitted without the necessary approvals.

The authority rests with the state agency to deny payment for nursing home care when an alternative plan of care has been developed, referrals have been made and an agency has been designated to implement the plan of care, Minn. Stat. §256B.091, Subd. 6, (1980). The suitability of the plan may be appealed, but nursing home care will not be reimbursed through the Medical Assistance system pending outcome of the appeal.

Since the Medical Assistance program pays providers and not recipients, the providers must bear the cost of lost payment if the screening requirements are not met. Minn. Stat. §256B.03 (1980). These requirements are not onerous. In most cases, they require giving immediate notice to the county that a person who seeks admission is covered by the screening requirement.

The nursing homes must accept responsibility for complying with the statute and rule in order to avoid loss of reimbursement. Nursing homes should not admit Medical Assistance recipients who have not been screened. If the recipients have been on the nursing home's waiting list, they should have been referred to the screening team at the time they originally applied. All nursing homes will be notified of the screening requirement and will be informed of the consequences of non-compliance. There may be instances where recipients have not been informed of the screening requirement. It is essential that the nursing homes have a financial incentive for referring applicants to the county pre-admission screening team, if the program is to work. Because there are exceptions for emergency admissions and admissions from hospitals, this should not impose an unfair burden on the recipients or the nursing homes.

I.1. Non-emergencies; unscreened applicants. Section I.1. sets forth guidelines to be followed when an individual covered by the screening requirement is admitted to a facility on a non-emergency basis. The facility must assume responsibility for the admission until they have notified the screening team and the screening team has had five working days to conduct the screenings and make a decision. If the screening team determines that the individual is able to remain outside the nursing home, the facility must cover the cost of care for the period that the patient resides in the nursing home. The screening team will develop a plan of care for the individual in accordance with specifications in the rule. The purpose of this section is to discourage the facility from accepting any person who has not been screened. The two-day notice is reasonable in light of the fact that the nursing home's administration would know immediately upon admission (if not before) how the patient planned to cover the cost of care. A medical assistance eligibility determination would be required immediately for any person without funds to pay for his/her own care.

I.2. Emergencies; unscreened applicants. Section I.2. sets forth guidelines to be followed when an individual covered by the screening requirement is admitted to a facility because of a medical emergency. In this instance, the facility is required to notify the screening team within two working days of the admission. If the facility fails to notify the screening team within two working days, the facility will be required to cover the cost of care for the individual's stay until the screening team has been notified and has had five working days to conduct the screening and make a decision. Admission in an emergency should be rare; most patients with a medical emergency would receive immediate care at a hospital and be admitted from a hospital. However, if there is an emergency, full Medical Assistance reimbursement will be allowed so long as the admitting facility notifies the screening team within the specified

time, and the screening team has determined that institutionalization is necessary.

Medical Assistance reimbursement will also be allowed when the screening team fails to conduct the screening within the five working days specified in the rule.

Limited Medical Assistance reimbursement will be allowed for an emergency admission when the screening team was notified within the specified period of time, but the decision of the screening team is for the individual to remain in the community. Reimbursement will be allowed only through the day the screening team notifies the nursing home of their decision or until the plan for alternative care can be implemented, whichever is later. The screening team will develop a plan of care for the individual in accordance with specifications in the rule.

In both emergencies and non-emergencies, no Medical Assistance reimbursement will be allowed until after the screening team has made a decision if the nursing home failed to notify the screening team within the two working days specified in the rule. This is to ensure that the nursing home does not take unfair advantage of the circumstances surrounding the initial admission to keep the patient when nursing home care is inappropriate.

These provisions are not intended to deny any applicant necessary care because of the screening requirement, but to ensure that there is no undue delay in determining the patient's need for nursing home care. In emergencies the nursing home is denied Medical Assistance reimbursement only when an individual covered by the screening requirement is admitted to the facility without the screening, and the facility fails to notify the screening team of an admission within the stated time limit. This reimbursement policy is necessary in order to effectively reduce the number of Medical Assistance expenditures for nursing home care.

In both I.1. and I.2. the nursing home is required to count the patient days resulting from the admission for the purpose of rate calculation under DPW 49. The purpose of this is to insure that DPW does not pay indirectly through the nursing home rate determination that which cannot be paid directly. "Patient Days" are calculated by adding the number of days each individual patient remains in the nursing home in a year. If 25 patients each stay 10 days, the nursing home has accumulated 250 patient days.

Under Rule 49, the rate paid to the nursing home for fixed costs is determined, in part, by dividing the number of patient days into the total fixed costs. The higher the number of days, the lower the average. However, to encourage high occupancy, DPW gives an occupancy incentive to nursing homes which maintain high occupancy. If average occupancy is above 93 percent, the fixed costs are divided by 93 percent of occupancy rather than by actual patient days. In order to preserve the balance in Rule 49, this rule requires the nursing homes to count as patient days the days for patients who have not been screened and were denied reimbursement. This insures that low-occupancy nursing homes, most likely to accept the risk of admitting patients who have not been screened, will not receive any indirect benefit when their fixed costs are calculated. High-occupancy nursing homes will be less likely to take such a risk. This provision is necessary to insure that Rule 65 and Rule 49 are consistent in purpose and result.

I.3. Screened applicants. Section I.3. clarifies the financial consequences for nursing homes which admit a person who has been screened and denied approval for admission. As provided for in the rule, the recipient has the right to notification and a fair hearing on such denial of payment. The hearing shall be requested and conducted in accordance with provisions set forth in Minn. Stat. §256.045.

I.4. Persons not screened. Section I.4. clarifies the responsibility of the nursing home to determine whether individuals will be eligible for Medical Assistance reimbursement. The facility must document that the question was considered and that a determination was made based on information provided by the applicant. Documentation may be requested by the county agency at a future date if Medical Assistance reimbursement is requested. The facility must make a reasonable attempt to determine whether the patient can cover his/her own costs from private funds for 90 days.

J. Reimbursement for screening costs. This section governs the reimbursement allowance for counties participating in the pre-admission screening program. According to the legislation, there are three groups to be screened: (1) those who are eligible for Medical Assistance at the time of the screening, (2) those who are not eligible for Medical Assistance, but who would be eligible for Medical Assistance within 90 days of admission to a nursing home (groups 1 and 2 are mandated by the screening requirement), and (3) those who do not expect to request Medical Assistance but are interested in having the screening.

J.1. Persons eligible for Medical Assistance. Section J.1. allows for reimbursement to counties participating in the screening program as agreed upon by the Department of Public Welfare and the county agency. The amount of reimbursement per screening will be contingent upon that allowed for home health nurse visits and physician consultation through the Medical Assistance reimbursement program.

J.2. Persons not receiving assistance. Section J.2. establishes the sliding fee schedule required by the statute for persons who are not covered by the screening mandate. This is intended to enable persons who are ineligible for Medical Assistance to obtain the screening at a minimal charge. The schedule uses average annual cost of nursing home care in the state as the base annual gross income per individual. This is determined to be the maximum amount allowed for an individual to obtain the screening without cost. The Department of Public Welfare will provide a reimbursement based on a percent of the reimbursement allowed for applicants who will be eligible for Medical Assistance within 90 days of admission to a nursing home.

K. Right to appeal. This section sets forth appeal procedures for persons who are recipients of or applying for Medical Assistance, physician's who disagree with the screening team's decision, and acknowledges that the screening recommendation is advisory for persons who are not applying for Medical Assistance within the 90 day period.

K.1. Appeal procedures. The procedure cited here is the general provision for appeals set forth for Medical Assistance recipients. It is not the purpose of the screening team to deny nursing home admission where it is necessary. Therefore, if there is a change in circumstances that warrant re-assessment, the referee is instructed to send the case back to the screening team for reconsideration.

K.2. Appeal by physician. Section K.2. clarifies the statutory provision that an appeal is automatic if the individual's physician does not agree with the recommendation of the screening team. For purposes of administration, the rule requires that in this instance the physician must notify the screening team and request an appeal on behalf of the individual. This simple requirement is necessary in order for the screening team to know whether the physician concurs with or disagrees with its recommendation. The rule allows the appeal to be withdrawn with the consent of the individual and the treating physician.

K.3. Persons not receiving assistance. Section K.3. recognizes that persons who receive the pre-admission screening but are not applying for or receiving Medical Assistance

shall consider the recommendation by the screening team to be advisory, and that neither the nursing home nor the applicant are bound by the screening team's recommendation. However, if the person's financial circumstances change in 90 days the person will be bound by the recommendation. Of course, such a person would have the right to reapply based on a change of circumstances, or to appeal the screening team's recommendation. This provision is necessary to insure that persons who become leigible for Medical Assistance within 90 days of admission to a nursing home are bound by the language of Minn. Stat. §256B.091 (1980).

L. County reports. This section sets forth reporting requirements for the counties. Frequency of the reports can be determined based on program needs at any given time. Format of the reports shall be determined by the commissioner and include items specified in rule. The county agency shall also provide information requested by the commissioner for continued assessment of the program. This is consistent with Minn. Stat. §256B.05, Subd. 1, (1980) and §256B.091.

The state agency expects to call the following expert witnesses:

Grace Nelson, President, Minnesota Senior Federation. Testimony will relate to needs of the elderly, and advantages of independent living as an alternative to institutionalization.

Senator Linda Berglin, Minnesota Senate. Testimony will be in support of the program generally as a means of re-directing public money toward non-institutional services.

Iris Freeman, Executive Director, Nursing Home Advocates. Will present testimony in support of concept of pre-admission screening, and point out the need for alternative care services in the community.

Dick Flesher, Administrator, Program for Aging for Catholic Charities. Will give support to the pre-admission screening and alternative care program, and reiterate findings and recommendations that strongly support keeping people at home as long as possible.

Linda Stein, Health Planner, Ramsey County Community Services. Will discuss experience in Ramsey County with Home Care Demonstration Project and results of that project that are relevant to pre-admission screening and alternative care program.

Barb Ogrady, Representative of Metro Health Board. Will discuss how pre-admission screening contributes on a statewide basis to better and more efficient utilization of home care services.

Arthur E. Noot, Commissioner
Department of Public Welfare

November 20, 198
Date

IN THE MATTER OF THE PROPOSED ADOPTION OF THE DEPARTMENT OF PUBLIC WELFARE RULE GOVERNING THE ADMINISTRATION AND PROVISION OF PRE-ADMISSION SCREENING AND LONG TERM CARE AND ALTERNATIVE CARE GRANTS (12 MCAR 2.065)

STATEMENT OF COMPLIANCE WITH RULE-MAKING PROCEDURES

I, Beverly Jones Heydinger, do hereby declare that I have examined the rules and all related documents and that, based on my examination and my personal familiarity with the applicable procedures, the Administrative Procedures Act, the rules of the Office of Administrative Hearings, and the rules of the Attorney General have been followed. Any exceptions are noted below.

Beverly Jones Heydinger
Special Assistant - Attorney General

Dated: June 29, 1982

IN THE MATTER OF THE PROPOSED ADOPTION OF THE DEPARTMENT OF PUBLIC WELFARE RULE GOVERNING THE ADMINISTRATION AND PROVISION OF PRE-ADMISSION SCREENING AND LONG TERM CARE AND ALTERNATIVE CARE GRANTS (12 MCAR 2.065)

AFFIDAVIT OF MAILING NOTICE OF SUBMISSION TO THE ATTORNEY GENERAL

STATE OF MINNESOTA)
) SS
COUNTY OF RAMSEY)

Robert Hamper, being first duly sworn, deposes and says:

That on the 29th day of June, 1982, in the City of St. Paul, County of Ramsey, State of Minnesota, he served the attached Notice of Submission to the Attorney General by depositing in the State of Minnesota Central Mail System for United State mailing at said City of St. Paul, a copy thereof, properly enveloped, with postage prepaid, on all persons and associations who requested notice that the rules in the above-entitled matter have been submitted to the Attorney General.

Robert Hamper

Subscribed and sworn to before me
this 29th day of June, 1982.

Marjorie A. Flowers

MARJORIE A. FLOWERS
NOTARY PUBLIC MINNESOTA
RAMSEY COUNTY
My Commission Expires Aug 30 1986

IN THE MATTER OF THE PROPOSED ADOPTION OF
THE DEPARTMENT OF PUBLIC WELFARE RULE
GOVERNING THE ADMINISTRATION AND PROVISION
OF PRE-ADMISSION SCREENING AND LONG TERM CARE
AND ALTERNATIVE CARE GRANTS (12 MCAR 2.065)

NOTICE OF
SUBMISSION TO THE
ATTORNEY GENERAL

Pursuant to your request and in accordance with Minnesota Statutes, section 15.0412:

PLEASE TAKE NOTICE that the above-captioned rules have been submitted to the Office of the Attorney General on this date, June 29, 1982, for review as to form and legality. Pursuant to 1 MCAR § 1.206 B., the Attorney General will not approve the rules for at least 10 calendar days after receipt to allow any person or association time to comment on the legality of the rules, after which that Office will complete its review. If you desire to comment on the legality of the above-captioned rules, you should direct your comments to the Office of the Attorney General, G-25 State Administration Building, 50 Sherburne Avenue, Saint Paul, Minnesota 55155, telephone (612) 296-7030. Please note that the above-cited rule of the Attorney General also provides that a copy of any written comments submitted to the Attorney General must be submitted simultaneously to this agency.

If you are interested in determining what changes, if any, were made in the proposed rules after the hearing and before submission to the Attorney General, you may contact:

Nancy J. Feldman, Supervisor
Health Care Programs
Policy Section
Department of Public Welfare
1st Floor, Space Center
444 Layfayette Road
St. Paul, MN 55101
(612) 297-3200

BT/aba