

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

RULE REVIEW CHECKLIST

File No. 1500 Docket No 25.0009.0865

DATE RECEIVED 6/30/88 ADOPTED W/O HEARING X

REVIEW DATE 7/9/88 EMERGENCY RULE _____

DUE DATE 7/14/88 REVISOR APPROVED X

APPROVED 7/11/88 gaz REVISOR DISAPPROVED _____

DISAPPROVED _____ FILED W/SEC. OF STATE 7/11/88

WITHDRAWN _____ RETURNED TO AGENCY _____

✓ Rule as adopted (4 copies)

✓ Notice to Solicit Outside Information/Opinion (if applicable)

9/9/85 Date published in State Register
_____ Comments

_____ ~~Petition for Adoption of a Rule (if applicable)~~

_____ ~~Board's Authorizing Resolution~~

_____ ~~Date adopted~~

✓ Proposed Rule

Yes Revisor's Certificate

✓ Notice of Intent to Adopt Rule

256B.091 Statutory Authority
no Small Business Statement
yes Expenditure of public money statement
yes Signature

✓ Statement of Need and Reasonableness (if applicable)

no Small Business Statement
n/a Fees - § 16A.128

✓ Affidavit of Mailing Notice of Intent to Adopt Rule

3/9/88 Date (30)/25 days before adoption
yes Notice attached
no Copy of rule or summary attached

✓ Publication in State Register

3/14/88 Date (30)/25 days before adoption

_____ 180-day deadline from:

4/13/88 end of comment period (§ 14.26) (rules without hearing)
_____ ~~effective date of statutory authority (§ 14.29) (emergency rules)~~

✓ ~~Resolution Adopting~~

~~6/20/88 Date adopted~~

✓ Findings of Fact, Conclusions & Order Adopting

6/20/88 Date

✓ Written requests, submissions or comments (9)

✓ Declaration of attorney

Deborah Huskins Name of SAAG representing agency

_____ ~~Notice of Submission to Atty. Gen. (if applicable)~~

_____ ~~Aff. of Mailing Notice to Atty. Gen. (if applicable)~~

ATTORNEY GENERAL

July 12, 1988

ELEANOR WEBER
Supervisor

JULIE A. LEPPINK
Special Assistant
Attorney General

6-9421

In the Matter of the Adopted Rule Relating to
Preadmission Screening and Alternative Care Grants

The above-refernced rule has been approved as to its legality by the Attorney General on July 11, 1988.

Enclosed is the agency's copy of the approved rule. This office has already filed two copies with the Secretary of State who will forward one copy to the Revisor of Statutes. The fourth is being retained by this division of the Attorney General's Office for its records.

Also enclosed are any petitions, requests, submission or comments received by the agency and any extra copies of documents which the agency submitted to the Attorney General.

In order for a permanent rule without a hearing to become effective, your agency must publish a notice of adoption in the State Register in accoradance with Minn. Stat. §14.27. An emergency rule becomes effective five working days after approval by the Attorney General; however, the agency must publish a notice in the State Register in accordance with Minn. Stat. §14.34.

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

JAL:rer

Enclosures

cc: Maryanne Hruby
Executive Director
Legislative Commission to Review
Administrative Rules

Duane Harves
Chief Administrative Law Judge
Office of Administrative Hearings

Department of Human Services

Adopted Permanent Rules Relating to Preadmission Screening and Alternative Care Grants

Rules as Adopted

9505.2390 SCOPE AND EFFECT.

Subpart 1. **Scope.** Parts 9505.2390 to 9505.2500 establish the standards and procedures applicable to the preadmission screening and alternative care grant program. The preadmission screening program screens persons who are applicants for admission to a nursing home or nursing home residents who request a screening as required under part 9505.2435, subpart 2. An alternative care grant pays for some community services in lieu of nursing home admission or continued nursing home resident status for persons who meet the requirements of parts 9505.2390 to 9505.2500.

Parts 9505.2390 to 9505.2500 must be read in conjunction with Minnesota Statutes, sections 256B.04, subdivision 2, 256B.05, 256B.091, subdivisions 1 to 9, and Code of Federal Regulations, title 42, sections 440.180 and 441.300 to 441.310. Unless otherwise specified, citations of Code of Federal Regulations, title 42, refer to the code amended as of October 1, 1986.

Parts 9505.2390 to 9505.2500 also must be read in conjunction with the requirements of the waiver obtained by the state from the United States Department of Health and Human Services.

Subp. 2. **Effect.** References to the waiver and waiver provisions that occur in parts 9505.2390 to 9505.2500 shall continue in effect only as long as the waiver from the United States Department of Health and Human Services remains in effect in Minnesota.

9505.2395 DEFINITIONS.

Subpart 1. **Applicability.** The definitions in this part

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apply to parts 9505.2390 to 9505.2500.

Subp. 2. **Adult day care services.** "Adult day care services" means services provided to alternative care grant clients by adult day care programs established under Minnesota Statutes, sections 245A.01 to 245A.17, including adult day care centers licensed under parts 9555.9600 to 9555.9730.

Subp. 3. **Adult foster care services.** "Adult foster care services" means supervised living arrangements for adults in an adult foster care home licensed under parts 9555.5105 to 9555.6265.

Subp. 4. **Alternative care grant or ACG.** "Alternative care grant" or "ACG" means funds allocated to a local agency by the commissioner under Minnesota Statutes, section 256B.091 to pay for alternative care services.

Subp. 5. **Alternative care grant client or ACG client.** "Alternative care grant client" or "ACG client" means a person who has been determined eligible to receive or is receiving services funded by an alternative care grant.

Subp. 6. **Alternative care grant services.** "Alternative care grant services" means the services listed in items A to G provided to ACG clients:

A. case management services;

B. respite care services;

C. homemaker services;

D. home health aide services;

E. adult foster care services;

F. adult day care services; and

G. personal care services.

Subp. 7. **Applicant.** "Applicant" means a person who is seeking admission to a nursing home or who has been admitted to a nursing home but has not yet been screened by the preadmission screening team as required in part 9505.2420.

Subp. 8. **Assessment form.** "Assessment form" means the form supplied by the commissioner that is used to record the information required under parts 9505.2425, subpart 1 and 9505.2455, subpart 12.

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Subp. 9. **Case management services.** "Case management services" means services that identify, acquire, authorize, and coordinate services for an ACG client; monitor the delivery of services to the ACG client; and adjust services to the needs of the ACG client.

Subp. 10. **Case manager.** "Case manager" means a social worker employed by or under contract with the local agency or a registered nurse who is employed by the local public health department and under contract with the local agency to provide case management services. "Local agency" in this subpart refers to the county of service.

Subp. 11. **Commissioner.** "Commissioner" means the commissioner of the Minnesota Department of Human Services or the commissioner's authorized representative.

Subp. 12. **Community services.** "Community services" means home and community-based services including services provided under the ACG as specified in part 9505.2430, subpart 4, item B, subitem (3), that can be used to meet the health or social needs of an ACG client.

Subp. 13. **County of financial responsibility.** "County of financial responsibility" means the county responsible for paying for preadmission screening of a recipient or the county responsible for paying for ACG services under part 9505.2455, subpart 3.

Subp. 14. **County of service.** "County of service" means the county whose local agency performs preadmission screening of an applicant or nursing home resident or arranges case management services for an ACG client. The county of service may be the same as or different from the county of financial responsibility.

Subp. 15. **Delay of screening.** "Delay of screening" means that preadmission screening has not been completed for an applicant but will be completed according to the time requirements established for:

A. emergency admission under part 9505.2420, subpart 3;

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B. preadmission screening of hospital patients under part 9505.2420, subpart 2;

C. 30-day exemption from screening under part 9505.2420, subpart 4; or

D. admission of an applicant from another state under part 9505.2420, subpart 6.

Subp. 16. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 17. **Directory of services.** "Directory of services" means the list of all community services available in a geographic area that is developed under part 9505.2425, subpart 7.

Subp. 18. **Discharge planner.** "Discharge planner" means a person qualified as a public health nurse or a social worker who is employed by a hospital to coordinate the development of an individual service plan of a person who no longer needs the services of the hospital.

Subp. 19. **Emergency admission.** "Emergency admission" means the admission of an applicant from the community to a nursing home before completion of preadmission screening when a physician has determined that the delay in admission needed for preadmission screening would adversely affect the applicant's health and safety. For purposes of this definition, "community" does not include a hospital.

Subp. 20. **Formal caregivers.** "Formal caregivers" means persons or entities providing ACG services who are employed or who are under contract with a local agency, or other agency or organization, public or private.

Subp. 21. **Home health aide.** "Home health aide" means a person who meets the requirements of part 9505.2470 and provides home health aide services to an ACG client.

Subp. 22. **Home health aide services.** "Home health aide services" means services provided under part 9505.2470 that are written in the individual treatment plan. Home health aide services include the performance of procedures as an extension of therapy services, personal care, ambulation and exercise,

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household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the ACG client's condition and needs, and completing necessary records.

Subp. 23. **Homemaker services.** "Homemaker services" means services that assist an ACG client as set forth in items A to G:

A. performing house cleaning activities;

B. laundering, ironing, and mending;

C. meal planning, preparation, and cleanup;

D. assisting with money management;

E. providing companionship, emotional support, and social stimulation;

F. observing and evaluating home safety practices and seeking to improve these practices where appropriate; and

G. performing essential errands and shopping.

Subp. 24. **Hospital.** "Hospital" has the definition given in Minnesota Statutes, section 144.696, subdivision 3.

Subp. 25. **Individual service plan.** "Individual service plan" means the written plan of a community service or a combination of community services designed to meet the health and social needs of an applicant or nursing home resident screened according to part 9505.2430. The individual service plan is the plan of care referred to in Minnesota Statutes, section 256B.091.

Subp. 26. **Individual treatment plan.** "Individual treatment plan" means the written treatment plan of care for providing personal care and home health aide services under part 9505.2475 to an ACG client.

Subp. 27. **Informal caregivers.** "Informal caregivers" means family, friends, neighbors, or others who provide services and assistance to the elderly without the sponsorship of an agency or organization.

Subp. 28. **Local agency.** "Local agency" means the county or multicounty agency that is required under Minnesota Statutes, section 256B.05, to administer the medical assistance program.

Subp. 29. **Medical assistance or MA.** "Medical assistance"

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or "MA" means the program established under title XIX of the Social Security Act and Minnesota Statutes, chapter 256B.

Subp. 30. **Mental illness.** "Mental illness" means an illness as defined in Minnesota Statutes, section 245.462, subdivision 20, clause (2).

Subp. 31. **Nursing home.** "Nursing home" means a facility licensed under Minnesota Statutes, chapter 144A or sections 144.50 to 144.56, that is certified to participate in the medical assistance program as a skilled nursing facility or an intermediate care facility. This definition includes boarding care homes.

Subp. 32. **Nursing home resident.** "Nursing home resident" means a person who resides, and expects to continue to reside, in a nursing home for more than 30 days. For purposes of parts 9505.2390 to 9505.2500, "nursing home resident" does not include a person who is in a nursing home for respite care.

Subp. 33. **Personal care services.** "Personal care services" means services meeting the requirements of part 9505.2465.

Subp. 34. **Personal care assistant.** "Personal care assistant" means a person who provides personal care services under part 9505.2465 and meets the training requirements of part 9505.2465, subpart 2.

Subp. 35. **Person with mental retardation or related conditions.** "Person with mental retardation or related conditions" means a person as defined in part 9525.0015, subpart 20.

Subp. 36. **Physician.** "Physician" means a person who is authorized to practice medicine under Minnesota Statutes, chapter 147.

Subp. 37. **Preadmission screening.** "Preadmission screening" means the activities performed by a preadmission screening team under Minnesota Statutes, section 256B.091, and parts 9505.2390 to 9505.2500. This definition does not include the activities of teams authorized under Minnesota Statutes, section 256B.092, and established in parts 9525.0015 to 9525.0165 and under the Minnesota Comprehensive Mental Health

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Act, Minnesota Statutes, sections 245.461 to 245.486.

Subp. 38. **Preadmission screening document.** "Preadmission screening document" means the document required in part 9505.2495, subpart 1, and supplied by the commissioner.

Subp. 39. **Preadmission screening team.** "Preadmission screening team" means the team authorized in Minnesota Statutes, section 256B.091, and required by part 9505.2410, to assess the financial, health, and social needs of an applicant or a nursing home resident.

Subp. 40. **Primary caregiver.** "Primary caregiver" means the informal caregiver who customarily provides care to the ACG client and cooperates with the case manager in assuring the provision of services by the formal caregivers.

Subp. 41. **Public health nurse.** "Public health nurse" means a registered nurse certified by the Minnesota Department of Health as a public health nurse under Minnesota Statutes, section 145A.02, subdivision 18, and employed by a local board of health under Minnesota Statutes, ~~sections 145.08 to 145.123~~ section 145A.10, subdivision 1.

Subp. 42. **Public health nursing services.** "Public health nursing services" means the nursing ~~services~~ program provided by a board of health under Minnesota Statutes, ~~sections 145.911 to 145.92~~ section 145A.10, subdivision 1.

Subp. 43. **Reassessment.** "Reassessment" means the reevaluation of an ACG client's financial, health, and social needs under part 9505.2455, subparts 11 and 12.

Subp. 44. **Recipient.** "Recipient" means a person who has been determined by the local agency to be eligible for medical assistance under parts 9505.0010 to 9505.0150.

Subp. 45. **Registered nurse.** "Registered nurse" means a person licensed under Minnesota Statutes, section 148.211.

Subp. 46. **Representative.** "Representative" means a person appointed by the court as a guardian or conservator under Minnesota Statutes, sections 252A.01 to 252A.21 or 525.539 to 525.6198 or a parent of a child under age 18 unless the parent's parental rights have been terminated.

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Subp. 47. **Rescreening.** "Rescreening" means the completion of the activities in part 9505.2435, subpart 3, after an initial preadmission screening.

Subp. 48. **Resident class.** "Resident class" refers to the case mix classification required under Minnesota Statutes, section 256B.091, subdivision 2, and assigned to a person as required under parts 9549.0058, subpart 2, and 9549.0059.

Subp. 49. **Resident day.** "Resident day" means a day for which nursing services in a nursing home are rendered or a day for which a nursing home bed is held.

Subp. 50. **Respite care services.** "Respite care services" means short-term supervision, assistance, and care provided to an ACG client due to the temporary absence or need for relief of the ACG client's primary caregiver. Respite care services may be provided in the client's home or in a facility approved by the state such as a hospital, nursing home, foster home, or community residential facility.

Subp. 51. **Room and board costs.** "Room and board costs" means costs associated with providing food and shelter to a person, including the directly identifiable costs of:

A. private and common living space;

B. normal and special diet food preparation and service;

C. linen, bedding, laundering, and laundry supplies;

D. housekeeping, including cleaning and lavatory supplies;

E. maintenance and operation of the building and grounds, including fuel, electricity, water, supplies, and parts and tools to repair and maintain equipment and facilities; and

F. allocation of salaries and other costs related to items A to E.

Subp. 52. **Skilled nursing service.** "Skilled nursing service" refers to the term described in Code of Federal Regulations, title 42, section 405.1224.

Subp. 53. **Social worker.** "Social worker" means a person who has met the minimum qualifications of a social worker under

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the Minnesota Merit System or a county civil service system in Minnesota.

Subp. 54. **Unscreened applicant.** "Unscreened applicant" means an applicant for whom preadmission screening has not been completed under parts 9505.2390 to 9505.2500.

Subp. 55. **Waiver.** "Waiver" means the approval given by the United States Department of Health and Human Services which allows the state to pay for home and community-based services authorized under Code of Federal Regulations, title 42, section 441, subpart G. The term includes all amendments to the waiver including any amendments made after the effective date of parts 9505.2395 to 9505.2500, as approved by the United States Department of Health and Human Services.

Subp. 56. **Working day.** "Working day" means the hours of a day, excluding Saturdays, Sundays, and holidays, when a local agency is open for business.

9505.2396 COMPUTATION OF TIME INTERVALS TO MEET NOTICE REQUIREMENTS.

For purposes of parts 9505.2390 to 9505.2500, a required time interval to meet notice requirements must be computed to exclude the first and include the last day of the prescribed interval of time. The term "day" includes Saturday, Sunday, and holidays unless it is modified as "working day."

9505.2400 PREADMISSION SCREENING REQUIREMENT.

Subpart 1. **Coverage.** The preadmission screening team established by the local agency must complete the preadmission screening of all applicants except individuals who are exempt under subpart 2 and the preadmission screening of current nursing home residents who request a screening. The preadmission screening team shall complete the screening as specified in part 9505.2425, except in the cases of persons with mental retardation or related conditions. Persons with mental retardation or related conditions must be provided services according to parts 9525.0015 to 9525.0165. Persons with mental illness must be provided services according to the Minnesota

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Comprehensive Mental Health Act, Minnesota Statutes, sections 245.461 to 245.486.

Subp. 2. **Exemptions.** The following individuals are exempt from the requirement of subpart 1:

A. a nursing home resident who transfers from one nursing home located within Minnesota directly to another nursing home located within Minnesota, regardless of the location of either nursing home;

B. a nursing home resident who is admitted to a hospital from a nursing home and who returns to a nursing home;

C. a nursing home resident who changes certified levels of care within the same nursing home;

D. an applicant for whom preadmission screening was completed within the previous three months;

E. an applicant who has been screened and who is currently receiving ACG services;

F. an applicant who has been screened and who is currently receiving services from a certified home health agency;

G. an applicant who is not eligible for medical assistance and whose length of residency in a nursing home is expected to be 30 days or less as determined under part 9505.2420, subpart 4;

H. an applicant whose nursing home care is paid for indefinitely by the United States Veterans Administration;

I. an applicant who enters a nursing home administered by and for the adherents of a recognized church or religious denomination described in Minnesota Statutes, section 256B.091, subdivision 4; and

J. an applicant to a nursing home described in Minnesota Statutes, section 256B.431, subdivision 4, paragraph (c).

9505.2405 INFORMATION REGARDING AVAILABILITY OF PREADMISSION SCREENING.

The local agency must annually publish a notice that

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preadmission screening is available to persons in the area served by the local agency. At a minimum, the notice must appear in the newspaper that has the largest circulation within the geographic area served by the local agency. The notice must:

A. explain the purpose of preadmission screening as stated in Minnesota Statutes, section 256B.091, subdivision 1;

B. instruct the public how to contact the preadmission screening team; and

C. state who is subject to and who may request preadmission screening under Minnesota Statutes, section 256B.091, subdivisions 2 and 4, and part 9505.2400.

9505.2410 ESTABLISHMENT OF PREADMISSION SCREENING TEAM.

Subpart 1. **Establishment.** A local agency must establish at least one preadmission screening team to complete preadmission screening of applicants and nursing home residents. In addition, a local agency may contract with a nonprofit hospital to perform the functions of a preadmission screening team under part 9505.2413 for applicants being discharged from the hospital. If a nonprofit hospital performs the functions of a preadmission screening team under contract with a local agency, the hospital's discharge planner shall not be a member of the team unless the applicant is a person being discharged from the hospital. If a nonprofit hospital does not have a contract with the local agency to perform the functions of a screening team, the hospital's discharge planner may be present at the preadmission screenings and may participate in the discussions but not in making the screening team's recommendations.

Subp. 2. **Composition of preadmission screening team.** A preadmission screening team must be composed as specified in items A to C.

A. The preadmission screening team must include a social worker and a public health nurse. The team must also include the applicant's or nursing home resident's physician if the physician chooses to participate.

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B. The social worker of the local agency's preadmission screening team must be employed by or under contract with the local agency and must be designated by name as a member of the preadmission screening team.

C. If a local agency has a human services board organized under Minnesota Statutes, sections 402.01 to 402.10, the local agency must designate by name the public health nurse member of the preadmission screening team. If a local agency does not have a human services board organized under Minnesota Statutes, sections 402.01 to 402.10, the local agency must contract with the board of health organized under Minnesota Statutes, section 145.913, or a public or nonprofit agency under contract with the local agency to provide public health nursing services to provide the public health nurse member of the preadmission screening team. The local board of health or a public or nonprofit agency under contract with the local agency to provide public health nursing services must designate by name the public health nurse member of a preadmission screening team.

Subp. 3. **Number of preadmission screening team members present at screening.** Except as provided in subpart 5, the social worker and the public health nurse designated as members of the preadmission screening team must be present at a preadmission screening. The applicant's or nursing home resident's physician may be present if the physician chooses to participate in the preadmission screening.

Subp. 4. **Physician notification of preadmission screening.** The local agency must notify the physician of the applicant or nursing home resident being screened, by telephone, of the date, time, and place the person's preadmission screening is to take place. The telephone notice must be made on the day that the preadmission screening team schedules the screening. The notice must state the physician's right to participate as a member of the preadmission screening team. No later than ten working days after the telephone notice, the local agency must send the physician a written notice that contains the information given in the telephone notice.

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Subp. 5. **Preadmission screening by public health nurse.** Preadmission screening may be completed by the public health nurse member of the team, in consultation with the social worker, for applicants who are being admitted to a nursing home from a hospital and who are not eligible for medical assistance under parts 9505.0010 to 9505.0150. For the purpose of this subpart, "consultation" means a meeting or telephone conversation between the public health nurse and the social worker that takes place after the public health nurse has completed the preadmission screening. The purpose of the consultation is to discuss the assessment, the recommendation, and, as appropriate, the applicant's individual service plan or the applicant's plans for discharge from the nursing home.

Subp. 6. **Physician consultant to preadmission screening team.** A local agency must designate a physician who practices within the local agency's service area to serve as a consultant to the preadmission screening teams designated under subpart 2.

9505.2413 CONTRACTS FOR PREADMISSION SCREENING TEAM MEMBERS FOR APPLICANTS DISCHARGED FROM HOSPITALS.

The local agency may contract with a nonprofit hospital to provide one or both members of a preadmission screening team to screen applicants being discharged from the nonprofit hospital and to make recommendations for the screened applicants about nursing home admission and community services necessary for the applicant's individual service plan. The contract between the local agency and the nonprofit hospital must:

A. set beginning and ending dates of the contract;

B. specify the duties and responsibilities of the local agency and the nonprofit hospital;

C. specify that a member of the preadmission screening team to be provided by the hospital must be a discharge planner;

D. designate by name the person or persons to be provided by the hospital;

E. require the designated preadmission screening team

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member or members to comply with parts 9505.2390 to 9505.2500;

F. specify that the member or members of the preadmission screening team under contract will screen only applicants being discharged from that nonprofit hospital;

G. designate the person employed by the hospital and the person employed by the local agency who are responsible for proper performance under the contract;

H. state that the nonprofit hospital must complete a preadmission screening for an applicant before the applicant's discharge from the nonprofit hospital;

I. require that a member of the nonprofit hospital's screening team have no direct or indirect financial or self-serving interest in a nursing home or other referral such that it would not be possible for the member to consider each case objectively;

J. specify the amount the local agency must pay the nonprofit hospital for carrying out the terms of the contract;

K. specify the person employed by the hospital who is responsible for implementing appropriate data practices; and

L. specify reports and records to be kept by the nonprofit hospital.

9505.2415 HOSPITAL NOTICE REQUIREMENTS.

Subpart 1. **Notification of preadmission screening team.** Except as indicated under subpart 2, the discharge planner of a hospital must notify the preadmission screening team about a hospital patient who is an applicant. Oral and written notices must be given. The oral notice must be given to the preadmission screening team at least three working days before discharge of the applicant. The hospital must document the oral notice by sending the preadmission screening team a written notice within ten working days after the oral notice. The notice must:

A. provide the name of the applicant;

B. provide the name of the nursing home that the applicant is considering;

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C. provide the applicant's primary diagnosis;

D. indicate the interval in which the applicant is expected to be discharged from the nursing home. The intervals are: less than 30 consecutive days; 30 days but less than three months; three months but less than six months; or six months or more;

E. indicate that the discharge planner gave information to the applicant about the purpose of preadmission screening and community services; and

F. indicate if the discharge planner wants to participate in the preadmission screening.

Subp. 2. **Exception to notice required of hospital.** If the applicant is in the hospital for less than three working days and preadmission screening is not completed, the hospital may discharge the applicant to a nursing home, but the hospital discharge planner must contact the preadmission screening team by telephone or in person before the applicant's discharge and complete the notice required under subpart 1.

9505.2420 TIME REQUIREMENTS FOR PREADMISSION SCREENING.

Subpart 1. **General time requirements.** Except as provided in subparts 2 to 6, the local agency must schedule a preadmission screening within five working days of receiving a request for the preadmission screening from an applicant or an applicant's representative. Except as provided in subparts 2 to 6, the preadmission screening must be completed within the period of ten working days following the applicant's request for preadmission screening.

Subp. 2. **Preadmission screening of hospital patients.** Notwithstanding subpart 1, the local agency must complete the preadmission screening of an applicant who is a hospital patient within three working days of receiving oral notice from the discharge planner under part 9505.2415, subpart 1. However, the local agency may delay the preadmission screening of an applicant who is a hospital patient when, based on information given in the oral notice, the preadmission screening cannot be

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completed before discharge from the hospital and the applicant's discharge plan indicates that the applicant must be admitted to a nursing home. If preadmission screening is delayed and the local agency and the nursing home are located in the same county, the local agency must notify the nursing home orally and in writing of the scheduled date for the preadmission screening and perform the preadmission screening within ten working days after the applicant's admission to the nursing home.

If preadmission screening is delayed and the nursing home and the local agency are located in different counties, the local agency of the county in which the nursing home is located must be responsible for the preadmission screening. The local agency of the county in which the hospital is located must send an oral and a written notice of the applicant's discharge plan to the local agency in the county where the nursing home is located. Oral notice must be given on the day that the local agency of the county in which the hospital is located delays preadmission screening. The written notice must be sent within ten working days after the oral notice. The written notice must include a copy of the delay-of-screening form completed by the local agency of the county in which the hospital is located and a copy of the hospital's discharge notice. The preadmission screening team from the local agency in the county where the nursing home is located must then notify the nursing home orally and in writing of the scheduled date for the preadmission screening and perform the preadmission screening within ten working days after the applicant's admission to the nursing home.

Subp. 3. **Emergency admission.** When preadmission screening is not completed due to an emergency admission, the procedures in items A to C must be followed.

A. The attending physician must certify the reason for the emergency in the applicant's medical record.

B. The nursing home must orally notify the preadmission screening team within two working days after the date of the emergency admission.

C. The preadmission screening team must complete the

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preadmission screening of the applicant within ten working days of the date of the applicant's admission to the nursing home or within ten working days after receiving the oral referral for preadmission screening, whichever is earlier.

Subp. 4. **Thirty-day exemption from preadmission screening.** A local agency must grant a 30-day exemption from preadmission screening to applicants who are not eligible for medical assistance if the requirements in items A and B are met.

A. The nursing home must notify the local agency of the applicant's admission no later than the day of the applicant's admission to the nursing home. The notice must include information stating that the requirements of item B have been met.

B. The attending physician must certify in the applicant's medical record in the nursing home that the applicant's expected length of stay in the nursing home will be 30 consecutive days or less.

The preadmission screening team of the local agency that has determined that the applicant's request for a 30-day exemption from preadmission screening meets the requirements in items A and B must complete and send the nursing home a form supplied by the commissioner authorizing the 30-day exemption and at the same time must send a copy of the form to the applicant.

The nursing home must provide an update to the preadmission screening team before or on the 30th day of the applicant's stay if the applicant will continue to live in the nursing home for more than 30 consecutive days. The local agency must complete preadmission screening within ten working days after the 30th day unless the applicant is discharged within these ten working days, does not return to the nursing home, and does not become an applicant to a different nursing home.

Subp. 5. **Nursing home applicant admitted to a hospital from a nursing home before completion of preadmission screening.** The local agency must complete preadmission screening of a nursing home applicant who has been admitted to a nursing home

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within the periods required under subparts 1 to 4 unless the nursing home applicant is admitted to a hospital during these periods. If a nursing home applicant is admitted to a hospital during the periods under subparts 1 to 4, the preadmission screening time requirements begin again on the date of readmission to the nursing home.

Subp. 6. **Applicant from another state.** When an applicant from another state is admitted to a nursing home in Minnesota, the nursing home must notify the preadmission screening team within two working days after the date of the admission. The notice may be oral or written. The preadmission screening team must then complete the preadmission screening of the applicant within ten working days after the date of admission to the nursing home.

9505.2425 SCREENING AND ASSESSMENT PROCEDURES REQUIRED DURING PREADMISSION SCREENING.

Subpart 1. **General requirements.** The preadmission screening team must assess the health and social needs of the applicant or nursing home resident being screened using the assessment form provided by the commissioner. The preadmission screening team must carry out the responsibilities specified in subparts 2 to 14 and the duties listed in part 9505.0295, subpart 3, item C. The preadmission screening team must ask whether the person being screened has been determined eligible for or is receiving medical assistance and must give a person whose eligibility for medical assistance has not been determined information about making a medical assistance application.

Subp. 2. **Assessment interview.** The preadmission screening team must conduct the assessment in a face-to-face interview with the person being screened and the person's representative, if any.

Subp. 3. **Information given to person being screened by screening team during preadmission screening.** The preadmission screening team must give the person being screened or the person's representative the form or forms supplied by the

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commissioner containing the information specified in items A to E:

A. the purpose of the preadmission screening and alternative care grant program under Minnesota Statutes, section 256B.091;

B. the person's freedom to accept or reject the recommendation of the preadmission screening team;

C. the person's right to confidentiality under the Minnesota Government Data Practices Act, Minnesota Statutes, chapter 13;

D. the person's right to appeal the preadmission screening team's recommendation under part 9505.2500 and Minnesota Statutes, sections 256.045, subdivisions 2 and 3 and 256B.091, subdivision 5; and

E. if the person is not a recipient, the right of the person and the person's spouse to retain liquid assets up to the amount specified in Minnesota Statutes, sections 256B.14, subdivision 2; 256B.17; and 256B.48.

The preadmission screening team must document compliance with this subpart by signing and placing in the local agency's records of the person being screened the forms supplied by the commissioner that state the required information was given to the person being screened.

Subp. 4. **Access to medical records.** The preadmission screening team must ask the person being screened or the person's representative to sign forms necessary to authorize the team's access to the person's medical records. Furthermore, a nursing home or a hospital's discharge planner that conducts a preadmission screening must ask the person being screened or the person's representative to sign forms necessary to authorize the team's access to information that is needed to complete preadmission screening for the person. If the person or the person's representative agrees to sign the forms, the authorization must be completed as prescribed in subpart 14.

Subp. 5. **Preadmission screening team recommendations.** After completing the assessment form required in subpart 1, the

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preadmission screening team must offer the person being screened or the person's representative the most cost-effective alternatives available to meet the person's needs and must recommend one of the choices specified in items A to E.

A. The preadmission screening team must recommend admission to a nursing home for an applicant or continued stay for a nursing home resident when the assessment indicates that the applicant or nursing home resident requires community services that are not available or that the anticipated cost of providing the required community services would exceed the annual monthly statewide average payment of the resident class under parts 9549.0050 to 9549.0059 that would be applicable to the person being screened if the person were placed in a nursing home, calculated from the payments made for that resident class in the previous fiscal year.

B. The preadmission screening team must recommend use of community services when the assessment indicates that the community services needed by the person are available and the anticipated cost of providing the community services is less than the total annual statewide monthly average payment of the resident class under parts 9549.0050 to 9549.0059 that would be applicable to the person if the person were placed in a nursing home, calculated from the payments made for that resident class in the previous fiscal year.

C. The preadmission screening team must recommend that the person live in the community without community services if the assessment indicates that the person does not need either admission to a nursing home or community services.

D. A preadmission screening team that has reason to believe that a person being screened has or may have a diagnosis of mental retardation or related conditions must refer the person for services including screening, development of the individual service plan, and case management services according to parts 9525.0015 to 9525.0165.

E. A preadmission screening team that has reason to believe that a person being screened has been diagnosed or may

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be diagnosed as mentally ill must refer the person for a diagnostic assessment as defined in Minnesota Statutes, section 245.462, subdivision 9. If the person is determined by the diagnostic assessment to have serious and persistent mental illness as defined in Minnesota Statutes, section 245.462, subdivision 20, and the person chooses community services under an ACG, the preadmission screening team must establish the individual service plan as required in part 9505.2430, subpart 4, and assure the assignment of a case manager as specified in part 9505.2430, subpart 6. The case manager shall incorporate the person's individual community support plan as defined in Minnesota Statutes, section 245.462, subdivision 12, into the person's individual service plan and shall coordinate the person's services that are specified in the Comprehensive Mental Health Act, Minnesota Statutes, sections 245.461 to 245.486.

Are you awake?

Subp. 6. **Required application for ACG services.** If the person being screened chooses to remain in the community with community services the preadmission screening team must request the person or the person's representative to sign an application for the community services under the ACG. To be eligible to receive the community services under the ACG, the person being screened or the person's representative must sign the application. The application shall be on a form prescribed by the commissioner.

Subp. 7. **Use of directory of services during preadmission screening.** The preadmission screening team must use a directory of services provided by the local agency during the preadmission screening in determining the individual service plan of a person being screened. The local agency must make a directory of services available to the preadmission screening team, the person being screened, and other persons present at a screening. The local agency may compile its own directory of services or use a directory prepared by a community resource. In either event, the directory must be one that is updated annually.

Subp. 8. **Notification of preadmission screening team**

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recommendation. The preadmission screening team must give or send a written notice stating the team's recommendation to the person being screened, the person's representative, if any, and the person's physician. The preadmission screening team must also send the written notice to the county of financial responsibility. Both types of notice must be given or sent within ten working days after the date of the request for the preadmission screening.

Subp. 9. **Individual service plan.** The preadmission screening team must develop an individual service plan according to part 9505.2430 when the person or the person's representative chooses to use community services.

Subp. 10. **Submittal of ACG client information to county of financial responsibility.** If the county of service is different from the county of financial responsibility for an ACG client, the county of service must submit client information to the county of financial responsibility for approval of the individual service plan. The information must include items A to D:

A. ~~the original preadmission screening assessment form, including~~ the original individual service plan;

B. the original signed application if required under subpart 6;

C. the original preadmission screening document; and

D. a copy of the completed financial information form required in part 9505.2455, subpart 1, item C.

Subp. 11. **County of financial responsibility review of individual service plan.** The county of financial responsibility for an ACG client under part 9505.2455, subpart 3, must approve or reject the proposed individual service plan under items A to E and part 9505.2455, subpart 2.

A. If the costs of ACG services, together with the costs of skilled nursing services provided by public health nursing services that are reimbursable under medical assistance, if applicable, do not exceed the cost limitations in subpart 5, item B, the county of financial responsibility must approve the

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proposed individual service plan. If the cost of ACG services together with the costs of skilled nursing services provided by public health nursing services that are reimbursable under medical assistance exceeds the cost limitations in subpart 5, item B, the county of financial responsibility must reject the individual service plan. Rejection of an individual service plan by the county of financial responsibility shall occur only if cost limitations of subpart 5, item B, are not met. If the county of financial responsibility and the county of service are the same, the county shall not reject the individual service plan prepared by the county's preadmission screening team if the individual service plan falls within the cost limitations of subpart 5, item B.

B. The county of financial responsibility must orally notify the preadmission screening team of the approval or rejection of the individual service plan within three working days after receiving the plan from the county of service. The county of financial responsibility must mail a written notice to the preadmission screening team within ten working days after receiving the individual service plan.

C. If the individual service plan is approved by the county of financial responsibility, the county of service must implement the plan upon oral notice of approval from the county of financial responsibility.

D. If the individual service plan is rejected by the county of financial responsibility because it exceeds the cost limitations in subpart 5, item B, the oral and written notice of rejection sent to the preadmission screening team must explain the reasons for the rejection and define the corrections needed to obtain approval. The preadmission screening team must develop a revised individual service plan for an ACG client whose initial individual service plan was rejected by the county of financial responsibility. The preadmission screening team must send the revised individual service plan to the county of financial responsibility within ten days after receiving the oral rejection.

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E. If the revised individual service plan includes ACG services that meet the cost limitations in subpart 5, item B, the county of financial responsibility must approve the individual service plan and orally notify the preadmission screening team of the approval within three working days after receiving the revised plan. The county of financial responsibility must send a written notice of approval to the preadmission screening team within ten working days after receiving the revised plan.

Subp. 12. **Sending individual service plan to county of service.** If the county of financial responsibility approves an individual service plan, the preadmission screening team must send the written individual service plan to the county of service within ten working days after the approval.

Subp. 13. **Resident class assessment.** The preadmission screening team must complete the resident class assessment of the applicant required under parts 9549.0058 and 9549.0059 for an applicant who is not exempt from preadmission screening under part 9505.2400, subpart 5, or 9549.0059, subpart 1, item A, subitem (2). The resident class assessment shall be completed concurrently with preadmission screening performed within the time requirements of part 9505.2420.

Subp. 14. **Authorization to release information.** When a preadmission screening team, nursing home, or hospital's discharge planner asks a person being screened or the person's representative to sign forms needed to have access to information necessary to complete the preadmission screening, the following information must be on the form above the person's signature:

A. the person's name;

B. the date;

C. the information authorized;

D. who is authorized to give the information;

E. to whom the information is to be given;

F. the information's use during the screening to determine the appropriateness of nursing home admission or

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continued nursing home placement or use of community services for the person; and

G. the date of expiration of the authorization.

A separate form must be completed and signed for each authorization of access to a medical record. The period of the authorization must not exceed one year.

9505.2426 APPLICANT'S AND NURSING HOME RESIDENT'S RIGHT TO CHOOSE COMMUNITY SERVICES.

After completion of the preadmission screening required under part 9505.2425, subpart 5, or the rescreening required under part 9505.2435, the applicant, nursing home resident, or the representative of the applicant or nursing home resident shall decide whether to accept or reject the recommendations of the preadmission screening team. If the applicant, nursing home resident, or the representative of the applicant or nursing home resident who is eligible for ACG services decides to receive the ACG services identified in his or her individual service plan, the applicant, nursing home resident, or the representative of the applicant or nursing home resident shall have the freedom to choose among the ACG providers under contract with the local agency to provide the identified ACG services.

9505.2430 ESTABLISHMENT OF INDIVIDUAL SERVICE PLAN.

Subpart 1. **Individual service plan required.** The preadmission screening team must establish an individual service plan for each applicant or nursing home resident who requests preadmission screening and who has been assessed under part 9505.2425, and who has chosen community services except persons referred under part 9505.2425, subpart 5, items D and E. The preadmission screening team must consult the applicant or nursing home resident or the person's representative in establishing the plan. Additionally, the preadmission screening team must ask the applicant or the nursing home resident or the representative of the applicant or nursing home resident whether he or she chooses to have other persons consulted about the plan. The preadmission screening team must consult the persons

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that the applicant, nursing home resident, or the representative of the applicant or nursing home resident has designated by name to be consulted about the plan.

Subp. 2. **Request for information about eligibility for medical assistance or 180-day eligibility determination.** The preadmission screening team must ask the applicant, nursing home resident, or the representative of the applicant or nursing home resident whether the applicant or nursing home resident receives medical assistance, is a recipient, or would be eligible to receive medical assistance within 180 days after admission to a nursing home. If the preadmission screening team has reason to believe the person being screened would be eligible to receive medical assistance within 180 days after admission to a nursing home, the preadmission screening team must estimate what the person's financial eligibility would be 180 days after admission using a form prescribed by the commissioner.

Subp. 3. **Individual service plan for a person not eligible for an ACG.** The individual service plan prepared by the preadmission screening team for a person being screened who is not eligible for an ACG must document compliance with items A to D:

A. the preadmission screening team determined that the person is not eligible for community services funded by an ACG under part 9505.2455, subpart 2;

B. the preadmission screening team discussed with the person the community services identified as needed in the assessment under part 9505.2425;

C. the preadmission screening team told the person what information is available in the directory of services; and

D. the preadmission screening team gave a copy of the individual service plan to the person.

Subp. 4. **Individual service plan for a person who is eligible for an ACG.** The individual service plan prepared by the preadmission screening team for a person being screened who is eligible for an ACG must document compliance with items A to D. The person or the person's representative and a member of

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the preadmission screening team must sign the individual service plan. The preadmission screening team must give the person or the person's representative a copy of the individual service plan.

A. The preadmission screening team has determined that the person being screened is eligible for community services funded by an ACG under part 9505.2455, subpart 2.

B. Recommendation of an individual service plan that identifies:

(1) any treatment prescribed by the individual's attending physician as necessary and any follow-up treatment as necessary;

(2) the community services needed by the person;

(3) the available providers of the identified community services including ACG service providers under contract with or employed by the local agency and informal support networks such as family, friends, volunteers, and church groups;

(4) the needed frequency of the services;

(5) the initial date on which each service must begin;

(6) the funding sources for the community services;

(7) the estimated cost of skilled nursing services provided by public health nursing services;

(8) the total cost of the ACG services;

(9) an estimate of the total cost of the community services; and

(10) the name of the case manager assigned by the county of service.

C. The preadmission screening team allowed the person or the person's representative to choose among the available providers listed in the directory of services who are under contract with or employed by the county of service.

D. The preadmission screening team reviewed the individual service plan with the person or the person's

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representative at the time of the completion of the preadmission screening.

Subp. 5. **Sliding fee information.** The preadmission screening team must tell the person being screened who would be eligible to receive medical assistance within 180 days after admission to the nursing home about the amount of the sliding fee that the person is required to pay for alternative care grant services according to the sliding fee schedule established by the commissioner under Minnesota Statutes, section 256B.091, subdivision 8, if the person will be receiving ACG services under an individual service plan developed under subpart 4.

Subp. 6. **Assignment of case manager.** Upon completion of the individual service plan, the local agency of the county of service shall assign a case manager to implement the individual service plan prepared for an ACG client under subpart 4.

9505.2435 RESCREENING.

Subpart 1. **Applicability.** The preadmission screening team must conduct a rescreening when the local agency receives either a written or oral request under subpart 2 suggesting that a recommendation resulting from a rescreening would differ from the recommendation given by the preadmission screening team at the last preadmission screening. Rescreenings must be conducted for all persons who meet the above criteria except ACG clients.

Subp. 2. **Request for rescreening.** The applicant, nursing home resident, or person's representative must submit a request to the local agency to be rescreened when the applicant or nursing home resident meets the criteria in subpart 1. The request may be oral or written and must state the date and location of the person's last preadmission screening and any changes in the person's health and social needs that have occurred since the last screening.

Subp. 3. **Rescreening procedure.** The rescreening must be conducted according to the procedures for preadmission screening in parts 9505.2390 to 9505.2450.

Subp. 4. **Reimbursement for rescreening.** Reimbursement to

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the local agency for rescreening must be the same as reimbursement of a preadmission screening under parts 9505.2440 and 9505.2445.

9505.2440 PREADMISSION SCREENING RATE.

For rate years beginning on January 1 following the effective date of parts 9505.2390 to 9505.2500, the commissioner shall annually establish the maximum statewide rate allowed for reimbursement of preadmission screening and the maximum reimbursement rate of a local agency for preadmission screening. The maximum statewide rate and the maximum reimbursement rate of a local agency shall not exceed the prior year's rate by more than the percentage change between the two previous Junes in the all urban consumer price index (CPI-U) for Minneapolis-St. Paul new series index (1967=100) as published by the Bureau of Labor Statistics, United States Department of Labor. The CPI-U is incorporated by reference and is available from the Minitex interlibrary loan system. The CPI-U is subject to frequent change. By January 15 of each year, the commissioner must send a written notice of the maximum reimbursement rate to a local agency.

9505.2445 **REIMBURSEMENT FOR PREADMISSION SCREENING.**

Subpart 1. County of financial responsibility for preadmission screening of a recipient. The county of financial responsibility for a recipient is as defined in Minnesota Statutes, chapter 256G.

Subp. 2. **Medical assistance reimbursement for preadmission screening of a recipient.** The medical assistance program must reimburse a local agency for the preadmission screening of a recipient if the local agency has complied with the time requirements of part 9505.2420. The local agency of the county of financial responsibility shall submit invoices for reimbursement of preadmission screening costs for a recipient to the department at the times and as required in part 9505.0450, subpart 2.

Subp. 3. **Reimbursement for preadmission screening of**

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persons who are not recipients. Reimbursement for the preadmission screening of persons who are not recipients must be made according to Minnesota Statutes, section 256B.091, subdivision 4.

Subp. 4. **Required local agency estimate of the cost and number of preadmission screenings of persons other than recipients.** Annually by February 15, a local agency must prepare and submit to the department an estimate for the following state fiscal year of the number and costs of preadmission screenings of persons who are not recipients and who will be applicants or nursing home residents for whom the county will provide preadmission screening.

Subp. 5. **Local agency's allocation of cost estimate to a nursing home.** Using the annual estimate of the number and costs of preadmission screenings required in subpart 4, a local agency must calculate the monthly amount to be paid by a nursing home to the local agency for preadmission screenings performed by the local agency for the following state fiscal year. The amount must be based on the nursing home's percentage of the number of licensed beds in nursing homes in the county of the local agency. The local agency must submit the amount to the nursing home by February 15.

Subp. 6. **Reconciliation of estimate required in subpart 4 with actual cost.** Annually by January 15, the department shall reconcile its estimated cost of a nursing home's number of preadmission screenings of persons who are not recipients as calculated under subpart 4 with the actual cost of preadmission screenings of these persons performed in the previous state fiscal year. The department shall notify the local agency of the amount of the overpayment or underpayment that the local agency must use in completing the calculation required under subpart 4.

9505.2450 PENALTIES.

Subpart 1. **Penalty to nursing home for admission of an unscreened applicant.** A nursing home that admits an unscreened

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applicant who is subject to the preadmission screening requirement under part 9505.2400 or that fails to notify the preadmission screening team about an emergency admission as required under part 9505.2420, subpart 3, item B, is subject to the penalties in items A to C.

A. If the applicant is a recipient, the nursing home must not be reimbursed by medical assistance for the applicant's resident days that preceded the date of completion of the applicant's assessment by the preadmission screening team under part 9505.2425. Furthermore, the nursing home must not bill an unreimbursed resident day to the unscreened applicant who is a recipient.

B. If the applicant is not a recipient, the nursing home must not bill the applicant for the applicant's resident days that preceded the date of completion of the applicant's assessment by the preadmission screening team under part 9505.2420.

C. The nursing home must include an unreimbursed resident day in the nursing home's resident day total reported to the department for the purpose of rate calculation under parts 9549.0010 to 9549.0080.

Subp. 2. Penalty to county of service for late screening. A county of service required to act within the time requirements in part 9505.2420 that fails to act within the time requirements shall not receive reimbursement for the preadmission screening under part 9505.2445, subparts 2 and 3, from medical assistance in the case of a recipient or from the nursing home in the case of a person who is not a recipient. Under these circumstances, the county of service shall be solely responsible for the costs of the preadmission screening. Nevertheless, the county of service must complete the preadmission screening as required in parts 9505.2400 and 9505.2425.

9505.2455 ALTERNATIVE CARE GRANTS.

Subpart 1. **Preadmission screening determination of eligibility.** The preadmission screening team must determine if

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the applicant or nursing home resident is eligible for an ACG under the criteria in subpart 2. If the person being screened is eligible for an ACG, the preadmission screening team must:

A. determine the county of financial responsibility according to subpart 3;

B. determine the county of service; and

C. determine the amount of the fee to be paid by the person if the person would be eligible to receive medical assistance within 180 days after admission to a nursing home. The amount of the sliding fee must be determined according to the sliding fee schedule established by the commissioner under Minnesota Statutes, section 256B.091, subdivision 8, and on forms provided by the commissioner.

Subp. 2. Eligibility criteria. A person is eligible for an ACG if the person meets the criteria in items A to ~~G~~ H:

A. the person has been screened by the preadmission screening team;

B. the person is 65 years or older;

C. the person is a recipient or is eligible for medical assistance under parts 9505.0010 to 9505.0150 or would be eligible to receive medical assistance within 180 days after admission to a nursing home;

D. the person would require nursing home care if community services were not available;

E. the person is an applicant who chooses to remain in the community and use community services or a nursing home resident who chooses to leave the nursing home and receive community services;

F. the person requires community services that cannot be provided by services funded by sources other than alternative care grants;

G. the person has completed an application for community services; and

H. the cost of an ACG is within the monthly limitation specified in subpart 8.

Subp. 3. Determination of county of financial

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responsibility for alternative care grants. The preadmission screening team must determine the county of financial responsibility for an ACG client according to item A or B.

A. The county of financial responsibility for an ACG client who is a recipient is the county as defined in Minnesota Statutes, chapter 256G.

B. When ACG services begin, the county of financial responsibility for an ACG client who would be eligible to receive medical assistance within 180 days after admission to a nursing home is the county of financial responsibility as defined in Minnesota Statutes, chapter 256G for medical assistance recipients.

Subp. 4. **Use of alternative care grants.** ACG services may be reimbursed through an ACG if the person is eligible under subpart 2 and if the services are identified as needed in the ACG client's individual service plan and if the services are subject to the rates established in part 9505.2490. However, reimbursement for respite care services is limited to payment for 30 days of service in one state fiscal year.

Subp. 5. **Supplies and equipment.** If the ACG client is a recipient and the supplies and equipment are covered services under part 9505.0310, the cost of the supplies and equipment shall be paid as provided in the medical assistance program under parts 9505.0170 to 9505.0475 to the extent that reimbursement of the cost is not available from Medicare and a third party payer as defined in part 9505.0015, subpart 46. A local agency shall use ACG money to buy or rent care-related supplies and equipment for an ACG client as specified in items A to C.

A. If the supplies and equipment are not covered services under part 9505.0310 or the ACG client is not a recipient and the cost of the supplies and equipment for the ACG client is not more than $100 per month, the local agency shall authorize the use of ACG funds.

B. If the supplies and equipment are not covered services under part 9505.0315 or the ACG client is not a

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recipient and the cost of the supplies and equipment exceeds $100 per month, the local agency must obtain prior authorization from the department to use ACG funds to pay the cost of the supplies and equipment. For purposes of this subpart, "prior authorization" means written approval and authorization given by the department to the local agency before the purchase or rental of the supply or equipment.

C. The department shall have the right to determine whether the supplies and equipment are necessary to enable the client to remain in the community. If the department determines that the supplies and equipment are necessary to enable the ACG client to remain in the community and if the cost of the supplies and equipment together with all other ACG services and skilled nursing services provided by public health nursing services is less than the limitation in subpart 8, the department shall authorize the use of the ACG funds to pay the cost.

Subp. 6. **Supervision costs.** The cost of supervising a home health aide or personal care assistant must be included in the rate for home health aide or personal care services, unless payment for the cost of supervision is included in the rate for skilled nursing service. If the cost of supervising a home health aide or personal care assistant is included in the rate for skilled nursing service, the cost must not be included in the payment for a home health aide or personal care assistant. The cost of supervising an alternative care grant service other than a personal care service or a health aide service must be included in the rate for the service.

Subp. 7. **Unallowable costs.** Alternative care grants must not be used:

A. to establish community services for which funding sources are available through other programs;

B. to pay for community services that can be reimbursed through other funding sources including Medicare and third party payers as defined in part 9505.0015, subpart 46;

C. to pay for room and board costs except for respite

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care provided outside of the ACG client's residence; or

D. to pay providers that are not under contract with the local agency under Minnesota Statutes, section 256B.091, subdivision 8.

Subp. 8. **Costs included within the monthly limitation of an ACG to an ACG client.** In a calendar month, the total cost of an ACG to an ACG client must not exceed the total statewide monthly average payment of the resident class to which the ACG client would be assigned under parts 9549.0050 to 9549.0059, calculated from the payments made for that resident class in the previous fiscal year. The following costs must be included in determining the total costs of an ACG:

A. cost of all ACG services;

B. cost of skilled nursing services provided by public health nursing services and reimbursable under parts 9505.0170 to 9505.0475; and

C. cost of supplies and equipment funded by an ACG.

Subp. 9. **Criteria for selection as an ACG provider.** A provider who provides ACG services must meet the criteria in items A and B.

A. The provider must be employed by or have contracted with the local agency to provide ACG services.

B. The provider must meet all licensure requirements and professional standards established in Minnesota Statutes, Minnesota Rules, and the Code of Federal Regulations that apply to the services provided.

Subp. 10. **Contract for ACG services.** If the local agency contracts with a provider under subpart 9, the contract must:

A. set beginning and ending dates for the term of the contract;

B. specify the duties and responsibilities of the local agency and the provider;

C. require the provider to comply with parts 9505.2390 to 9505.2500;

D. specify the amount that the local agency must reimburse the provider for the services;

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E. specify reports and record retention required of the provider by the local agency;

F. specify the conditions under which the local agency shall terminate the provider's contract; and

G. specify documentation of an individual abuse prevention plan that complies with parts 9555.8000 to 9555.8500 if such a plan is required of the provider by Minnesota Statutes, section 626.557.

Subp. 11. **Reassessment of ACG clients.** A face-to-face reassessment of an ACG client must be conducted by the case manager at least once every six months after ACG services have begun. The case manager must also reassess an ACG client when the case manager determines that changes in the health and social needs or the financial status of the ACG client require revisions in the individual service plan. When an ACG client leaves the county of service and establishes residence in another Minnesota county, the case manager responsible for implementing the ACG client's individual service plan must notify the local agency of the other county about the client's change in residence and request the other county to assign a case manager and conduct a reassessment.

Subp. 12. **Record of reassessment.** At the time of an ACG client's reassessment, the case manager must complete an assessment form and give the ACG client an information form or forms supplied by the commissioner containing the information required in part 9505.2425, subpart 3, items C to E. The case manager must document in the ACG client's case record that the client received the required information. The ACG client's case record of reassessment shall contain at least the information in items A to G:

A. the completed assessment form;

B. the reason for the reassessment;

C. a redetermination of financial eligibility for the ACG client;

D. the names and relationship to the client of the persons consulted during the reassessment;

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E. any revisions of the individual service plan that will occur in type, frequency, and cost of ACG services resulting from the reassessment;

F. a completed quality assurance and review (QA&R) form, as required by part 9549.0059, with an estimate of the client's resident class; and

G. a recomputed sliding fee for the client who would be eligible to receive medical assistance within 180 days after admission to a nursing home.

9505.2458 CASE MANAGER ACTIONS TO ASSURE SAFETY AND HEALTH OF ACG CLIENT WHO IS A VULNERABLE ADULT.

A case manager who has reason to believe an ACG client who is a vulnerable adult is or has been subject to abuse or neglect as defined in Minnesota Statutes, section 626.557, subdivision 2, that occurs at the client's residence or the place where the client receives the ACG service shall immediately comply with the reporting and other actions required under Minnesota Statutes, section 626.557, and shall determine how to assure the client's health and safety during the local agency's investigation. The case manager shall determine whether to withdraw the services, ~~provide~~ work out another living arrangement for the client, or arrange for the services of another ACG provider. When the case manager receives the findings of the local agency's investigation, the case manager shall amend the ACG client's individual service plan as needed to assure the client's health and safety.

9505.2460 LOCAL AGENCY SELECTION OF ACG PROVIDERS.

Subpart 1. **Public meeting to inform providers.** The local agency must hold an annual public meeting with possible providers of ACG services to inform providers about the criteria for provider selection as listed in subpart 4 and the date by which requests to be an ACG provider must be submitted to the local agency. The local agency may hold the annual public meeting at a time convenient to its schedule for completing service contracts to be included in its annual plan. The local

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agency must document that the notice required in subpart 2 was given and that the public meeting was held.

Subp. 2. **Notice of annual public meeting.** The local agency must place a notice of the public meeting required under subpart 1 in the newspaper that is the official newspaper designated by the county board of commissioners of the local agency under Minnesota Statutes, section 279.08. The notice must appear at least 14 days before the public meeting and must state the date, time, and place of the meeting, the type of services for which a need is anticipated, the criteria in subpart 3 for selection as an ACG provider, the date by which the local agency will complete its selection of ACG providers, and the name, telephone number, and address of the local agency's contact person who can provide information about the criteria for selection and contract terms.

Subp. 3. **Selection criteria.** The local agency must select providers for ACG contracts as required in Minnesota Statutes, section 256B.091, subdivision 8, using the criteria in items A to G and other criteria established by the local agency that are consistent with items A to G:

A. the need for the particular service offered by the provider;

B. ~~the service needs of the ACG clients of the local agency~~ the population to be served including the number of ACG clients ~~to be served~~, the length of time service will be provided, and the ~~health status~~ medical condition of the ACG clients;

C. the geographic area to be served;

D. the quality assurance methods to be used by the provider including compliance with required licensures, certifications, or standards and supervision of employees as required by parts 9505.2390 to 9505.2500;

E. the rate for each service or unit of service exclusive of county administrative costs;

F. evaluation of services previously or currently provided by the provider; and

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G. the provider's previous compliance with contract provisions and future ability to comply with contract provisions including billing requirements, and terms related to contract cancellation and indemnification. The local agency must evaluate the ACG services that it provides to ACG clients using the criteria in this subpart.

Subp. 4. **Written record of reason for not selecting a provider.** A local agency must keep a written record of the reason a provider who requests a contract to provide ACG services was not selected and must notify the provider of the reasons.

9505.2465 STANDARDS FOR PERSONAL CARE SERVICES.

Subpart 1. **Definitions.** For purposes of this part, the following terms have the meanings given them.

A. "Personal care provider" means a home health agency that meets the requirements of subpart 5 and is under contract to the local agency to provide personal care assistants or a local agency licensed as a home health agency under Minnesota Statutes, sections 144A.43 to 144A.47, or registered under Minnesota Statutes, section 144A.49.

B. "Personal care service" means a service listed in subpart 3 that is ordered by a physician and provided by a personal care assistant to an ACG client to maintain the ACG client in his or her residence.

Subp. 2. **Training requirements.** Personal care services must be provided by a personal care assistant who has successfully completed one of the training requirements in items A to E:

A. a homemaker or home health aide preservice training program using a curriculum recommended by the Minnesota Department of Health;

B. a nursing assistant training program or its equivalent for which competency as a nursing assistant is determined according to a test administered by the State Board of Vocational Technical Education;

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C. an accredited educational program for registered nurses or licensed practical nurses;

D. a training program that provides the personal care assistant with skills required to perform the services specified in subpart 3; or

E. determination by the supervising registered nurse that the personal care assistant has, through training or experience, the skills required to perform the duties specified in subpart 3.

Subp. 3. **Personal care services.** The duties specified in items A to N are components of personal care services:

A. bowel and bladder care;

B. skin care done to maintain the health of the skin, including prophylactic routine and palliative measures such as exposure to air, use of nondurable medical equipment, application of lotions, powders, ointments, and treatments such as heat lamp and foot soaks;

C. range of motion exercises;

D. respiratory assistance;

E. transfers;

F. bathing, grooming, and hairwashing necessary for personal hygiene;

G. turning and positioning;

H. assistance with furnishing medication that is ordinarily self-administered;

I. application and maintenance of prosthetics and orthotics;

J. cleaning equipment;

K. dressing or undressing;

L. assistance with food, nutrition, and diet activities;

M. accompanying an ACG client to obtain medical diagnosis or treatment and to attend other activities such as church if the personal care assistant is needed to provide personal care services while the recipient is absent from his or her residence; and

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N. performing other services essential to the effective performance of the duties in items A to M.

Subp. 4. **Employment of personal care assistants.** A personal care assistant who provides personal care services under the ACG program is not an employee of the ACG client but must be employed by or under contract with a personal care provider. A personal care assistant employed by a personal care provider must meet the training requirements in subpart 2. The personal care provider shall terminate the personal care assistant's employment or assignment to an ACG client if the supervising registered nurse determines that the personal care assistant is not performing satisfactorily.

Subp. 5. **Personal care provider; eligibility.** Except as provided in subpart 11, a local agency that is not licensed as a home health agency under Minnesota Statutes, sections 144A.43 to 144A.47 or registered under Minnesota Statutes, section 144A.49, and that wants to provide personal care services under the ACG program must contract with a personal care provider to provide the personal care services. To be eligible to contract with the local agency as a personal care provider, the provider must meet the criteria in items A to K. The local agency must assure the provider's compliance with the criteria in items A to K:

A. be licensed as a home health agency under Minnesota Statutes, sections 144A.43 to 144A.47, or registered under Minnesota Statutes, section 144A.49;

B. possess the capacity to enter into a legally binding contract;

C. possess demonstrated ability to fulfill the responsibilities in this subpart and subpart 6;

D. demonstrate the cost effectiveness of its proposal for the provision of personal care services;

E. demonstrate a knowledge of, sensitivity to, and experience with the special needs, including communication needs, and the condition of the ACG client;

F. provide a quality assurance mechanism;

G. demonstrate the financial ability to produce a

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cash flow sufficient to cover operating expenses for 30 days;

H. disclose fully the names of persons with an ownership or control interest of five percent or more in the contracting agency;

I. demonstrate an accounting or financial system that complies with generally accepted accounting principles;

J. demonstrate a system of personnel management; and

K. if offering personal care services to a ventilator-dependent ACG client, demonstrate the ability to train and to supervise the personal care assistant and the ACG client in ventilator operation and maintenance.

Subp. 6. **Personal care provider responsibilities.** The personal care provider shall:

A. employ or contract with personal care assistants to provide personal care services and to train personal care assistants as necessary;

B. supervise the personal care services as in subpart 9;

C. if the provider is not the local agency, submit a bill to the local agency for personal care services provided by the personal care assistant;

D. establish a grievance mechanism to resolve consumer complaints about personal care services;

E. keep records as required in parts 9505.1750 to 9505.1880;

F. perform functions and provide services specified in the personal care provider's contract under subpart 5;

G. comply with applicable rules and statutes; and

H. perform other functions as necessary to carry out the responsibilities in items A to G.

Subp. 7. **Employment prohibition.** A local agency that provides ACG services to an ACG client whether the services are provided by the local agency as a personal care provider or under contract with a personal care provider must prohibit the employment of a person to provide personal care services for an ACG client if the personal care assistant:

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A. refuses to provide full disclosure of criminal history records as specified in subpart 8;

B. has been convicted of a crime that directly relates to the occupation of providing personal care services to a qualified recipient;

C. has jeopardized the health or welfare of a vulnerable adult through physical abuse, sexual abuse, or neglect as defined in Minnesota Statutes, section 626.557; or

D. is misusing or is dependent on mood-altering chemicals including alcohol to the extent that the personal care provider knows or has reason to believe that the use of chemicals has a negative effect on the ability of the personal care assistant to provide personal care services or the use of chemicals is apparent during the hours the personal care assistant is providing personal care services.

Subp. 8. **Preemployment check of criminal history.** Before employing a person as a personal care assistant for an ACG client, the personal care provider shall require from the applicant for employment full disclosure of conviction and criminal history records pertaining to any crime related to the provision of health services under the medical assistance program or to the occupation of a personal care assistant.

Subp. 9. **Supervision of personal care assistant.** A personal care assistant must be under the supervision of a registered nurse. The supervising registered nurse shall not be a member of the family of the ACG client who is receiving personal care service from the personal care assistant under the registered nurse's supervision. The supervising registered nurse must:

A. ensure that the personal care assistant is capable of providing the personal care services required in the ACG client's individual treatment plan required by part 9505.2475 through direct observation of the assistant's performance or through consultation with the ACG client and the ACG client's primary caregiver when possible;

B. ensure that the personal care assistant is

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knowledgeable about the individual treatment plan before the personal care assistant performs the personal care services;

C. ensure that the personal care assistant is knowledgeable about essential observations of the ACG client's health, and about any conditions that should immediately be brought to the attention of either the nurse or the ACG client's physician;

D. evaluate the personal care services of an ACG client through direct observation of the personal care assistant's work or through consultation with the ACG client;

E. review the individual treatment plan with the ACG client and the personal care assistant at least once every 120 days and revise the individual treatment plan as necessary;

F. ensure that the personal care assistant and ACG client are knowledgeable about any change in the individual treatment plan; and

G. review all entries made in the ACG client's health care record showing the services provided and the time spent by the personal care assistant.

Subp. 10. **Evaluation of services.** The supervising registered nurse shall evaluate the personal care assistant's work under the schedule in items A to C.

The supervising registered nurse must record in writing the results of the evaluation and action taken to correct any deficiencies in the work of the personal care assistant.

A. Within 14 days after the placement of a personal care assistant with the ACG client.

B. At least once every 30 days during the first 90 days after the ACG client first begins to receive personal care services under the individual service plan developed by the screening team.

C. At least once every 120 days following the period of evaluations in item B.

Subp. 11. **Employment and reimbursement of a relative as a personal care assistant.** A relative of an ACG client, with the exception of the ACG client's spouse, shall be reimbursed for

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providing personal care services to an ACG client only if the relative and the local agency meet the requirements in items A to D.

A. The relative must be employed by or under contract with the local agency or a personal care provider. A local agency employing a relative under this subpart does not have to be licensed as a home health agency under Minnesota Statutes, sections 144A.43 to 144A.47.

B. The relative would suffer financial hardship as a result of providing the ACG client's personal care services or a personal care assistant who is not a relative is not available to perform the ACG client's personal care services. For purposes of this subpart, financial hardship refers to a situation in which a relative incurs a substantial reduction in income because he or she resigns from a full-time job, goes from a full-time to a part-time job paying considerably less compensation, takes a leave of absence without pay from a full-time job to care for an ACG client, or incurs substantial expenses in making arrangements necessary to enable the relative to care for an ACG client.

C. The relative and the local agency must meet the requirements of subparts 2, 3, and 7 to 10.

D. The local agency has obtained the department's prior approval.

9505.2470 STANDARDS FOR HOME HEALTH AIDE SERVICES.

Subpart 1. **Employment of home health aide.** A home health aide who provides home health aide services under the ACG program to an ACG client must be an employee of a provider of home health aide services. The home health aide must be under the supervision of a registered nurse. Registered nurses and practical nurses licensed under Minnesota Statutes, sections 148.29 to 148.299 shall not be employed as home health aides under the ACG program.

Subp. 2. **Eligible providers.** To be eligible as a provider of home health aide services under the ACG program, a home

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health agency must be licensed under Minnesota Statutes, sections 144A.43 to 144A.46, and certified to participate under titles XVIII and XIX of the Social Security Act.

Subp. 3. **Approval and supervision of home health aide services.** A home health aide providing home health aide services in the ACG program must be approved by the supervising registered nurse to perform the medically oriented tasks written in the ACG client's individual treatment plan. The supervising registered nurse must be an employee of a home health agency that is providing the home health aide services.

Subp. 4. **Record of home health aide services.** A home health agency providing home health aide services to an ACG client must keep a record documenting the provision of home health aide services in the client's individual treatment plan. The documentation shall include the date and nature of the services provided and the names of the home health aide and the supervising registered nurse.

9505.2473 STANDARDS FOR HOMEMAKER SERVICES.

Subpart 1. **Qualified homemakers.** The local agency shall assure that each ACG client receiving homemaker services is served by a homemaker qualified under part 9565.1200, subpart 2. A person who is providing a homemaker service under the ACG program to an ACG client who is the person's relative must meet the standards in part 9565.1200, subpart 2.

Subp. 2. **Contracting for homemaker services and supervision of a homemaker.** The local agency may directly provide or contract for homemaker services that are part of the ACG client's individual service plan. If the local agency provides homemaker services directly, the local agency must also provide supervision of the homemaker's activities. If the local agency contracts with a provider for homemaker services, the provider must meet the requirements of Minnesota Statutes, sections 144A.43 to 144A.46 or 144A.49.

Subp. 3. **Payment limitations; homemaker.** ACG payments shall be made only for the homemaker tasks specified in part

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9505.2395, subpart 23, that are required by and indicated in the ACG client's individual service plan.

9505.2475 ESTABLISHMENT OF INDIVIDUAL TREATMENT PLAN.

Subpart 1. **Requirement.** An individual treatment plan must be developed for an ACG client who receives home health aide services or personal care services. The ACG client's physician and the supervising registered nurse, together with the personal care assistant or the home health aide, the ACG client and the ACG client's representative, if any, must develop the individual treatment plan. The ACG client's physician and the supervising registered nurse must review the plan every 60 days and revise the plan if a revision is necessary to help the ACG client meet his or her needs. The supervising registered nurse must give a copy of the client's individual treatment plan to the ACG client's case manager and the home health agency that provides the home health or personal care services.

Subp. 2. **Contents of ACG client's individual treatment plan.** The ACG client's individual treatment plan must meet the requirements of Code of Federal Regulations, title 42, section 405.1223.

9505.2480 ALLOCATION OF STATE ACG MONEY.

Subpart 1. **Formula for allocation of state ACG money.** Annually before July 1, the commissioner must allocate state money available for alternative care grants to each local agency. The allocation must include the state share of money for services provided to recipients under the waiver and the state share of money for services to persons who would be eligible to receive medical assistance within 180 days after nursing home admission. The allocation must be made according to Minnesota Statutes, section 256B.091, subdivision 8. State funds allocated by the commissioner to a local agency for ACG services provided under the waiver shall not be used for any purpose other than services under the waiver.

Subp. 2. **Review of allocation; reallocation of state ACG money.** The commissioner must review the local agencies'

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projected and expended state ACG money on a quarterly basis. The commissioner must reduce the allocation of state ACG money to a local agency if the commissioner determines that the local agency will not use the full state allocation during the state fiscal year. The commissioner must reallocate the unused portion of the local agency's allocation to a local agency that has or wants to have more ACG clients than were projected to be served in its biennial plan.

9505.2485 ALLOCATION OF NUMBER OF ACG CLIENTS TO BE SERVED UNDER THE WAIVER.

Subpart 1. **Local agency allocation of ACG clients under the waiver.** At least annually, the commissioner must allocate the number of ACG clients who are recipients and for whom each local agency is financially responsible under the waiver. The commissioner must determine from the medical assistance eligibility data provided as of March 1 by the counties to the department each local agency's allocation according to the county's percentage of the statewide total number of recipients who are age 65 or older.

Subp. 2. **Review of allocation; reallocation of number of ACG clients under the waiver.** The commissioner shall review the projected and actual number of ACG clients served under the waiver by all local agencies on a quarterly basis. The commissioner may reduce the number of ACG clients allocated to a local agency if the commissioner determines that the local agency will serve fewer than its allocated number of ACG clients during the allocation period. The commissioner may reallocate the unused portion of the local agency's initial allocation to another local agency.

Broad discretion with allocation & funds.

Subp. 3. **Notice to local agency.** The commissioner shall notify a local agency annually before May 15 of the number of recipients to be served as ACG clients under the waiver under subpart 1 and shall notify a local agency at least 15 days before the effective date of a change in the number of ACG clients allocated to the local agency under subpart 2.

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9505.2486 LOCAL AGENCY ESTIMATION OF NUMBER OF PERSONS OTHER THAN RECIPIENTS TO BE SERVED AS ACG CLIENTS.

A local agency must estimate the number of persons other than recipients to be served as ACG clients. The estimate shall depend on the extent that ACG funds allocated to the local agency as required by part 9505.2480 are available. The local agency must report the estimate in the biennial plan and revisions to the biennial plan required in part 9505.2495, subpart 2.

9505.2490 RATES FOR ACG SERVICES.

Subpart 1. **Statewide maximum ACG service rate.** For years beginning on July 1 following the effective date of parts 9505.2390 to 9505.2500, the commissioner must annually set a statewide maximum rate allowed for payment of providing an ACG service. The statewide maximum rate must not exceed the prior fiscal year's rate by more than the percentage change between the two previous Januarys indicated by the all urban consumer price index (CPI-U) for Minneapolis-St. Paul new series index (1967=100), as published by the Bureau of Labor Statistics, United States Department of Labor. The CPI-U is incorporated by reference and is available from the Minitex interlibrary loan system. The CPI-U is subject to frequent change.

Subp. 2. **Local agency maximum ACG service rate set by commissioner; general.** The commissioner shall annually set the maximum rate that is available to a local agency for reimbursing an ACG provider for an ACG service. For years beginning on the first of July following the effective date of parts 9505.2390 to 9505.2500, the commissioner shall authorize an increase in the ACG rate available to a local agency for reimbursing an ACG provider equal to the percentage change between the two previous Januarys indicated by the all urban consumer price index (CPI-U) for Minneapolis-St. Paul new series index (1967=100), as published by the Bureau of Labor Statistics, United States Department of Labor.

Subp. 3. **Local agency maximum ACG service rate set by**

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commissioner; new ACG service. A local agency that wants to contract for an ACG service that has not been provided before the effective date of parts 9505.2390 to 9505.2500 shall propose a maximum rate to the commissioner that does not exceed the statewide maximum ACG service rate established by the commissioner under subpart 1.

Subp. 4. **Notice to local agency.** Annually by May 15, the commissioner shall notify each local agency of the statewide maximum rate allowed for payment of providing an ACG service under subpart 1. Additionally, the commissioner shall notify the local agency in writing of the percentage increase allowed under subpart 2.

Subp. 5. **Local agency request to exceed county's maximum rate.** Notwithstanding the limitation on the local agency's maximum rate for an ACG service in subpart 2, a local agency that wants to increase an ACG service rate more than the percentage authorized by the commissioner under subpart 2 may submit a request for the increase to the commissioner. The local agency must justify the need for the greater increase by submitting evidence that documents an increase in costs, such as wages established under a union contract, taxes, utility costs, or transportation charges, that exceeds the percentage change or that shows that the higher rate is necessary to obtain the desired service within the local agency's local trade area. For purposes of this subpart, "local trade area" has the meaning given in part 9505.0175, subpart 22.

Subp. 6. **Local agency ACG service rate subject to audit and approval.** A local agency ACG service rate and a request to exceed the local agency's maximum ACG service rate are subject to audit and approval by the commissioner.

Commissioner Need guidelines?

9505.2495 LOCAL AGENCY REPORTS AND RECORDS.

Subpart 1. **Preadmission screening documents.** The local agency must complete and submit to the commissioner a preadmission screening document that summarizes the assessment and recommendations of the preadmission screening team on an

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applicant, nursing home resident, or ACG client for whom the local agency has completed a preadmission screening or a reassessment. The document must be submitted by the tenth of the month following the month in which a preadmission screening or reassessment was completed.

Subp. 2. **Local agency biennial plans.** The local agency must submit a biennial plan for preadmission screening and ACGs on forms prepared by the commissioner. The local agency must submit the biennial plan to the commissioner by July 1 of odd-numbered years in order for the local agency to receive preadmission screening funds or ACG funds during the next two state fiscal years. The local agency must submit revisions to the biennial plan to the commissioner for approval before implementing the revisions. The biennial plan must include items A to F:

A. name and address of the local agency;

B. names and titles of the preadmission screening team;

C. names of ACG service providers;

D. identification of the types of ACG services the local agency will provide and the rates for the services;

E. an ACG budget and estimates of the number of recipients and other persons to be served as ACG clients for the first year of the biennium and an estimated budget and estimated number of clients to be served for the second year of the biennium. No later than July 1 of the second year of the biennium, each local agency must submit the actual budget and revised estimate of the number of clients to be served proposed for the second year of the biennium; and

F. assurances of compliance with Minnesota Statutes, section 256B.091, and parts 9505.2390 to 9505.2500.

Subp. 3. **Commissioner approval of local agency biennial plan.** The commissioner must approve or reject by August 15 a biennial plan submitted by the local agency as required in subpart 2, item E.

Subp. 4. **ACG provider records.** The local agency and each

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ACG provider under contract with the local agency must maintain complete program and fiscal records and supporting documentation identifying the ACG clients served, the services provided, and the costs incurred. The records must be identified and maintained separate from other provider records. The local agency's and provider's records including the local agency's contract with the ACG provider are subject to the maintenance schedule, audit availability requirements, and other provisions in parts 9505.1750 to 9505.2150.

9505.2496 CRITERION FOR DELAY IN SENDING REQUIRED NOTICES.

If information that the commissioner needs to prepare and send the notices required under parts 9505.2390 to 9505.2500 is not provided in time for the commissioner to meet the time specified in these parts, the required notices shall be sent as soon as possible after the commissioner receives the needed information.

9505.2500 APPEALS OF SCREENINGS, RESCREENINGS, AND REASSESSMENTS.

Subpart 1. Information about the right to appeal. A preadmission screening team must provide a person being screened under part 9505.2400, rescreened under part 9505.2435, or reassessed under part 9505.2455, subpart 11, or the person's representative, information about the person's right to appeal the recommendation of the screening team. The information must be in writing and must be given to the person or the person's representative during the preadmission screening. The information must state the grounds for an appealable action and that ACG services will not be reduced, suspended, or terminated if the appeal is filed before the date specified in the information unless the person requests in writing not to receive continued ACG services while the appeal is pending.

Subp. 2. Appealable actions. A person being screened, rescreened, or reassessed may appeal if:

A. the recommendation of the preadmission screening team is to deny ACG services;

B. the preadmission screening team fails to determine

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with reasonable promptness whether the person is eligible for ACG services; or

C. the recommendation of the case manager based on a reassessment under part 9505.2455, subpart 11, is to reduce, suspend, or terminate ACG services.

Subp. 3. **Denial, reduction, suspension, or termination because of insufficient ACG funds or openings.** A denial, reduction, suspension, or termination of ACG services is not an appealable action if the county of financial responsibility has depleted the amount of money allocated under part 9505.2480 or assigned all the openings to serve ACG clients allocated under parts 9505.2485 and 9505.2486 or if the client's case manager withdraws ACG services as provided under part 9505.2458. Additionally, termination of an ACG service being provided to an ACG client under the waiver is not appealable if the termination results from termination of the waiver.

Subp. 4. **Submission of appeals.** The person being screened or the representative of the person being screened who wants to appeal the screening team's recommendation must submit the appeal in writing to the local agency of the county of service or to the department within 30 days after receiving written notice of the appealable action, or within 90 days of the written notice if a justified reason for delay can be shown.

Subp. 5. **Appeal of action.** An appeal of issues meeting the criteria under subparts 1, 2, and 4 shall be heard and decided in accordance with Minnesota Statutes, section 256.045.

REPEALER. Minnesota Rules, parts 9505.2250; 9505.2260; 9505.2270; 9505.2280; 9505.2290; 9505.2300; 9505.2310; 9505.2320; 9505.2330; 9505.2340; 9505.2350; 9505.2360; 9505.2370; and 9505.2380, are repealed.

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STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED

JUL 11 1988

Joan Anderson Growe
Secretary of State

10:52 AM

APPROVED AS TO FORM AND LEGALITY

July 11 19 88

HUBERT H. HUMPHREY, III
ATTORNEY GENERAL

BY Julie A Lepinski
SPECIAL ASSISTANT ATTORNEY GENERAL

Department of Human Services

Proposed Permanent Rules Relating to Preadmission Screening and Alternative Care Grants

Rules as Proposed (all new material)

9505.2390 SCOPE AND EFFECT.

Subpart 1. **Scope.** Parts 9505.2390 to 9505.2500 establish the standards and procedures applicable to the preadmission screening and alternative care grant program. The preadmission screening program screens persons who are applicants for admission to a nursing home or nursing home residents who request a screening as required under part 9505.2435, subpart 2. An alternative care grant pays for some community services in lieu of nursing home admission or continued nursing home resident status for persons who meet the requirements of parts 9505.2390 to 9505.2500.

Parts 9505.2390 to 9505.2500 must be read in conjunction with Minnesota Statutes, sections 256B.04, subdivision 2, 256B.05, 256B.091, subdivisions 1 to 9, and Code of Federal Regulations, title 42, sections 440.180 and 441.300 to 441.310. Unless otherwise specified, citations of Code of Federal Regulations, title 42, refer to the code amended as of October 1, 1986.

Parts 9505.2390 to 9505.2500 also must be read in conjunction with the requirements of the waiver obtained by the state from the United States Department of Health and Human Services.

Subp. 2. **Effect.** References to the waiver and waiver provisions that occur in parts 9505.2390 to 9505.2500 shall continue in effect only as long as the waiver from the United States Department of Health and Human Services remains in effect in Minnesota.

9505.2395 DEFINITIONS.

Subpart 1. **Applicability.** The definitions in this part

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apply to parts 9505.2390 to 9505.2500.

Subp. 2. **Adult day care services.** "Adult day care services" means services provided to alternative care grant clients by adult day care programs established under Minnesota Statutes, sections 245A.01 to 245A.17, including adult day care centers licensed under parts 9555.9600 to 9555.9730.

Subp. 3. **Adult foster care services.** "Adult foster care services" means supervised living arrangements for adults in an adult foster care home licensed under parts 9555.5105 to 9555.6265.

Subp. 4. **Alternative care grant or ACG.** "Alternative care grant" or "ACG" means funds allocated to a local agency by the commissioner under Minnesota Statutes, section 256B.091 to pay for alternative care services.

Subp. 5. **Alternative care grant client or ACG client.** "Alternative care grant client" or "ACG client" means a person who has been determined eligible to receive or is receiving services funded by an alternative care grant.

Subp. 6. **Alternative care grant services.** "Alternative care grant services" means the services listed in items A to G provided to ACG clients:

A. case management services;

B. respite care services;

C. homemaker services;

D. home health aide services;

E. adult foster care services;

F. adult day care services; and

G. personal care services.

Subp. 7. **Applicant.** "Applicant" means a person who is seeking admission to a nursing home or who has been admitted to a nursing home but has not yet been screened by the preadmission screening team as required in part 9505.2420.

Subp. 8. **Assessment form.** "Assessment form" means the form supplied by the commissioner that is used to record the information required under parts 9505.2425, subpart 1 and 9505.2455, subpart 12.

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Subp. 9. **Case management services.** "Case management services" means services that identify, acquire, authorize, and coordinate services for an ACG client; monitor the delivery of services to the ACG client; and adjust services to the needs of the ACG client.

Subp. 10. **Case manager.** "Case manager" means a social worker employed by or under contract with the local agency or a registered nurse who is employed by the local public health department and under contract with the local agency to provide case management services. "Local agency" in this subpart refers to the county of service.

Subp. 11. **Commissioner.** "Commissioner" means the commissioner of the Minnesota Department of Human Services or the commissioner's authorized representative.

Subp. 12. **Community services.** "Community services" means home and community-based services including services provided under the ACG as specified in part 9505.2430, subpart 4, item B, subitem (3), that can be used to meet the health or social needs of an ACG client.

Subp. 13. **County of financial responsibility.** "County of financial responsibility" means the county responsible for paying for preadmission screening of a recipient or the county responsible for paying for ACG services under part 9505.2455, subpart 3.

Subp. 14. **County of service.** "County of service" means the county whose local agency performs preadmission screening of an applicant or nursing home resident or arranges case management services for an ACG client. The county of service may be the same as or different from the county of financial responsibility.

Subp. 15. **Delay of screening.** "Delay of screening" means that preadmission screening has not been completed for an applicant but will be completed according to the time requirements established for:

A. emergency admission under part 9505.2420, subpart 3;

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B. preadmission screening of hospital patients under part 9505.2420, subpart 2;

C. 30-day exemption from screening under part 9505.2420, subpart 4; or

D. admission of an applicant from another state under part 9505.2420, subpart 6.

Subp. 16. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 17. **Directory of services.** "Directory of services" means the list of all community services available in a geographic area that is developed under part 9505.2425, subpart 7.

Subp. 18. **Discharge planner.** "Discharge planner" means a person qualified as a public health nurse or a social worker who is employed by a hospital to coordinate the development of an individual service plan of a person who no longer needs the services of the hospital.

Subp. 19. **Emergency admission.** "Emergency admission" means the admission of an applicant from the community to a nursing home before completion of preadmission screening when a physician has determined that the delay in admission needed for preadmission screening would adversely affect the applicant's health and safety. For purposes of this definition, "community" does not include a hospital.

Subp. 20. **Formal caregivers.** "Formal caregivers" means persons or entities providing ACG services who are employed or who are under contract with a local agency, or other agency or organization, public or private.

Subp. 21. **Home health aide.** "Home health aide" means a person who meets the requirements of part 9505.2470 and provides home health aide services to an ACG client.

Subp. 22. **Home health aide services.** "Home health aide services" means services provided under part 9505.2470 that are written in the individual treatment plan. Home health aide services include the performance of procedures as an extension of therapy services, personal care, ambulation and exercise,

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household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the ACG client's condition and needs, and completing necessary records.

Subp. 23. **Homemaker services.** "Homemaker services" means services that assist an ACG client as set forth in items A to G:

A. performing house cleaning activities;

B. laundering, ironing, and mending;

C. meal planning, preparation, and cleanup;

D. assisting with money management;

E. providing companionship, emotional support, and social stimulation;

F. observing and evaluating home safety practices and seeking to improve these practices where appropriate; and

G. performing essential errands and shopping.

Subp. 24. **Hospital.** "Hospital" has the definition given in Minnesota Statutes, section 144.696, subdivision 3.

Subp. 25. **Individual service plan.** "Individual service plan" means the written plan of a community service or a combination of community services designed to meet the health and social needs of an applicant or nursing home resident screened according to part 9505.2430. The individual service plan is the plan of care referred to in Minnesota Statutes, section 256B.091.

Subp. 26. **Individual treatment plan.** "Individual treatment plan" means the written treatment plan of care for providing personal care and home health aide services under part 9505.2475 to an ACG client.

Subp. 27. **Informal caregivers.** "Informal caregivers" means family, friends, neighbors, or others who provide services and assistance to the elderly without the sponsorship of an agency or organization.

Subp. 28. **Local agency.** "Local agency" means the county or multicounty agency that is required under Minnesota Statutes, section 256B.05, to administer the medical assistance program.

Subp. 29. **Medical assistance or MA.** "Medical assistance"

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or "MA" means the program established under title XIX of the Social Security Act and Minnesota Statutes, chapter 256B.

Subp. 30. **Mental illness.** "Mental illness" means an illness as defined in Minnesota Statutes, section 245.462, subdivision 20, clause (2).

Subp. 31. **Nursing home.** "Nursing home" means a facility licensed under Minnesota Statutes, chapter 144A or sections 144.50 to 144.56, that is certified to participate in the medical assistance program as a skilled nursing facility or an intermediate care facility. This definition includes boarding care homes.

Subp. 32. **Nursing home resident.** "Nursing home resident" means a person who resides, and expects to continue to reside, in a nursing home for more than 30 days. For purposes of parts 9505.2390 to 9505.2500, "nursing home resident" does not include a person who is in a nursing home for respite care.

Subp. 33. **Personal care services.** "Personal care services" means services meeting the requirements of part 9505.2465.

Subp. 34. **Personal care assistant.** "Personal care assistant" means a person who provides personal care services under part 9505.2465 and meets the training requirements of part 9505.2465, subpart 2.

Subp. 35. **Person with mental retardation or related conditions.** "Person with mental retardation or related conditions" means a person as defined in part 9525.0015, subpart 20.

Subp. 36. **Physician.** "Physician" means a person who is authorized to practice medicine under Minnesota Statutes, chapter 147.

Subp. 37. **Preadmission screening.** "Preadmission screening" means the activities performed by a preadmission screening team under Minnesota Statutes, section 256B.091, and parts 9505.2390 to 9505.2500. This definition does not include the activities of teams authorized under Minnesota Statutes, section 256B.092, and established in parts 9525.0015 to 9525.0165 and under the Minnesota Comprehensive Mental Health

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Act, Minnesota Statutes, sections 245.461 to 245.486.

Subp. 38. **Preadmission screening document.** "Preadmission screening document" means the document required in part 9505.2495, subpart 1, and supplied by the commissioner.

Subp. 39. **Preadmission screening team.** "Preadmission screening team" means the team authorized in Minnesota Statutes, section 256B.091, and required by part 9505.2410, to assess the financial, health, and social needs of an applicant or a nursing home resident.

Subp. 40. **Primary caregiver.** "Primary caregiver" means the informal caregiver who customarily provides care to the ACG client and cooperates with the case manager in assuring the provision of services by the formal caregivers.

Subp. 41. **Public health nurse.** "Public health nurse" means a registered nurse certified by the Minnesota Department of Health as a public health nurse and employed by a local board of health under Minnesota Statutes, sections 145.08 to 145.123.

Subp. 42. **Public health nursing services.** "Public health nursing services" means the nursing services provided by a board of health under Minnesota Statutes, sections 145.911 to 145.92.

Subp. 43. **Reassessment.** "Reassessment" means the reevaluation of an ACG client's financial, health, and social needs under part 9505.2455, subparts 11 and 12.

Subp. 44. **Recipient.** "Recipient" means a person who has been determined by the local agency to be eligible for medical assistance under parts 9505.0010 to 9505.0150.

Subp. 45. **Registered nurse.** "Registered nurse" means a person licensed under Minnesota Statutes, section 148.211.

Subp. 46. **Representative.** "Representative" means a person appointed by the court as a guardian or conservator under Minnesota Statutes, sections 252A.01 to 252A.21 or 525.539 to 525.6198 or a parent of a child under age 18 unless the parent's parental rights have been terminated.

Subp. 47. **Rescreening.** "Rescreening" means the completion of the activities in part 9505.2435, subpart 3, after an initial preadmission screening.

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Subp. 48. **Resident class.** "Resident class" refers to the case mix classification required under Minnesota Statutes, section 256B.091, subdivision 2, and assigned to a person as required under parts 9549.0058, subpart 2, and 9549.0059.

Subp. 49. **Resident day.** "Resident day" means a day for which nursing services in a nursing home are rendered or a day for which a nursing home bed is held.

Subp. 50. **Respite care services.** "Respite care services" means short-term supervision, assistance, and care provided to an ACG client due to the temporary absence or need for relief of the ACG client's primary caregiver. Respite care services may be provided in the client's home or in a facility approved by the state such as a hospital, nursing home, foster home, or community residential facility.

Subp. 51. **Room and board costs.** "Room and board costs" means costs associated with providing food and shelter to a person, including the directly identifiable costs of:

A. private and common living space;

B. normal and special diet food preparation and service;

C. linen, bedding, laundering, and laundry supplies;

D. housekeeping, including cleaning and lavatory supplies;

E. maintenance and operation of the building and grounds, including fuel, electricity, water, supplies, and parts and tools to repair and maintain equipment and facilities; and

F. allocation of salaries and other costs related to items A to E.

Subp. 52. **Skilled nursing service.** "Skilled nursing service" refers to the term described in Code of Federal Regulations, title 42, section 405.1224.

Subp. 53. **Social worker.** "Social worker" means a person who has met the minimum qualifications of a social worker under the Minnesota Merit System or a county civil service system in Minnesota.

Subp. 54. **Unscreened applicant.** "Unscreened applicant"

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means an applicant for whom preadmission screening has not been completed under parts 9505.2390 to 9505.2500.

Subp. 55. **Waiver.** "Waiver" means the approval given by the United States Department of Health and Human Services which allows the state to pay for home and community-based services authorized under Code of Federal Regulations, title 42, section 441, subpart G. The term includes all amendments to the waiver including any amendments made after the effective date of parts 9505.2395 to 9505.2500, as approved by the United States Department of Health and Human Services.

Subp. 56. **Working day.** "Working day" means the hours of a day, excluding Saturdays, Sundays, and holidays, when a local agency is open for business.

9505.2396 COMPUTATION OF TIME INTERVALS TO MEET NOTICE REQUIREMENTS.

For purposes of parts 9505.2390 to 9505.2500, a required time interval to meet notice requirements must be computed to exclude the first and include the last day of the prescribed interval of time. The term "day" includes Saturday, Sunday, and holidays unless it is modified as "working day."

9505.2400 **PREADMISSION SCREENING REQUIREMENT.**

Subpart 1. Coverage. The preadmission screening team established by the local agency must complete the preadmission screening of all applicants except individuals who are exempt under subpart 2 and the preadmission screening of current nursing home residents who request a screening. The preadmission screening team shall complete the screening as specified in part 9505.2425, except in the cases of persons with mental retardation or related conditions. Persons with mental retardation or related conditions must be provided services according to parts 9525.0015 to 9525.0165. Persons with mental illness must be provided services according to the Minnesota Comprehensive Mental Health Act, Minnesota Statutes, sections 245.461 to 245.486.

Subp. 2. **Exemptions.** The following individuals are exempt

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from the requirement of subpart 1:

A. a nursing home resident who transfers from one nursing home located within Minnesota directly to another nursing home located within Minnesota, regardless of the location of either nursing home;

B. a nursing home resident who is admitted to a hospital from a nursing home and who returns to a nursing home;

C. a nursing home resident who changes certified levels of care within the same nursing home;

D. an applicant for whom preadmission screening was completed within the previous three months;

E. an applicant who has been screened and who is currently receiving ACG services;

F. an applicant who has been screened and who is currently receiving services from a certified home health agency;

G. an applicant who is not eligible for medical assistance and whose length of residency in a nursing home is expected to be 30 days or less as determined under part 9505.2420, subpart 4;

H. an applicant whose nursing home care is paid for indefinitely by the United States Veterans Administration;

I. an applicant who enters a nursing home administered by and for the adherents of a recognized church or religious denomination described in Minnesota Statutes, section 256B.091, subdivision 4; and

J. an applicant to a nursing home described in Minnesota Statutes, section 256B.431, subdivision 4, paragraph (c).

9505.2405 INFORMATION REGARDING AVAILABILITY OF PREADMISSION SCREENING.

The local agency must annually publish a notice that preadmission screening is available to persons in the area served by the local agency. At a minimum, the notice must appear in the newspaper that has the largest circulation within the geographic area served by the local agency. The notice must:

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A. explain the purpose of preadmission screening as stated in Minnesota Statutes, section 256B.091, subdivision 1;

B. instruct the public how to contact the preadmission screening team; and

C. state who is subject to and who may request preadmission screening under Minnesota Statutes, section 256B.091, subdivisions 2 and 4, and part 9505.2400.

9505.2410 ESTABLISHMENT OF PREADMISSION SCREENING TEAM.

Subpart 1. **Establishment.** A local agency must establish at least one preadmission screening team to complete preadmission screening of applicants and nursing home residents. In addition, a local agency may contract with a nonprofit hospital to perform the functions of a preadmission screening team under part 9505.2413 for applicants being discharged from the hospital. If a nonprofit hospital performs the functions of a preadmission screening team under contract with a local agency, the hospital's discharge planner shall not be a member of the team unless the applicant is a person being discharged from the hospital. If a nonprofit hospital does not have a contract with the local agency to perform the functions of a screening team, the hospital's discharge planner may be present at the preadmission screenings and may participate in the discussions but not in making the screening team's recommendations.

Subp. 2. **Composition of preadmission screening team.** A preadmission screening team must be composed as specified in items A to C.

A. The preadmission screening team must include a social worker and a public health nurse. The team must also include the applicant's or nursing home resident's physician if the physician chooses to participate.

B. The social worker of the local agency's preadmission screening team must be employed by or under contract with the local agency and must be designated by name as a member of the preadmission screening team.

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C. If a local agency has a human services board organized under Minnesota Statutes, sections 402.01 to 402.10, the local agency must designate by name the public health nurse member of the preadmission screening team. If a local agency does not have a human services board organized under Minnesota Statutes, sections 402.01 to 402.10, the local agency must contract with the board of health organized under Minnesota Statutes, section 145.913, or a public or nonprofit agency under contract with the local agency to provide public health nursing services to provide the public health nurse member of the preadmission screening team. The local board of health or a public or nonprofit agency under contract with the local agency to provide public health nursing services must designate by name the public health nurse member of a preadmission screening team.

Subp. 3. **Number of preadmission screening team members present at screening.** Except as provided in subpart 5, the social worker and the public health nurse designated as members of the preadmission screening team must be present at a preadmission screening. The applicant's or nursing home resident's physician may be present if the physician chooses to participate in the preadmission screening.

Subp. 4. **Physician notification of preadmission screening.** The local agency must notify the physician of the applicant or nursing home resident being screened, by telephone, of the date, time, and place the person's preadmission screening is to take place. The telephone notice must be made on the day that the preadmission screening team schedules the screening. The notice must state the physician's right to participate as a member of the preadmission screening team. No later than ten working days after the telephone notice, the local agency must send the physician a written notice that contains the information given in the telephone notice.

Subp. 5. **Preadmission screening by public health nurse.** Preadmission screening may be completed by the public health nurse member of the team, in consultation with the social worker, for applicants who are being admitted to a nursing home

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from a hospital and who are not eligible for medical assistance under parts 9505.0010 to 9505.0150. For the purpose of this subpart, "consultation" means a meeting or telephone conversation between the public health nurse and the social worker that takes place after the public health nurse has completed the preadmission screening. The purpose of the consultation is to discuss the assessment, the recommendation, and, as appropriate, the applicant's individual service plan or the applicant's plans for discharge from the nursing home.

Subp. 6. **Physician consultant to preadmission screening team.** A local agency must designate a physician who practices within the local agency's service area to serve as a consultant to the preadmission screening teams designated under subpart 2.

9505.2413 CONTRACTS FOR PREADMISSION SCREENING TEAM MEMBERS FOR APPLICANTS DISCHARGED FROM HOSPITALS.

The local agency may contract with a nonprofit hospital to provide one or both members of a preadmission screening team to screen applicants being discharged from the nonprofit hospital and to make recommendations for the screened applicants about nursing home admission and community services necessary for the applicant's individual service plan. The contract between the local agency and the nonprofit hospital must:

A. set beginning and ending dates of the contract;

B. specify the duties and responsibilities of the local agency and the nonprofit hospital;

C. specify that a member of the preadmission screening team to be provided by the hospital must be a discharge planner;

D. designate by name the person or persons to be provided by the hospital;

E. require the designated preadmission screening team member or members to comply with parts 9505.2390 to 9505.2500;

F. specify that the member or members of the preadmission screening team under contract will screen only applicants being discharged from that nonprofit hospital;

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G. designate the person employed by the hospital and the person employed by the local agency who are responsible for proper performance under the contract;

H. state that the nonprofit hospital must complete a preadmission screening for an applicant before the applicant's discharge from the nonprofit hospital;

I. require that a member of the nonprofit hospital's screening team have no direct or indirect financial or self-serving interest in a nursing home or other referral such that it would not be possible for the member to consider each case objectively;

J. specify the amount the local agency must pay the nonprofit hospital for carrying out the terms of the contract;

K. specify the person employed by the hospital who is responsible for implementing appropriate data practices; and

L. specify reports and records to be kept by the nonprofit hospital.

9505.2415 HOSPITAL NOTICE REQUIREMENTS.

Subpart 1. **Notification of preadmission screening team.** Except as indicated under subpart 2, the discharge planner of a hospital must notify the preadmission screening team about a hospital patient who is an applicant. Oral and written notices must be given. The oral notice must be given to the preadmission screening team at least three working days before discharge of the applicant. The hospital must document the oral notice by sending the preadmission screening team a written notice within ten working days after the oral notice. The notice must:

A. provide the name of the applicant;

B. provide the name of the nursing home that the applicant is considering;

C. provide the applicant's primary diagnosis;

D. indicate the interval in which the applicant is expected to be discharged from the nursing home. The intervals are: less than 30 consecutive days; 30 days but less than three

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months; three months but less than six months; or six months or more;

E. indicate that the discharge planner gave information to the applicant about the purpose of preadmission screening and community services; and

F. indicate if the discharge planner wants to participate in the preadmission screening.

Subp. 2. **Exception to notice required of hospital.** If the applicant is in the hospital for less than three working days and preadmission screening is not completed, the hospital may discharge the applicant to a nursing home, but the hospital discharge planner must contact the preadmission screening team by telephone or in person before the applicant's discharge and complete the notice required under subpart 1.

9505.2420 TIME REQUIREMENTS FOR PREADMISSION SCREENING.

Subpart 1. **General time requirements.** Except as provided in subparts 2 to 6, the local agency must schedule a preadmission screening within five working days of receiving a request for the preadmission screening from an applicant or an applicant's representative. Except as provided in subparts 2 to 6, the preadmission screening must be completed within the period of ten working days following the applicant's request for preadmission screening.

Subp. 2. **Preadmission screening of hospital patients.** Notwithstanding subpart 1, the local agency must complete the preadmission screening of an applicant who is a hospital patient within three working days of receiving oral notice from the discharge planner under part 9505.2415, subpart 1. However, the local agency may delay the preadmission screening of an applicant who is a hospital patient when, based on information given in the oral notice, the preadmission screening cannot be completed before discharge from the hospital and the applicant's discharge plan indicates that the applicant must be admitted to a nursing home. If preadmission screening is delayed and the local agency and the nursing home are located in the same

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county, the local agency must notify the nursing home orally and in writing of the scheduled date for the preadmission screening and perform the preadmission screening within ten working days after the applicant's admission to the nursing home.

If preadmission screening is delayed and the nursing home and the local agency are located in different counties, the local agency of the county in which the nursing home is located must be responsible for the preadmission screening. The local agency of the county in which the hospital is located must send an oral and a written notice of the applicant's discharge plan to the local agency in the county where the nursing home is located. Oral notice must be given on the day that the local agency of the county in which the hospital is located delays preadmission screening. The written notice must be sent within ten working days after the oral notice. The written notice must include a copy of the delay-of-screening form completed by the local agency of the county in which the hospital is located and a copy of the hospital's discharge notice. The preadmission screening team from the local agency in the county where the nursing home is located must then notify the nursing home orally and in writing of the scheduled date for the preadmission screening and perform the preadmission screening within ten working days after the applicant's admission to the nursing home.

Subp. 3. **Emergency admission.** When preadmission screening is not completed due to an emergency admission, the procedures in items A to C must be followed.

A. The attending physician must certify the reason for the emergency in the applicant's medical record.

B. The nursing home must orally notify the preadmission screening team within two working days after the date of the emergency admission.

C. The preadmission screening team must complete the preadmission screening of the applicant within ten working days of the date of the applicant's admission to the nursing home or within ten working days after receiving the oral referral for preadmission screening, whichever is earlier.

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Subp. 4. **Thirty-day exemption from preadmission screening.** A local agency must grant a 30-day exemption from preadmission screening to applicants who are not eligible for medical assistance if the requirements in items A and B are met.

A. The nursing home must notify the local agency of the applicant's admission no later than the day of the applicant's admission to the nursing home. The notice must include information stating that the requirements of item B have been met.

B. The attending physician must certify in the applicant's medical record in the nursing home that the applicant's expected length of stay in the nursing home will be 30 consecutive days or less.

The preadmission screening team of the local agency that has determined that the applicant's request for a 30-day exemption from preadmission screening meets the requirements in items A and B must complete and send the nursing home a form supplied by the commissioner authorizing the 30-day exemption and at the same time must send a copy of the form to the applicant.

The nursing home must provide an update to the preadmission screening team before or on the 30th day of the applicant's stay if the applicant will continue to live in the nursing home for more than 30 consecutive days. The local agency must complete preadmission screening within ten working days after the 30th day unless the applicant is discharged within these ten working days, does not return to the nursing home, and does not become an applicant to a different nursing home.

Subp. 5. **Nursing home applicant admitted to a hospital from a nursing home before completion of preadmission screening.** The local agency must complete preadmission screening of a nursing home applicant who has been admitted to a nursing home within the periods required under subparts 1 to 4 unless the nursing home applicant is admitted to a hospital during these periods. If a nursing home applicant is admitted to a hospital during the periods under subparts 1 to 4, the preadmission

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screening time requirements begin again on the date of readmission to the nursing home.

Subp. 6. **Applicant from another state.** When an applicant from another state is admitted to a nursing home in Minnesota, the nursing home must notify the preadmission screening team within two working days after the date of the admission. The notice may be oral or written. The preadmission screening team must then complete the preadmission screening of the applicant within ten working days after the date of admission to the nursing home.

9505.2425 SCREENING AND ASSESSMENT PROCEDURES REQUIRED DURING PREADMISSION SCREENING.

Subpart 1. **General requirements.** The preadmission screening team must assess the health and social needs of the applicant or nursing home resident being screened using the assessment form provided by the commissioner. The preadmission screening team must carry out the responsibilities specified in subparts 2 to 14 and the duties listed in part 9505.0295, subpart 3, item C. The preadmission screening team must ask whether the person being screened has been determined eligible for or is receiving medical assistance and must give a person whose eligibility for medical assistance has not been determined information about making a medical assistance application.

Subp. 2. **Assessment interview.** The preadmission screening team must conduct the assessment in a face-to-face interview with the person being screened and the person's representative, if any.

Subp. 3. **Information given to person being screened by screening team during preadmission screening.** The preadmission screening team must give the person being screened or the person's representative the form or forms supplied by the commissioner containing the information specified in items A to E:

A. the purpose of the preadmission screening and alternative care grant program under Minnesota Statutes, section

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256B.091;

B. the person's freedom to accept or reject the recommendation of the preadmission screening team;

C. the person's right to confidentiality under the Minnesota Government Data Practices Act, Minnesota Statutes, chapter 13;

D. the person's right to appeal the preadmission screening team's recommendation under part 9505.2500 and Minnesota Statutes, sections 256.045, subdivisions 2 and 3 and 256B.091, subdivision 5; and

E. if the person is not a recipient, the right of the person and the person's spouse to retain liquid assets up to the amount specified in Minnesota Statutes, sections 256B.14, subdivision 2; 256B.17; and 256B.48.

The preadmission screening team must document compliance with this subpart by signing and placing in the local agency's records of the person being screened the forms supplied by the commissioner that state the required information was given to the person being screened.

Subp. 4. **Access to medical records.** The preadmission screening team must ask the person being screened or the person's representative to sign forms necessary to authorize the team's access to the person's medical records. Furthermore, a nursing home or a hospital's discharge planner that conducts a preadmission screening must ask the person being screened or the person's representative to sign forms necessary to authorize the team's access to information that is needed to complete preadmission screening for the person. If the person or the person's representative agrees to sign the forms, the authorization must be completed as prescribed in subpart 14.

Subp. 5. **Preadmission screening team recommendations.** After completing the assessment form required in subpart 1, the preadmission screening team must offer the person being screened or the person's representative the most cost-effective alternatives available to meet the person's needs and must recommend one of the choices specified in items A to E.

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A. The preadmission screening team must recommend admission to a nursing home for an applicant or continued stay for a nursing home resident when the assessment indicates that the applicant or nursing home resident requires community services that are not available or that the anticipated cost of providing the required community services would exceed the annual monthly statewide average payment of the resident class under parts 9549.0050 to 9549.0059 that would be applicable to the person being screened if the person were placed in a nursing home, calculated from the payments made for that resident class in the previous fiscal year.

B. The preadmission screening team must recommend use of community services when the assessment indicates that the community services needed by the person are available and the anticipated cost of providing the community services is less than the total annual statewide monthly average payment of the resident class under parts 9549.0050 to 9549.0059 that would be applicable to the person if the person were placed in a nursing home, calculated from the payments made for that resident class in the previous fiscal year.

C. The preadmission screening team must recommend that the person live in the community without community services if the assessment indicates that the person does not need either admission to a nursing home or community services.

D. A preadmission screening team that has reason to believe that a person being screened has or may have a diagnosis of mental retardation or related conditions must refer the person for services including screening, development of the individual service plan, and case management services according to parts 9525.0015 to 9525.0165.

E. A preadmission screening team that has reason to believe that a person being screened has been diagnosed or may be diagnosed as mentally ill must refer the person for a diagnostic assessment as defined in Minnesota Statutes, section 245.462, subdivision 9. If the person is determined by the diagnostic assessment to have serious and persistent mental

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illness as defined in Minnesota Statutes, section 245.462, subdivision 20, and the person chooses community services under an ACG, the preadmission screening team must establish the individual service plan as required in part 9505.2430, subpart 4, and assure the assignment of a case manager as specified in part 9505.2430, subpart 6. The case manager shall incorporate the person's individual community support plan as defined in Minnesota Statutes, section 245.462, subdivision 12, into the person's individual service plan and shall coordinate the person's services that are specified in the Comprehensive Mental Health Act, Minnesota Statutes, sections 245.461 to 245.486.

Subp. 6. **Required application for ACG services.** If the person being screened chooses to remain in the community with community services the preadmission screening team must request the person or the person's representative to sign an application for the community services under the ACG. To be eligible to receive the community services under the ACG, the person being screened or the person's representative must sign the application. The application shall be on a form prescribed by the commissioner.

Subp. 7. **Use of directory of services during preadmission screening.** The preadmission screening team must use a directory of services provided by the local agency during the preadmission screening in determining the individual service plan of a person being screened. The local agency must make a directory of services available to the preadmission screening team, the person being screened, and other persons present at a screening. The local agency may compile its own directory of services or use a directory prepared by a community resource. In either event, the directory must be one that is updated annually.

Subp. 8. **Notification of preadmission screening team recommendation.** The preadmission screening team must give or send a written notice stating the team's recommendation to the person being screened, the person's representative, if any, and the person's physician. The preadmission screening team must

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also send the written notice to the county of financial responsibility. Both types of notice must be given or sent within ten working days after the date of the request for the preadmission screening.

Subp. 9. **Individual service plan.** The preadmission screening team must develop an individual service plan according to part 9505.2430 when the person or the person's representative chooses to use community services.

Subp. 10. **Submittal of ACG client information to county of financial responsibility.** If the county of service is different from the county of financial responsibility for an ACG client, the county of service must submit client information to the county of financial responsibility for approval of the individual service plan. The information must include items A to D:

A. the original preadmission screening assessment form, including the original individual service plan;

B. the original signed application if required under subpart 6;

C. the original preadmission screening document; and

D. a copy of the completed financial information form required in part 9505.2455, subpart 1, item C.

Subp. 11. **County of financial responsibility review of individual service plan.** The county of financial responsibility for an ACG client under part 9505.2455, subpart 3, must approve or reject the proposed individual service plan under items A to E and part 9505.2455, subpart 2.

A. If the costs of ACG services, together with the costs of skilled nursing services provided by public health nursing services that are reimbursable under medical assistance, if applicable, do not exceed the cost limitations in subpart 5, item B, the county of financial responsibility must approve the proposed individual service plan. If the cost of ACG services together with the costs of skilled nursing services provided by public health nursing services that are reimbursable under medical assistance exceeds the cost limitations in subpart 5,

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item B, the county of financial responsibility must reject the individual service plan. Rejection of an individual service plan by the county of financial responsibility shall occur only if cost limitations of subpart 5, item B, are not met. If the county of financial responsibility and the county of service are the same, the county shall not reject the individual service plan prepared by the county's preadmission screening team if the individual service plan falls within the cost limitations of subpart 5, item B.

B. The county of financial responsibility must orally notify the preadmission screening team of the approval or rejection of the individual service plan within three working days after receiving the plan from the county of service. The county of financial responsibility must mail a written notice to the preadmission screening team within ten working days after receiving the individual service plan.

C. If the individual service plan is approved by the county of financial responsibility, the county of service must implement the plan upon oral notice of approval from the county of financial responsibility.

D. If the individual service plan is rejected by the county of financial responsibility because it exceeds the cost limitations in subpart 5, item B, the oral and written notice of rejection sent to the preadmission screening team must explain the reasons for the rejection and define the corrections needed to obtain approval. The preadmission screening team must develop a revised individual service plan for an ACG client whose initial individual service plan was rejected by the county of financial responsibility. The preadmission screening team must send the revised individual service plan to the county of financial responsibility within ten days after receiving the oral rejection.

E. If the revised individual service plan includes ACG services that meet the cost limitations in subpart 5, item B, the county of financial responsibility must approve the individual service plan and orally notify the preadmission

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screening team of the approval within three working days after receiving the revised plan. The county of financial responsibility must send a written notice of approval to the preadmission screening team within ten working days after receiving the revised plan.

Subp. 12. **Sending individual service plan to county of service.** If the county of financial responsibility approves an individual service plan, the preadmission screening team must send the written individual service plan to the county of service within ten working days after the approval.

Subp. 13. **Resident class assessment.** The preadmission screening team must complete the resident class assessment of the applicant required under parts 9549.0058 and 9549.0059 for an applicant who is not exempt from preadmission screening under part 9505.2400, subpart 5, or 9549.0059, subpart 1, item A, subitem (2). The resident class assessment shall be completed concurrently with preadmission screening performed within the time requirements of part 9505.2420.

Subp. 14. **Authorization to release information.** When a preadmission screening team, nursing home, or hospital's discharge planner asks a person being screened or the person's representative to sign forms needed to have access to information necessary to complete the preadmission screening, the following information must be on the form above the person's signature:

A. the person's name;

B. the date;

C. the information authorized;

D. who is authorized to give the information;

E. to whom the information is to be given;

F. the information's use during the screening to determine the appropriateness of nursing home admission or continued nursing home placement or use of community services for the person; and

G. the date of expiration of the authorization.

A separate form must be completed and signed for each

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authorization of access to a medical record. The period of the authorization must not exceed one year.

9505.2426 APPLICANT'S AND NURSING HOME RESIDENT'S RIGHT TO CHOOSE COMMUNITY SERVICES.

After completion of the preadmission screening required under part 9505.2425, subpart 5, or the rescreening required under part 9505.2435, the applicant, nursing home resident, or the representative of the applicant or nursing home resident shall decide whether to accept or reject the recommendations of the preadmission screening team. If the applicant, nursing home resident, or the representative of the applicant or nursing home resident who is eligible for ACG services decides to receive the ACG services identified in his or her individual service plan, the applicant, nursing home resident, or the representative of the applicant or nursing home resident shall have the freedom to choose among the ACG providers under contract with the local agency to provide the identified ACG services.

9505.2430 ESTABLISHMENT OF INDIVIDUAL SERVICE PLAN.

Subpart 1. **Individual service plan required.** The preadmission screening team must establish an individual service plan for each applicant or nursing home resident who requests preadmission screening and who has been assessed under part 9505.2425, and who has chosen community services except persons referred under part 9505.2425, subpart 5, items D and E. The preadmission screening team must consult the applicant or nursing home resident or the person's representative in establishing the plan. Additionally, the preadmission screening team must ask the applicant or the nursing home resident or the representative of the applicant or nursing home resident whether he or she chooses to have other persons consulted about the plan. The preadmission screening team must consult the persons that the applicant, nursing home resident, or the representative of the applicant or nursing home resident has designated by name to be consulted about the plan.

Subp. 2. **Request for information about eligibility for**

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medical assistance or 180-day eligibility determination. The preadmission screening team must ask the applicant, nursing home resident, or the representative of the applicant or nursing home resident whether the applicant or nursing home resident receives medical assistance, is a recipient, or would be eligible to receive medical assistance within 180 days after admission to a nursing home. If the preadmission screening team has reason to believe the person being screened would be eligible to receive medical assistance within 180 days after admission to a nursing home, the preadmission screening team must estimate what the person's financial eligibility would be 180 days after admission using a form prescribed by the commissioner.

Subp. 3. Individual service plan for a person not eligible for an ACG. The individual service plan prepared by the preadmission screening team for a person being screened who is not eligible for an ACG must document compliance with items A to D:

A. the preadmission screening team determined that the person is not eligible for community services funded by an ACG under part 9505.2455, subpart 2;

B. the preadmission screening team discussed with the person the community services identified as needed in the assessment under part 9505.2425;

C. the preadmission screening team told the person what information is available in the directory of services; and

D. the preadmission screening team gave a copy of the individual service plan to the person.

Subp. 4. Individual service plan for a person who is eligible for an ACG. The individual service plan prepared by the preadmission screening team for a person being screened who is eligible for an ACG must document compliance with items A to D. The person or the person's representative and a member of the preadmission screening team must sign the individual service plan. The preadmission screening team must give the person or the person's representative a copy of the individual service plan.

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A. The preadmission screening team has determined that the person being screened is eligible for community services funded by an ACG under part 9505.2455, subpart 2.

B. Recommendation of an individual service plan that identifies:

(1) any treatment prescribed by the individual's attending physician as necessary and any follow-up treatment as necessary;

(2) the community services needed by the person;

(3) the available providers of the identified community services including ACG service providers under contract with or employed by the local agency and informal support networks such as family, friends, volunteers, and church groups;

(4) the needed frequency of the services;

(5) the initial date on which each service must begin;

(6) the funding sources for the community services;

(7) the estimated cost of skilled nursing services provided by public health nursing services;

(8) the total cost of the ACG services;

(9) an estimate of the total cost of the community services; and

(10) the name of the case manager assigned by the county of service.

C. The preadmission screening team allowed the person or the person's representative to choose among the available providers listed in the directory of services who are under contract with or employed by the county of service.

D. The preadmission screening team reviewed the individual service plan with the person or the person's representative at the time of the completion of the preadmission screening.

Subp. 5. Sliding fee information. The preadmission screening team must tell the person being screened who would be

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eligible to receive medical assistance within 180 days after admission to the nursing home about the amount of the sliding fee that the person is required to pay for alternative care grant services according to the sliding fee schedule established by the commissioner under Minnesota Statutes, section 256B.091, subdivision 8, if the person will be receiving ACG services under an individual service plan developed under subpart 4.

Subp. 6. **Assignment of case manager.** Upon completion of the individual service plan, the local agency of the county of service shall assign a case manager to implement the individual service plan prepared for an ACG client under subpart 4.

9505.2435 RESCREENING.

Subpart 1. **Applicability.** The preadmission screening team must conduct a rescreening when the local agency receives either a written or oral request under subpart 2 suggesting that a recommendation resulting from a rescreening would differ from the recommendation given by the preadmission screening team at the last preadmission screening. Rescreenings must be conducted for all persons who meet the above criteria except ACG clients.

Subp. 2. **Request for rescreening.** The applicant, nursing home resident, or person's representative must submit a request to the local agency to be rescreened when the applicant or nursing home resident meets the criteria in subpart 1. The request may be oral or written and must state the date and location of the person's last preadmission screening and any changes in the person's health and social needs that have occurred since the last screening.

Subp. 3. **Rescreening procedure.** The rescreening must be conducted according to the procedures for preadmission screening in parts 9505.2390 to 9505.2450.

Subp. 4. **Reimbursement for rescreening.** Reimbursement to the local agency for rescreening must be the same as reimbursement of a preadmission screening under parts 9505.2440 and 9505.2445.

9505.2440 PREADMISSION SCREENING RATE.

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For rate years beginning on January 1 following the effective date of parts 9505.2390 to 9505.2500, the commissioner shall annually establish the maximum statewide rate allowed for reimbursement of preadmission screening and the maximum reimbursement rate of a local agency for preadmission screening. The maximum statewide rate and the maximum reimbursement rate of a local agency shall not exceed the prior year's rate by more than the percentage change between the two previous Junes in the all urban consumer price index (CPI-U) for Minneapolis-St. Paul new series index (1967=100) as published by the Bureau of Labor Statistics, United States Department of Labor. The CPI-U is incorporated by reference and is available from the Minitex interlibrary loan system. The CPI-U is subject to frequent change. By January 15 of each year, the commissioner must send a written notice of the maximum reimbursement rate to a local agency.

9505.2445 REIMBURSEMENT FOR PREADMISSION SCREENING.

Subpart 1. **County of financial responsibility for preadmission screening of a recipient.** The county of financial responsibility for a recipient is as defined in Minnesota Statutes, chapter 256G.

Subp. 2. **Medical assistance reimbursement for preadmission screening of a recipient.** The medical assistance program must reimburse a local agency for the preadmission screening of a recipient if the local agency has complied with the time requirements of part 9505.2420. The local agency of the county of financial responsibility shall submit invoices for reimbursement of preadmission screening costs for a recipient to the department at the times and as required in part 9505.0450, subpart 2.

Subp. 3. **Reimbursement for preadmission screening of persons who are not recipients.** Reimbursement for the preadmission screening of persons who are not recipients must be made according to Minnesota Statutes, section 256B.091, subdivision 4.

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Subp. 4. **Required local agency estimate of the cost and number of preadmission screenings of persons other than recipients.** Annually by February 15, a local agency must prepare and submit to the department an estimate for the following state fiscal year of the number and costs of preadmission screenings of persons who are not recipients and who will be applicants or nursing home residents for whom the county will provide preadmission screening.

Subp. 5. **Local agency's allocation of cost estimate to a nursing home.** Using the annual estimate of the number and costs of preadmission screenings required in subpart 4, a local agency must calculate the monthly amount to be paid by a nursing home to the local agency for preadmission screenings performed by the local agency for the following state fiscal year. The amount must be based on the nursing home's percentage of the number of licensed beds in nursing homes in the county of the local agency. The local agency must submit the amount to the nursing home by February 15.

Subp. 6. **Reconciliation of estimate required in subpart 4 with actual cost.** Annually by January 15, the department shall reconcile its estimated cost of a nursing home's number of preadmission screenings of persons who are not recipients as calculated under subpart 4 with the actual cost of preadmission screenings of these persons performed in the previous state fiscal year. The department shall notify the local agency of the amount of the overpayment or underpayment that the local agency must use in completing the calculation required under subpart 4.

9505.2450 PENALTIES.

Subpart 1. **Penalty to nursing home for admission of an unscreened applicant.** A nursing home that admits an unscreened applicant who is subject to the preadmission screening requirement under part 9505.2400 or that fails to notify the preadmission screening team about an emergency admission as required under part 9505.2420, subpart 3, item B, is subject to

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the penalties in items A to C.

A. If the applicant is a recipient, the nursing home must not be reimbursed by medical assistance for the applicant's resident days that preceded the date of completion of the applicant's assessment by the preadmission screening team under part 9505.2425. Furthermore, the nursing home must not bill an unreimbursed resident day to the unscreened applicant who is a recipient.

B. If the applicant is not a recipient, the nursing home must not bill the applicant for the applicant's resident days that preceded the date of completion of the applicant's assessment by the preadmission screening team under part 9505.2420.

C. The nursing home must include an unreimbursed resident day in the nursing home's resident day total reported to the department for the purpose of rate calculation under parts 9549.0010 to 9549.0080.

Subp. 2. **Penalty to county of service for late screening.** A county of service required to act within the time requirements in part 9505.2420 that fails to act within the time requirements shall not receive reimbursement for the preadmission screening under part 9505.2445, subparts 2 and 3, from medical assistance in the case of a recipient or from the nursing home in the case of a person who is not a recipient. Under these circumstances, the county of service shall be solely responsible for the costs of the preadmission screening. Nevertheless, the county of service must complete the preadmission screening as required in parts 9505.2400 and 9505.2425.

9505.2455 ALTERNATIVE CARE GRANTS.

Subpart 1. **Preadmission screening determination of eligibility.** The preadmission screening team must determine if the applicant or nursing home resident is eligible for an ACG under the criteria in subpart 2. If the person being screened is eligible for an ACG, the preadmission screening team must:

A. determine the county of financial responsibility

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according to subpart 3;

B. determine the county of service; and

C. determine the amount of the fee to be paid by the person if the person would be eligible to receive medical assistance within 180 days after admission to a nursing home. The amount of the sliding fee must be determined according to the sliding fee schedule established by the commissioner under Minnesota Statutes, section 256B.091, subdivision 8, and on forms provided by the commissioner.

Subp. 2. Eligibility criteria. A person is eligible for an ACG if the person meets the criteria in items A to G:

A. the person has been screened by the preadmission screening team;

B. the person is 65 years or older;

C. the person is a recipient or is eligible for medical assistance under parts 9505.0010 to 9505.0150 or would be eligible to receive medical assistance within 180 days after admission to a nursing home;

D. the person would require nursing home care if community services were not available;

E. the person is an applicant who chooses to remain in the community and use community services or a nursing home resident who chooses to leave the nursing home and receive community services;

F. the person requires community services that cannot be provided by services funded by sources other than alternative care grants;

G. the person has completed an application for community services; and

H. the cost of an ACG is within the monthly limitation specified in subpart 8.

Subp. 3. Determination of county of financial responsibility for alternative care grants. The preadmission screening team must determine the county of financial responsibility for an ACG client according to item A or B.

A. The county of financial responsibility for an ACG

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client who is a recipient is the county as defined in Minnesota Statutes, chapter 256G.

B. When ACG services begin, the county of financial responsibility for an ACG client who would be eligible to receive medical assistance within 180 days after admission to a nursing home is the county of financial responsibility as defined in Minnesota Statutes, chapter 256G for medical assistance recipients.

Subp. 4. **Use of alternative care grants.** ACG services may be reimbursed through an ACG if the person is eligible under subpart 2 and if the services are identified as needed in the ACG client's individual service plan and if the services are subject to the rates established in part 9505.2490. However, reimbursement for respite care services is limited to payment for 30 days of service in one state fiscal year.

Subp. 5. **Supplies and equipment.** If the ACG client is a recipient and the supplies and equipment are covered services under part 9505.0310, the cost of the supplies and equipment shall be paid as provided in the medical assistance program under parts 9505.0170 to 9505.0475 to the extent that reimbursement of the cost is not available from Medicare and a third party payer as defined in part 9505.0015, subpart 46. A local agency shall use ACG money to buy or rent care-related supplies and equipment for an ACG client as specified in items A to C.

A. If the supplies and equipment are not covered services under part 9505.0310 or the ACG client is not a recipient and the cost of the supplies and equipment for the ACG client is not more than $100 per month, the local agency shall authorize the use of ACG funds.

B. If the supplies and equipment are not covered services under part 9505.0315 or the ACG client is not a recipient and the cost of the supplies and equipment exceeds $100 per month, the local agency must obtain prior authorization from the department to use ACG funds to pay the cost of the supplies and equipment. For purposes of this subpart, "prior

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authorization" means written approval and authorization given by the department to the local agency before the purchase or rental of the supply or equipment.

C. The department shall have the right to determine whether the supplies and equipment are necessary to enable the client to remain in the community. If the department determines that the supplies and equipment are necessary to enable the ACG client to remain in the community and if the cost of the supplies and equipment together with all other ACG services and skilled nursing services provided by public health nursing services is less than the limitation in subpart 8, the department shall authorize the use of the ACG funds to pay the cost.

Subp. 6. **Supervision costs.** The cost of supervising a home health aide or personal care assistant must be included in the rate for home health aide or personal care services, unless payment for the cost of supervision is included in the rate for skilled nursing service. If the cost of supervising a home health aide or personal care assistant is included in the rate for skilled nursing service, the cost must not be included in the payment for a home health aide or personal care assistant. The cost of supervising an alternative care grant service other than a personal care service or a health aide service must be included in the rate for the service.

Subp. 7. **Unallowable costs.** Alternative care grants must not be used:

A. to establish community services for which funding sources are available through other programs;

B. to pay for community services that can be reimbursed through other funding sources including Medicare and third party payers as defined in part 9505.0015, subpart 46;

C. to pay for room and board costs except for respite care provided outside of the ACG client's residence; or

D. to pay providers that are not under contract with the local agency under Minnesota Statutes, section 256B.091, subdivision 8.

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Subp. 8. Costs included within the monthly limitation of an ACG to an ACG client. In a calendar month, the total cost of an ACG to an ACG client must not exceed the total statewide monthly average payment of the resident class to which the ACG client would be assigned under parts 9549.0050 to 9549.0059, calculated from the payments made for that resident class in the previous fiscal year. The following costs must be included in determining the total costs of an ACG:

A. cost of all ACG services;

B. cost of skilled nursing services provided by public health nursing services and reimbursable under parts 9505.0170 to 9505.0475; and

C. cost of supplies and equipment funded by an ACG.

Subp. 9. Criteria for selection as an ACG provider. A provider who provides ACG services must meet the criteria in items A and B.

A. The provider must be employed by or have contracted with the local agency to provide ACG services.

B. The provider must meet all licensure requirements and professional standards established in Minnesota Statutes, Minnesota Rules, and the Code of Federal Regulations that apply to the services provided.

Subp. 10. Contract for ACG services. If the local agency contracts with a provider under subpart 9, the contract must:

A. set beginning and ending dates for the term of the contract;

B. specify the duties and responsibilities of the local agency and the provider;

C. require the provider to comply with parts 9505.2390 to 9505.2500;

D. specify the amount that the local agency must reimburse the provider for the services;

E. specify reports and record retention required of the provider by the local agency;

F. specify the conditions under which the local agency shall terminate the provider's contract; and

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G. specify documentation of an individual abuse prevention plan that complies with parts 9555.8000 to 9555.8500 if such a plan is required of the provider by Minnesota Statutes, section 626.557.

Subp. 11. **Reassessment of ACG clients.** A face-to-face reassessment of an ACG client must be conducted by the case manager at least once every six months after ACG services have begun. The case manager must also reassess an ACG client when the case manager determines that changes in the health and social needs or the financial status of the ACG client require revisions in the individual service plan. When an ACG client leaves the county of service and establishes residence in another Minnesota county, the case manager responsible for implementing the ACG client's individual service plan must notify the local agency of the other county about the client's change in residence and request the other county to assign a case manager and conduct a reassessment.

Subp. 12. **Record of reassessment.** At the time of an ACG client's reassessment, the case manager must complete an assessment form and give the ACG client an information form or forms supplied by the commissioner containing the information required in part 9505.2425, subpart 3, items C to E. The case manager must document in the ACG client's case record that the client received the required information. The ACG client's case record of reassessment shall contain at least the information in items A to G:

A. the completed assessment form;

B. the reason for the reassessment;

C. a redetermination of financial eligibility for the ACG client;

D. the names and relationship to the client of the persons consulted during the reassessment;

E. any revisions of the individual service plan that will occur in type, frequency, and cost of ACG services resulting from the reassessment;

F. a completed quality assurance and review (QA&R)

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form, as required by part 9549.0059, with an estimate of the client's resident class; and

G. a recomputed sliding fee for the client who would be eligible to receive medical assistance within 180 days after admission to a nursing home.

9505.2458 CASE MANAGER ACTIONS TO ASSURE SAFETY AND HEALTH OF ACG CLIENT WHO IS A VULNERABLE ADULT.

A case manager who has reason to believe an ACG client who is a vulnerable adult is or has been subject to abuse or neglect as defined in Minnesota Statutes, section 626.557, subdivision 2, that occurs at the client's residence or the place where the client receives the ACG service shall immediately comply with the reporting and other actions required under Minnesota Statutes, section 626.557, and shall determine how to assure the client's health and safety during the local agency's investigation. The case manager shall determine whether to withdraw the services, provide another living arrangement for the client, or arrange for the services of another ACG provider. When the case manager receives the findings of the local agency's investigation, the case manager shall amend the ACG client's individual service plan as needed to assure the client's health and safety.

9505.2460 LOCAL AGENCY SELECTION OF ACG PROVIDERS.

Subpart 1. Public meeting to inform providers. The local agency must hold an annual public meeting with possible providers of ACG services to inform providers about the criteria for provider selection as listed in subpart 4 and the date by which requests to be an ACG provider must be submitted to the local agency. The local agency may hold the annual public meeting at a time convenient to its schedule for completing service contracts to be included in its annual plan. The local agency must document that the notice required in subpart 2 was given and that the public meeting was held.

Subp. 2. Notice of annual public meeting. The local agency must place a notice of the public meeting required under

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subpart 1 in the newspaper that is the official newspaper designated by the county board of commissioners of the local agency under Minnesota Statutes, section 279.08. The notice must appear at least 14 days before the public meeting and must state the date, time, and place of the meeting, the type of services for which a need is anticipated, the criteria in subpart 3 for selection as an ACG provider, the date by which the local agency will complete its selection of ACG providers, and the name, telephone number, and address of the local agency's contact person who can provide information about the criteria for selection and contract terms.

Subp. 3. **Selection criteria.** The local agency must select providers for ACG contracts as required in Minnesota Statutes, section 256B.091, subdivision 8, using the criteria in items A to G and other criteria established by the local agency that are consistent with items A to G:

A. the need for the particular service offered by the provider;

B. the service needs of the ACG clients of the local agency including the number of ACG clients to be served, the length of time service will be provided, and the health status of the ACG clients;

C. the geographic area to be served;

D. the quality assurance methods to be used by the provider including compliance with required licensures, certifications, or standards and supervision of employees as required by parts 9505.2390 to 9505.2500;

E. the rate for each service or unit of service;

F. evaluation of services previously or currently provided by the provider; and

G. the provider's previous compliance with contract provisions and future ability to comply with contract provisions including billing requirements, and terms related to contract cancellation and indemnification. The local agency must evaluate the ACG services that it provides to ACG clients using the criteria in this subpart.

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Subp. 4. Written record of reason for not selecting a provider. A local agency must keep a written record of the reason a provider who requests a contract to provide ACG services was not selected and must notify the provider of the reasons.

9505.2465 STANDARDS FOR PERSONAL CARE SERVICES.

Subpart 1. **Definitions.** For purposes of this part, the following terms have the meanings given them.

A. "Personal care provider" means a home health agency that meets the requirements of subpart 5 and is under contract to the local agency to provide personal care assistants or a local agency licensed as a home health agency under Minnesota Statutes, sections 144A.43 to 144A.47.

B. "Personal care service" means a service listed in subpart 3 that is ordered by a physician and provided by a personal care assistant to an ACG client to maintain the ACG client in his or her residence.

Subp. 2. **Training requirements.** Personal care services must be provided by a personal care assistant who has successfully completed one of the training requirements in items A to E:

A. a homemaker or home health aide preservice training program using a curriculum recommended by the Minnesota Department of Health;

B. a nursing assistant training program or its equivalent for which competency as a nursing assistant is determined according to a test administered by the State Board of Vocational Technical Education;

C. an accredited educational program for registered nurses or licensed practical nurses;

D. a training program that provides the personal care assistant with skills required to perform the services specified in subpart 3; or

E. determination by the supervising registered nurse that the personal care assistant has, through training or

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experience, the skills required to perform the duties specified in subpart 3.

Subp. 3. **Personal care services.** The duties specified in items A to N are components of personal care services:

A. bowel and bladder care;

B. skin care done to maintain the health of the skin, including prophylactic routine and palliative measures such as exposure to air, use of nondurable medical equipment, application of lotions, powders, ointments, and treatments such as heat lamp and foot soaks;

C. range of motion exercises;

D. respiratory assistance;

E. transfers;

F. bathing, grooming, and hairwashing necessary for personal hygiene;

G. turning and positioning;

H. assistance with furnishing medication that is ordinarily self-administered;

I. application and maintenance of prosthetics and orthotics;

J. cleaning equipment;

K. dressing or undressing;

L. assistance with food, nutrition, and diet activities;

M. accompanying an ACG client to obtain medical diagnosis or treatment and to attend other activities such as church if the personal care assistant is needed to provide personal care services while the recipient is absent from his or her residence; and

N. performing other services essential to the effective performance of the duties in items A to M.

Subp. 4. **Employment of personal care assistants.** A personal care assistant who provides personal care services under the ACG program is not an employee of the ACG client but must be employed by or under contract with a personal care provider. A personal care assistant employed by a personal care

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provider must meet the training requirements in subpart 2. The personal care provider shall terminate the personal care assistant's employment or assignment to an ACG client if the supervising registered nurse determines that the personal care assistant is not performing satisfactorily.

Subp. 5. **Personal care provider; eligibility.** Except as provided in subpart 11, a local agency that is not licensed as a home health agency under Minnesota Statutes, sections 144A.43 to 144A.47, and that wants to provide personal care services under the ACG program must contract with a personal care provider to provide the personal care services. To be eligible to contract with the local agency as a personal care provider, the provider must meet the criteria in items A to K. The local agency must assure the provider's compliance with the criteria in items A to K:

A. be licensed as a home health agency under Minnesota Statutes, sections 144A.43 to 144A.47;

B. possess the capacity to enter into a legally binding contract;

C. possess demonstrated ability to fulfill the responsibilities in this subpart and subpart 6;

D. demonstrate the cost effectiveness of its proposal for the provision of personal care services;

E. demonstrate a knowledge of, sensitivity to, and experience with the special needs, including communication needs, and the condition of the ACG client;

F. provide a quality assurance mechanism;

G. demonstrate the financial ability to produce a cash flow sufficient to cover operating expenses for 30 days;

H. disclose fully the names of persons with an ownership or control interest of five percent or more in the contracting agency;

I. demonstrate an accounting or financial system that complies with generally accepted accounting principles;

J. demonstrate a system of personnel management; and

K. if offering personal care services to a

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ventilator-dependent ACG client, demonstrate the ability to train and to supervise the personal care assistant and the ACG client in ventilator operation and maintenance.

Subp. 6. **Personal care provider responsibilities.** The personal care provider shall:

A. employ or contract with personal care assistants to provide personal care services and to train personal care assistants as necessary;

B. supervise the personal care services as in subpart 9;

C. if the provider is not the local agency, submit a bill to the local agency for personal care services provided by the personal care assistant;

D. establish a grievance mechanism to resolve consumer complaints about personal care services;

E. keep records as required in parts 9505.1750 to 9505.1880;

F. perform functions and provide services specified in the personal care provider's contract under subpart 5;

G. comply with applicable rules and statutes; and

H. perform other functions as necessary to carry out the responsibilities in items A to G.

Subp. 7. **Employment prohibition.** A local agency that provides ACG services to an ACG client whether the services are provided by the local agency as a personal care provider or under contract with a personal care provider must prohibit the employment of a person to provide personal care services for an ACG client if the personal care assistant:

A. refuses to provide full disclosure of criminal history records as specified in subpart 8;

B. has been convicted of a crime that directly relates to the occupation of providing personal care services to a qualified recipient;

C. has jeopardized the health or welfare of a vulnerable adult through physical abuse, sexual abuse, or neglect as defined in Minnesota Statutes, section 626.557; or

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D. is misusing or is dependent on mood-altering chemicals including alcohol to the extent that the personal care provider knows or has reason to believe that the use of chemicals has a negative effect on the ability of the personal care assistant to provide personal care services or the use of chemicals is apparent during the hours the personal care assistant is providing personal care services.

Subp. 8. **Preemployment check of criminal history.** Before employing a person as a personal care assistant for an ACG client, the personal care provider shall require from the applicant for employment full disclosure of conviction and criminal history records pertaining to any crime related to the provision of health services under the medical assistance program or to the occupation of a personal care assistant.

Subp. 9. **Supervision of personal care assistant.** A personal care assistant must be under the supervision of a registered nurse. The supervising registered nurse shall not be a member of the family of the ACG client who is receiving personal care service from the personal care assistant under the registered nurse's supervision. The supervising registered nurse must:

A. ensure that the personal care assistant is capable of providing the personal care services required in the ACG client's individual treatment plan required by part 9505.2475 through direct observation of the assistant's performance or through consultation with the ACG client and the ACG client's primary caregiver when possible;

B. ensure that the personal care assistant is knowledgeable about the individual treatment plan before the personal care assistant performs the personal care services;

C. ensure that the personal care assistant is knowledgeable about essential observations of the ACG client's health, and about any conditions that should immediately be brought to the attention of either the nurse or the ACG client's physician;

D. evaluate the personal care services of an ACG

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client through direct observation of the personal care assistant's work or through consultation with the ACG client;

E. review the individual treatment plan with the ACG client and the personal care assistant at least once every 120 days and revise the individual treatment plan as necessary;

F. ensure that the personal care assistant and ACG client are knowledgeable about any change in the individual treatment plan; and

G. review all entries made in the ACG client's health care record showing the services provided and the time spent by the personal care assistant.

Subp. 10. **Evaluation of services.** The supervising registered nurse shall evaluate the personal care assistant's work under the schedule in items A to C.

The supervising registered nurse must record in writing the results of the evaluation and action taken to correct any deficiencies in the work of the personal care assistant.

A. Within 14 days after the placement of a personal care assistant with the ACG client.

B. At least once every 30 days during the first 90 days after the ACG client first begins to receive personal care services under the individual service plan developed by the screening team.

C. At least once every 120 days following the period of evaluations in item B.

Subp. 11. **Employment and reimbursement of a relative as a personal care assistant.** A relative of an ACG client, with the exception of the ACG client's spouse, shall be reimbursed for providing personal care services to an ACG client only if the relative and the local agency meet the requirements in items A to D.

A. The relative must be employed by or under contract with the local agency or a personal care provider. A local agency employing a relative under this subpart does not have to be licensed as a home health agency under Minnesota Statutes, sections 144A.43 to 144A.47.

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B. The relative would suffer financial hardship as a result of providing the ACG client's personal care services or a personal care assistant who is not a relative is not available to perform the ACG client's personal care services. For purposes of this subpart, financial hardship refers to a situation in which a relative incurs a substantial reduction in income because he or she resigns from a full-time job, goes from a full-time to a part-time job paying considerably less compensation, takes a leave of absence without pay from a full-time job to care for an ACG client, or incurs substantial expenses in making arrangements necessary to enable the relative to care for an ACG client.

C. The relative and the local agency must meet the requirements of subparts 2, 3, and 7 to 10.

D. The local agency has obtained the department's prior approval.

9505.2470 STANDARDS FOR HOME HEALTH AIDE SERVICES.

Subpart 1. **Employment of home health aide.** A home health aide who provides home health aide services under the ACG program to an ACG client must be an employee of a provider of home health aide services. The home health aide must be under the supervision of a registered nurse. Registered nurses and practical nurses licensed under Minnesota Statutes, sections 148.29 to 148.299 shall not be employed as home health aides under the ACG program.

Subp. 2. **Eligible providers.** To be eligible as a provider of home health aide services under the ACG program, a home health agency must be licensed under Minnesota Statutes, sections 144A.43 to 144A.46, and certified to participate under titles XVIII and XIX of the Social Security Act.

Subp. 3. **Approval and supervision of home health aide services.** A home health aide providing home health aide services in the ACG program must be approved by the supervising registered nurse to perform the medically oriented tasks written in the ACG client's individual treatment plan. The supervising

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registered nurse must be an employee of a home health agency that is providing the home health aide services.

Subp. 4. **Record of home health aide services.** A home health agency providing home health aide services to an ACG client must keep a record documenting the provision of home health aide services in the client's individual treatment plan. The documentation shall include the date and nature of the services provided and the names of the home health aide and the supervising registered nurse.

9505.2473 STANDARDS FOR HOMEMAKER SERVICES.

Subpart 1. **Qualified homemakers.** The local agency shall assure that each ACG client receiving homemaker services is served by a homemaker qualified under part 9565.1200, subpart 2. A person who is providing a homemaker service under the ACG program to an ACG client who is the person's relative must meet the standards in part 9565.1200, subpart 2.

Subp. 2. **Contracting for homemaker services and supervision of a homemaker.** The local agency may directly provide or contract for homemaker services that are part of the ACG client's individual service plan. If the local agency provides homemaker services directly, the local agency must also provide supervision of the homemaker's activities. If the local agency contracts with a provider for homemaker services, the provider must meet the requirements of Minnesota Statutes, sections 144A.43 to 144A.46.

Subp. 3. **Payment limitations; homemaker.** ACG payments shall be made only for the homemaker tasks specified in part 9505.2395, subpart 23, that are required by and indicated in the ACG client's individual service plan.

9505.2475 ESTABLISHMENT OF INDIVIDUAL TREATMENT PLAN.

Subpart 1. **Requirement.** An individual treatment plan must be developed for an ACG client who receives home health aide services or personal care services. The ACG client's physician and the supervising registered nurse, together with the personal care assistant or the home health aide, the ACG client and the

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ACG client's representative, if any, must develop the individual treatment plan. The ACG client's physician and the supervising registered nurse must review the plan every 60 days and revise the plan if a revision is necessary to help the ACG client meet his or her needs. The supervising registered nurse must give a copy of the client's individual treatment plan to the ACG client's case manager and the home health agency that provides the home health or personal care services.

Subp. 2. Contents of ACG client's individual treatment plan. The ACG client's individual treatment plan must meet the requirements of Code of Federal Regulations, title 42, section 405.1223.

9505.2480 ALLOCATION OF STATE ACG MONEY.

Subpart 1. Formula for allocation of state ACG money. Annually before July 1, the commissioner must allocate state money available for alternative care grants to each local agency. The allocation must include the state share of money for services provided to recipients under the waiver and the state share of money for services to persons who would be eligible to receive medical assistance within 180 days after nursing home admission. The allocation must be made according to Minnesota Statutes, section 256B.091, subdivision 8. State funds allocated by the commissioner to a local agency for ACG services provided under the waiver shall not be used for any purpose other than services under the waiver.

Subp. 2. Review of allocation; reallocation of state ACG money. The commissioner must review the local agencies' projected and expended state ACG money on a quarterly basis. The commissioner must reduce the allocation of state ACG money to a local agency if the commissioner determines that the local agency will not use the full state allocation during the state fiscal year. The commissioner must reallocate the unused portion of the local agency's allocation to a local agency that has or wants to have more ACG clients than were projected to be served in its biennial plan.

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9505.2485 ALLOCATION OF NUMBER OF ACG CLIENTS TO BE SERVED UNDER THE WAIVER.

Subpart 1. **Local agency allocation of ACG clients under the waiver.** At least annually, the commissioner must allocate the number of ACG clients who are recipients and for whom each local agency is financially responsible under the waiver. The commissioner must determine from the medical assistance eligibility data provided as of March 1 by the counties to the department each local agency's allocation according to the county's percentage of the statewide total number of recipients who are age 65 or older.

Subp. 2. **Review of allocation; reallocation of number of ACG clients under the waiver.** The commissioner shall review the projected and actual number of ACG clients served under the waiver by all local agencies on a quarterly basis. The commissioner may reduce the number of ACG clients allocated to a local agency if the commissioner determines that the local agency will serve fewer than its allocated number of ACG clients during the allocation period. The commissioner may reallocate the unused portion of the local agency's initial allocation to another local agency.

Subp. 3. **Notice to local agency.** The commissioner shall notify a local agency annually before May 15 of the number of recipients to be served as ACG clients under the waiver under subpart 1 and shall notify a local agency at least 15 days before the effective date of a change in the number of ACG clients allocated to the local agency under subpart 2.

9505.2486 LOCAL AGENCY ESTIMATION OF NUMBER OF PERSONS OTHER THAN RECIPIENTS TO BE SERVED AS ACG CLIENTS.

A local agency must estimate the number of persons other than recipients to be served as ACG clients. The estimate shall depend on the extent that ACG funds allocated to the local agency as required by part 9505.2480 are available. The local agency must report the estimate in the biennial plan and revisions to the biennial plan required in part 9505.2495,

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subpart 2.

9505.2490 RATES FOR ACG SERVICES.

Subpart 1. **Statewide maximum ACG service rate.** For years beginning on July 1 following the effective date of parts 9505.2390 to 9505.2500, the commissioner must annually set a statewide maximum rate allowed for payment of providing an ACG service. The statewide maximum rate must not exceed the prior fiscal year's rate by more than the percentage change between the two previous Januarys indicated by the all urban consumer price index (CPI-U) for Minneapolis-St. Paul new series index (1967=100), as published by the Bureau of Labor Statistics, United States Department of Labor. The CPI-U is incorporated by reference and is available from the Minitex interlibrary loan system. The CPI-U is subject to frequent change.

Subp. 2. **Local agency maximum ACG service rate set by commissioner; general.** The commissioner shall annually set the maximum rate that is available to a local agency for reimbursing an ACG provider for an ACG service. For years beginning on the first of July following the effective date of parts 9505.2390 to 9505.2500, the commissioner shall authorize an increase in the ACG rate available to a local agency for reimbursing an ACG provider equal to the percentage change between the two previous Januarys indicated by the all urban consumer price index (CPI-U) for Minneapolis-St. Paul new series index (1967=100), as published by the Bureau of Labor Statistics, United States Department of Labor.

Subp. 3. **Local agency maximum ACG service rate set by commissioner; new ACG service.** A local agency that wants to contract for an ACG service that has not been provided before the effective date of parts 9505.2390 to 9505.2500 shall propose a maximum rate to the commissioner that does not exceed the statewide maximum ACG service rate established by the commissioner under subpart 1.

Subp. 4. **Notice to local agency.** Annually by May 15, the commissioner shall notify each local agency of the statewide

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maximum rate allowed for payment of providing an ACG service under subpart 1. Additionally, the commissioner shall notify the local agency in writing of the percentage increase allowed under subpart 2.

Subp. 5. **Local agency request to exceed county's maximum rate.** Notwithstanding the limitation on the local agency's maximum rate for an ACG service in subpart 2, a local agency that wants to increase an ACG service rate more than the percentage authorized by the commissioner under subpart 2 may submit a request for the increase to the commissioner. The local agency must justify the need for the greater increase by submitting evidence that documents an increase in costs, such as wages established under a union contract, taxes, utility costs, or transportation charges, that exceeds the percentage change or that shows that the higher rate is necessary to obtain the desired service within the local agency's local trade area. For purposes of this subpart, "local trade area" has the meaning given in part 9505.0175, subpart 22.

Subp. 6. **Local agency ACG service rate subject to audit and approval.** A local agency ACG service rate and a request to exceed the local agency's maximum ACG service rate are subject to audit and approval by the commissioner.

9505.2495 LOCAL AGENCY REPORTS AND RECORDS.

Subpart 1. **Preadmission screening documents.** The local agency must complete and submit to the commissioner a preadmission screening document that summarizes the assessment and recommendations of the preadmission screening team on an applicant, nursing home resident, or ACG client for whom the local agency has completed a preadmission screening or a reassessment. The document must be submitted by the tenth of the month following the month in which a preadmission screening or reassessment was completed.

Subp. 2. **Local agency biennial plans.** The local agency must submit a biennial plan for preadmission screening and ACGs on forms prepared by the commissioner. The local agency must

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submit the biennial plan to the commissioner by July 1 of odd-numbered years in order for the local agency to receive preadmission screening funds or ACG funds during the next two state fiscal years. The local agency must submit revisions to the biennial plan to the commissioner for approval before implementing the revisions. The biennial plan must include items A to F:

A. name and address of the local agency;

B. names and titles of the preadmission screening team;

C. names of ACG service providers;

D. identification of the types of ACG services the local agency will provide and the rates for the services;

E. an ACG budget and estimates of the number of recipients and other persons to be served as ACG clients for the first year of the biennium and an estimated budget and estimated number of clients to be served for the second year of the biennium. No later than July 1 of the second year of the biennium, each local agency must submit the actual budget and revised estimate of the number of clients to be served proposed for the second year of the biennium; and

F. assurances of compliance with Minnesota Statutes, section 256B.091, and parts 9505.2390 to 9505.2500.

Subp. 3. **Commissioner approval of local agency biennial plan.** The commissioner must approve or reject by August 15 a biennial plan submitted by the local agency as required in subpart 2, item E.

Subp. 4. **ACG provider records.** The local agency and each ACG provider under contract with the local agency must maintain complete program and fiscal records and supporting documentation identifying the ACG clients served, the services provided, and the costs incurred. The records must be identified and maintained separate from other provider records. The local agency's and provider's records including the local agency's contract with the ACG provider are subject to the maintenance schedule, audit availability requirements, and other provisions

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in parts 9505.1750 to 9505.2150.

9505.2496 CRITERION FOR DELAY IN SENDING REQUIRED NOTICES.

If information that the commissioner needs to prepare and send the notices required under parts 9505.2390 to 9505.2500 is not provided in time for the commissioner to meet the time specified in these parts, the required notices shall be sent as soon as possible after the commissioner receives the needed information.

9505.2500 APPEALS OF SCREENINGS, RESCREENINGS, AND REASSESSMENTS.

Subpart 1. Information about the right to appeal. A preadmission screening team must provide a person being screened under part 9505.2400, rescreened under part 9505.2435, or reassessed under part 9505.2455, subpart 11, or the person's representative, information about the person's right to appeal the recommendation of the screening team. The information must be in writing and must be given to the person or the person's representative during the preadmission screening. The information must state the grounds for an appealable action and that ACG services will not be reduced, suspended, or terminated if the appeal is filed before the date specified in the information unless the person requests in writing not to receive continued ACG services while the appeal is pending.

Subp. 2. Appealable actions. A person being screened, rescreened, or reassessed may appeal if:

A. the recommendation of the preadmission screening team is to deny ACG services;

B. the preadmission screening team fails to determine with reasonable promptness whether the person is eligible for ACG services; or

C. the recommendation of the case manager based on a reassessment under part 9505.2455, subpart 11, is to reduce, suspend, or terminate ACG services.

Subp. 3. Denial, reduction, suspension, or termination because of insufficient ACG funds or openings. A denial, reduction, suspension, or termination of ACG services is not an

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appealable action if the county of financial responsibility has depleted the amount of money allocated under part 9505.2480 or assigned all the openings to serve ACG clients allocated under parts 9505.2485 and 9505.2486 or if the client's case manager withdraws ACG services as provided under part 9505.2458. Additionally, termination of an ACG service being provided to an ACG client under the waiver is not appealable if the termination results from termination of the waiver.

Subp. 4. **Submission of appeals.** The person being screened or the representative of the person being screened who wants to appeal the screening team's recommendation must submit the appeal in writing to the local agency of the county of service or to the department within 30 days after receiving written notice of the appealable action, or within 90 days of the written notice if a justified reason for delay can be shown.

Subp. 5. **Appeal of action.** An appeal of issues meeting the criteria under subparts 1, 2, and 4 shall be heard and decided in accordance with Minnesota Statutes, section 256.045.

REPEALER. Minnesota Rules, parts 9505.2250; 9505.2260; 9505.2270; 9505.2280; 9505.2290; 9505.2300; 9505.2310; 9505.2320; 9505.2330; 9505.2340; 9505.2350; 9505.2360; 9505.2370; and 9505.2380, are repealed.

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STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption of Department of Human Services Rules Governing Preadmission Screening and Alternative Care Grants, Minnesota Rules, Parts 9505.2390 to 9505.2500

NOTICE OF HEARING AND NOTICE OF INTENT TO CANCEL HEARING IF FEWER THAN TWENTY-FIVE PERSONS REQUEST A HEARING IN RESPONSE TO NOTICE OF INTENT TO ADOPT RULES WITHOUT A PUBLIC HEARING

NOTICE IS HEREBY GIVEN that a public hearing on the above-entitled matter will be held in Rooms 1 A and 1 B, First Floor, 444 Lafayette Road, St. Paul, MN 55155 on April 28, 1988 commencing at 9:00 a.m. and continuing until all interested or affected persons have an opportunity to participate. The proposed rules may be modified as a result of the hearing process. Therefore, if you are affected in any manner by the proposed rules, you are urged to participate in the rule hearing process.

PLEASE NOTE, HOWEVER, THAT THE HEARING WILL BE CANCELLED IF FEWER THAN TWENTY-FIVE PERSONS REQUEST A HEARING IN RESPONSE TO THE NOTICE OF INTENT TO ADOPT THESE SAME RULES WITHOUT A PUBLIC HEARING PUBLISHED IN THIS STATE REGISTER AND MAILED TO PERSONS REGISTERED WITH THE DEPARTMENT OF HUMAN SERVICES. To verify whether a hearing will be held, please call the Department of Human Services between April 14 and April 27, 1988 at (612) 297 4301.

Following the agency's presentation at the hearing, all interested or affected persons will have an opportunity to participate. Such persons may present their views either orally at the hearing or in writing at any time prior to the close of the hearing record. All evidence presented should be pertinent to the matter at hand. Written material not submitted at the time of the hearing which is to be included in the hearing record may be mailed to Peter Erickson, Administrative Law Judge, Office of Administrative Hearings, 500 Flour Exchange Building, 310 Fourth Avenue South, Minneapolis, Minnesota 55415; telephone (612) 341 7606, either before the hearing or within five working days after the public hearing ends. The Administrative Law Judge may at the hearing, order the record be kept open for a longer period not to exceed 20 calendar days. The comments received during the comment period shall be available for review at the Office of Administrative Hearings. Following the close of the comment period the agency and all interested persons have three business days to respond in writing to any new information submitted during the comment period. During the three-day period, the agency may indicate in writing whether there are amendments suggested by other persons which the agency is willing to adopt. No additional evidence may be submitted during the three-day period. The written responses shall be added to the rulemaking record. Upon the close of the record the Administrative Law

Judge will write a report as provided for in Minnesota Statutes, sections 14.15 and 14.50. The rule hearing is governed by Minnesota Statutes, sections 14.14 to 14.20 and by Minnesota Rules, parts 1400.0200 to 1400.1200. Questions about procedure may be directed to the Administrative Law Judge.

Minnesota Rules, Parts 9505.2390 to 9505.2500 establish the procedures that govern preadmission screening (PAS) for nursing home applicants and residents who request a screening, and alternative care (ACG) grants for eligible persons who choose to remain in the community with community services. The rules provide a framework for counties to: 1) maintain preadmission screening teams; 2) administer preadmission screening; 3) determine individual service plans which will enable persons to remain in the community; 4) select providers for alternative care grant services; 5) set standards for alternative care grant providers; 6) authorize services for reimbursement; 7) bill the department for reimbursement of eligible services; 8) provide for allocation and reallocation of the number of ACG clients a county may serve and the funds for the services; 9) establish penalties on counties and nursing homes that fail to provide preadmission screenings within required time limits; 10) establish standards for home health aide , homemaker, and personal care services that are provided under ACG grants; 11) require case managers to act to assure safety and health of ACG clients who are vulnerable adults; 12) establish limits on rates for services including screenings; and 13) set forth the conditions for appealing decisions resulting from screenings, rescreenings, and reassessments. The proposed rules, if adopted, will repeal the present rule, parts 9505.2250 to 9505.2380, and are necessary in order to ensure consistency with state and federal laws and regulations and the federal waiver granted under section 2176 of the Social Security Act which allows the state to use federal Medicaid funds to provide home and community-based services otherwise not allowed under the Medicaid program.

The agency's authority to adopt the proposed rules is contained in Minnesota Statutes, section 256B.091, subdivisions 1 to 9. Adoption of these rules will not result in additional spending by local public bodies in excess of $100,000 per year for the first two years following adoption under the requirements of Minnesota Statutes, section 14.11.. A fiscal note prepared according to the requirements of Minnesota Statutes, section 3.98, subdivision 2, estimating the fiscal impact of the rule is available upon request from:

Eleanor Weber
Rules Division
Department of Human Services.
444 Lafayette Road
St. Paul, MN 55155-3816
(612) 297 4301

Copies of the proposed rules are now available and at least one free copy may be obtained by writing to:

Eleanor Weber
Rules Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816

This rule is also available for viewing at each of the county welfare or human service agencies in the State of Minnesota.

Additional copies will be available at the hearing. If you have any questions on the content of the rule contact Mary Bruns, (612) 297 2243.

NOTICE: Any person may request notification of the date on which the Administrative Law Judge'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. If you desire to be notified, you may so indicate at the hearing. After the hearing, you may request notification by sending a written request to the Administrative Law Judge. Any person may request notification of the date on which the rules were adopted and filed with the secretary of state. The notice must be mailed on the same day the rules are filed. If you want to be so notified you may so indicate at the hearing or send a request in writing to the agency at any time prior to the filing of the rules with the secretary of state.

NOTICE IS HEREBY GIVEN that a Statement of Need and Reasonableness is now available for review at the agency and at the Office of Administrative Hearings. The Statement of Need and Reasonableness includes a summary of all the evidence and argument which the agency anticipates presenting at the hearing justifying both the need for and reasonableness of the proposed rules. Copies of the Statement of Need and Reasonableness may be reviewed at the agency or the Office of Administrative Hearings and copies may be obtained from the Office of Administrative Hearings at the cost of reproduction.

Minnesota Statutes, chapter 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 Minnesota Statutes, section 10A.01, subdivision 11, 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 travel expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communication or urging others to communicate with public officials; or

(b) who spends more than $250, not including 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, 625 North Robert Street, St. Paul, Minnesota 55101, telephone (612) 296-5148.

SANDRA S. GARDEBRING
Commissioner

Dated: 2/23/86

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

In the Matter of Proposed
Rules of the Department of
Human Services Governing the
Preadmission Screening and
Alternative Care Grant Programs,
Parts 9505.2390 to 9505.2500

STATEMENT OF NEED
AND REASONABLENESS

Introduction

The proposed rule parts 9505.2390 to 9505.2500 establish procedures that govern preadmission screening (PAS) for nursing home applicants and residents who request a screening, and alternative care grants (ACG) for eligible individuals who choose to remain in the community with community services. The authority for the establishment of this rule is Minnesota Statutes, section 256B.091, subdivisions 1 to 9.

Rule parts 9505.2255 to 9505.2320 enable the Department of Human Services to establish a framework for counties to: 1) maintain preadmission screening teams; 2) administer preadmission screening; 3) determine individual service plans which will enable individuals to remain in the community; 4) select providers for alternative care grant services; 5) set standards for alternative care grant service providers; 6) authorize services for reimbursement; 7) bill the Department for reimbursement of eligible services; 8) provide for allocation and reallocation of the number of ACG clients a county may serve and the funds for the service; and 9) establish limits on rates for payments including screenings.

History of Preadmission Screening and Alternative Care Grants

Minnesota historically has had one of the highest national rates of placing elderly persons in nursing homes, approximately 9 percent in comparison to a national average of 6 percent. In addition, Minnesota has ranked second nationally in the percentage of Medicaid dollars spent on nursing home care.

The state of Minnesota became concerned about the rising costs of the Medicaid Program in the late 1970s. In 1976, the Minnesota Department of Administration (DOA) studied Minnesota's long-term care system and published Medicaid Cost Containment and Long-Term Care in Minnesota. The report found that:

> The growth of the elderly population combined with an increasing life expectancy indicates that the need for and use of long-term care services in Minnesota will continue for some time into the future. Control of costs will not be possible through reducing their

> [long-term care services] need and use. The issue then is not how to reduce the use of long-term care services but how to ensure that institutional care is reserved for those who really need it and that those who need a lower level of care have options other than institutionalization.

The DOA report was followed by two reports by the Minnesota Department of Public Welfare (now the Department of Human Services): The Containment of Medical Assistance in 1977 and Cost Containment Report: Home Care in 1978. All three reports documented the increasing use and cost of nursing home care and recommended that alternatives to nursing home care be tried. The Cost Containment Report: Home Care specifically recommended the development of a preadmission screening (PAS) program for Minnesota. The intended goals of the program were to reduce the costs of long-term care in Minnesota, to reduce inappropriate nursing home and boarding care home placement, and to provide alternatives to institutionalization of the elderly.

Minnesota's 1980 Legislature responded to the recommendation to create a PAS screening program with pilot programs in Blue Earth and St. Louis counties. The pilot project proved to be a success and in 1981, although not mandating the program, the Legislature funded the PAS program for statewide implementation and expanded it to include funds for ACGs. Counties which chose to participate in the PAS/ACG program screened all applicants who were 65 years or older and eligible for Medical Assistance or who would have been eligible for Medical Assistance within 90 days of being admitted to a nursing home.

As of July 1, 1983, all counties were required to participate in the PAS/ACG program because of the Home and Community Based Services Waiver obtained from the federal government and the group of persons to be screened was expanded to include those who would become eligible for Medical Assistance within 180 days of admission to a nursing home. The 1983 Legislature also set a moratorium on the construction of new certified nursing home beds. The moratorium was extended in 1985 to include construction on licensed nursing home beds.

In 1985, amendments to Minnesota Statutes, section 256B.091 were enacted to require county preadmission screening teams to screen all applicants to nursing homes regardless of their age or financial status. Furthermore, the amended statute required county screening teams to assign a case mix classification to the applicant. The classification is necessary to tie reimbursement to the nursing home to the amount of care required by the nursing home applicant or resident, as required in parts 9549.0058 and 9549.0059.

In 1986, the legislature further amended the PAS/ACG program. The 1986 amendments included: 1) an exemption from preadmission screening for private paying nursing home applicants who are in the nursing home less than 30 days; 2) a provision for alternative care grants to nursing home and boarding care home residents who request a screening in order to receive community services outside of the nursing or boarding care home;

3) an exception to the use of two member screening teams for private pay nursing home applicants who are hospital transfers; 4) a revision in the method of reimbursement of PAS cost for private pay nursing home applicants; 5) a requirement for six month reassessments of ACG clients; and 6) a requirement that counties must ensure that ACG clients are free to select among qualified public and private providers of services.

In 1987, the legislature again amended Minnesota Statutes, section 256B.091. The amendments included: 1) a requirement of preadmission screening of all applicants for admission to boarding care homes; 2) a provision making the county responsible for the cost of preadmission screening if the county fails to meet preadmission screening time lines; 3) a required 14-day advance notice by the county of the opportunity to be selected as a service provider; 4) an annual public meeting in each county with persons who want to be ACG providers to explain criteria for selection; 5) criteria for selection as a provider; and 6) a requirement that counties record the reasons for not selecting providers.

At the heart of the preadmission screening program is the assessment of the nursing home applicant's health and social needs. This assessment is performed by the county preadmission screening team. Depending upon the outcome of the assessment, the team informs the applicant of optional services and recommends that the client remain in the community with the assistance of community services (including or excluding ACG services) or that the client live in a nursing home. In order to maintain a maximum client choice and right to self-determination, clients may choose to live in the community or in a nursing home regardless of the screening team's recommendation.

Minnesota has a state preadmission screening/alternative care grant law and a federal waiver. Minnesota Statutes, section 256B.091 requires the Department of Human Services to establish, implement and fund the program. The federal waiver granted under section 2176 of the Social Security Act allows the state to use federal Medicaid funds to provide home and community-based services otherwise not allowed under the Medicaid Program. Currently, the waiver allows Minnesota to provide services to 1,947 Medicaid clients statewide with an average per capita annual expenditure of $2,726. For these persons in federal fiscal year 1988, the federal government pays 53.98 percent of the costs, the state pays 41.42 percent, and the county pays 4.60 percent. Services to those clients who would be eligible 180 days after admission to the nursing home are 90 percent funded from state funds and 10 percent from county funds.

The federal waiver limits the modification the state may make to the PAS program. Many of the program requirements are stipulated in the waiver and the federal government granted the waiver based in part on these stipulations. Though the state legislature could change those requirements in state law, those changes may not be implemented without risking loss of federal financial participation. It is technically possible that changes in the waiver can be requested. However the federal government has indicated that waiver extension applications that were different from the original waiver would be treated as new applications.

New applications were not approved during 1985. Thus, it seems inadvisable at this time to request changes in the waiver. Therefore, the department must comply with the parameters set in the waiver as it now stands.

The PAS/ACG program is a cooperative effort between the state and counties. The state is responsible for overall administration, policy development, funding allocation, technical assistance, monitoring and evaluation. Counties are responsible for implementing the program, ensuring that individuals are assessed before admission to a nursing home as required by Minnesota Statutes, section 256B.091, subdivision 4, developing and training screening teams, conducting the assessments, developing care plans, contracting for or providing alternative care services, reporting on activities to the state, and submitting a biennial plan. In most of the 87 Minnesota counties the county social service agency serves as the lead agency for the program. However, the program requires cooperation between social services agencies, public health agencies and the state. Though each county may develop a PAS/ACG program to meet its needs, the PAS/ACG program is guided by the rules promulgated by the state according to Minnesota's Administrative Procedures Act (APA). Rules for the PAS/ACG program were first promulgated in 1982. The 1983, 1985, 1986 and 1987 changes to the PAS/ACG legislation and changes in administrative policy created the need to amend the PAS/ACG rules of 1982.

Rule Development Procedure

To make the proposed amendments to the 1982 PAS/ACG rules, the Department used the procedures mandated by the APA, the Office of Administrative Hearings, and internal department policies that ensure maximum public input. Public input was sought through a Notice to Solicit Outside Opinion published in the State Register, a survey mailed to nursing homes, hospitals and other persons interested in the PAS/ACG program, and a public advisory committee. The unstructured open-ended survey elicited comments and issues which were subsequently addressed in the proposed PAS/ACG rule. The public advisory committee consisted of 21 persons representing county agencies, nursing homes, hospitals, public health nursing services, and consumer, advocate, and nursing associations.

Committee members met on December 1, 1984; January 10, 1985; February 7, 1985; April 11, 1985; and January 22, 1987.

9505.2390 SCOPE.

Part 9505.2390 sets forth the scope and effect of the proposed rule and lists the federal and state laws and the federal regulations which authorize the department to adopt these rules and which state the requirements for the content of these rules. This part states that these rules must be read in conjunction with Minnesota Statutes, section 256B.091 and the waiver. The department call attentions to this section of Minnesota Statutes and the waiver because they authorize the program, and establish the eligible services. Other statutes also establish the conditions for these rules and will be cited in the statement of need and

reasonableness for the appropriate rule part. Therefore, this part is necessary and reasonable to inform persons affected by the preadmission screening and alternative care grant program of the scope and basis of these rules. The waiver is approved by the United States Department of Health and Human Services (HHS) for a specified period of time. The department must apply for its renewal. However, HHS may deny renewal of the waiver. If renewal is denied, Minnesota will no longer receive federal funds for providing waivered services. Therefore, it is necessary and reasonable to specify the effective period of rule parts related to the waiver in order to inform persons affected by these rules.

9505.2395 DEFINITIONS.

This part defines words and phrases that have meaning specific to parts 9505.2395 to 9505.2500, that otherwise may have several possible interpretations or that need exact definition to be consistent with statute and other Department rules.

Subpart 1. Applicability. This provision is necessary to clarify that the definitions apply to the entire sequence of parts 9505.2390 to 9505.2500.

Subp. 2. Adult day care services. This definition is necessary to clarify a term used in these rules and set a standard. Adult day care services are services that can be funded by alternative care grants, under Minnesota Statutes, section 256B.091, subdivision 8 or the waiver. The definition is reasonable because it differentiates day care from other forms of care that may be funded with alternative care grants and identifies the services by reference to the rule governing licensure of those services. It is consistent with Title 42, Code of Federal Regulations, section 440.180, which lists adult day health services as one type of home and community-based services.

Subp. 3. Adult foster care services. This definition is necessary to clarify a term used in this rule and set a standard. Adult foster care service can be funded by an ACG under Minnesota Statutes, section 256B.091, subdivision 8 and the waiver. The definition is reasonable because it differentiates adult foster care from other forms of care that may be funded with alternative care grants and is tied to an existing rule governing licensure of adult foster care.

Subp. 4. Alternative care grant or ACG. "Alternative care grant" is a phrase used in this rule. A definition is necessary to clarify its meaning. Alternative care grant is a phrase used in Minnesota Statutes, section 256B.091 to identify funds allocated by the commissioner to pay for community services to eligible individuals. Under the statute, federal funds obtained under the waiver are incorporated into the ACG program. Money allocated to the local agencies by the commissioner includes funds received under the waiver, for Medicaid eligible ACG clients, and from the state, for ACG clients who would be eligible for Medicaid within 180 days of admission to a nursing home. The definition is consistent with Minnesota Statutes, section 256B.091. It also is

reasonable to use the abbreviation "ACG" in order to shorten the length of the rule.

Subp. 5. Alternative care grant client or ACG client. "Alternative care grant client" is a term used in these rules. A definition is necessary to clarify its meaning. The definition is reasonable because it limits the use of the term to those who are eligible for or receiving ACG services.

Subp. 6. Alternative care grant services. This definition is necessary to identify services funded under the Alternative Care Grant program. The definition is reasonable because it offers the broadest possible program within the parameters of Title 42, Code of Federal Regulations, sections 440.180 and 441, subpart G and the waiver and provides comparable services both to recipients eligible under the waiver and to those who would be eligible to receive medical assistance within 180 days after admission to a nursing home. Furthermore, it is consistent with the parameters of Minnesota Statutes, section 256B.091 which requires the state to provide ACG services to prevent unnecessary nursing home placement of persons who would be eligible to receive medical assistance within 180 days after admission to a nursing home.

Subp. 7. Applicant. The definition is necessary to clarify a term used as an abbreviation in these rules. It identifies individuals who are subject to Preadmission Screening under Minnesota Statutes, section 256B.091, subdivision 1. The definition is consistent with the statute.

Subp. 8. Assessment form. "Assessment form" is a term used in these rules. The definition is necessary to clarify its meaning. It is reasonable that the assessment form be supplied by the commissioner in order to ensure the performance of a standardized, objective assessment which incorporates statutory requirements and up-to-date methods of assessing the elderly. Furthermore, it is reasonable to specify the information the form is to document in relation to the rule because this specification avoids confusion and arbitrary collection of data and is consistent with rule requirements.

Subp. 9. Case management services. "Case management services" is a term used in these rules. A definition is necessary to clarify its meaning and to set a standard. The waiver requires case management of services provided to an ACG client. The services listed are consistent with those specified in the waiver.

The current community-based long-term care system is complex and fragmented in terms of funding and service provision, and frequently confusing to consumers and providers. One of the problems inherent in a fragmented system is the lack of coordination. Coordination of the system requires management to ensure that the ACG client obtains the prescribed ACG services. Performing tasks listed in the definition - identifying, acquiring, and coordinating resources and adjusting resources - enables the case manager to protect the client's health and social needs while at the same time assuring that the ACG program is carried out in a cost effective manner.

Subp. 10. Case manager. "Case manager" is a term used in these rules. The definition is necessary to clarify its meaning and set a standard to qualify as a person who may provide case management services in the ACG program. Under the ACG program, community services are used to meet the physical, social, income and environmental needs of the elderly. Thus, case managers must have the education, knowledge and skills needed to incorporate provider and client input during the assessment process, to assess the ACG client's needs, and to manage the client's case. Therefore, it is reasonable to specify that the case manager must be a registered nurse or social worker because these persons are trained and knowledgeable about the health and social needs of the elderly.

It is necessary to fix the responsibility for employing or contracting for the case manager to ensure that the case manager is qualified and performs effectively and objectively. Under Minnesota Statutes, section 256B.091, subdivision 8, the local agency has responsibility for implementing the alternative care grant program, conducting the assessments, developing care plans, and contracting for or providing ACG services. The underlying assumption in the definition of case management is that the case manager performs objective assessments and makes objective recommendations. Consequently, it is important that the case manager be employed by an agency which does not benefit financially from providing an ACG service. Therefore, it is reasonable that the case manager be an employee of the local agency because the local agency is responsible for implementing the ACG program and because this arrangement avoids a conflict of interest that might occur if the service vendor employs the case manager. As part of its statutory responsibility to implement the ACG program under Minnesota Statutes, section 256B.091, subdivision 8, the local agency also has the responsibilities of controlling ACG costs, evaluating the ACG services, and authorizing expenditures. Thus, the local agency's employment of or contracting for the case manager is reasonable because it enables the local agency to carry out its statutory responsibility.

Subp. 11. Commissioner. This definition is necessary to identify the official responsible under Minnesota Statutes, section 256.01, subdivisions 1 and 2(1), for the administration of the Medical Assistance Program. Using this term in lieu of "Commissioner of Human Services" is reasonable to delete unnecessary words in a term frequently repeated in the rule. Minnesota Statutes, section 15.06, subdivision 6(1) allows the commissioner to delegate specified duties and powers. The commissioner is ultimately responsible for the actions of the department. The definition is consistent with these statutes.

Subp. 12. Community services. "Community services" is a term used in these rules. A definition is necessary to clarify its meaning and set a standard. The term as defined is in common usage by social work and health care professionals to refer to a broad spectrum of services that are offered by community health care or community social service agencies to persons who live in the community. These services may be given in the home of the person requiring them or in another place located in the community. Thus, the definition is reasonable because it is consistent

with common usage of health care and social work professionals as reported by the advisory committee and in discussions with the directors of local agencies.

Subp. 13. County of financial responsibility. "County of financial responsibility" is a term used in these rules. The definition is necessary to clarify its meaning. For ACG clients who are eligible for Medical Assistance the definition is consistent with Minnesota Statutes, chapter 256G (see also part 9505.2455, subpart 3 and its SNR).

Subp. 14. County of service. A county of service for an applicant, nursing resident, or ACG client may be the same as or different from the county of financial reasponsibility for the person. For example, when the person resides in the county of financial responsibility this county is also the county of service. However, when the person lives in a county other than the county of financial responsibility, the county where the person lives is responsible for providing the necessary services. This definition is needed to distinguish between counties of financial responsibility and those of service. Counties of service perform preadmission screening and case management functions when a person lives outside of the county of financial responsibility. This is administratively efficient; counties may be financially responsible for persons who reside hundreds of miles from the local agency's office. To require county workers or persons to travel that distance for required services would be inefficient and burdensome. Other activities such as telephone calls and verification are also more efficiently done by the local agency of the county where a person lives.

Subp. 15. Delay of screening. The definition is necessary to clarify a term used in these rules and set a standard. Minnesota Statutes, section 256B.091, subdivision 4 refers to delay of screening time lines. The statute requires that all applicants be screened prior to admission to nursing homes, except for applicants who meet the "delay of screening" criteria and certain other applicants who are exempt under Minnesota Statutes, section 256B.091, subdivision 4. Unusual situations may occur in which preadmission screening cannot be completed before admission to a nursing home because of circumstances beyond the control of the applicant or the screening team. The definition is reasonable because it is consistent with the statute and takes into account unusual circumstances that delay screening.

Subp. 16. Department. This definition is necessary to identify the state agency which, under the direction of the Commissioner, supervises the MA Program under the authority of Minnesota Statutes, section 256B.04, subdivision 1 and is responsible under Minnesota Statutes, section 256B.091, for the preadmission screening and alternative care grant program. It is reasonable to shorten "Department of Human Services" to "department" to reduce unnecessary words in these rules.

Subp. 17. Directory of services. This definition is necessary to clarify a term used in these rules and to set a standard. The definition is reasonable because it is an abbreviation used to shorten the rules.

Subp. 18. Discharge planner. This definition is necessary to clarify a term used in these rules and to set a standard. Under Minnesota Statutes, section 256B.091, subdivision 2, a local agency "may contract with an acute care facility to have the facility's discharge planners perform the functions of a screening team in regard to a person being discharged from the facility. These functions involve coordinating the development of a plan for the care of the person being discharged. The definition is consistent with Minnesota Statutes, section 256B.091, subdivision 2.

Subp. 19. Emergency admission. This definition is necessary to clarify a term used in these rules and set a standard. The term identifies one of the circumstances justifying a delay of screening. Delaying nursing home admission long enough to complete the required screening could reasonably be expected to jeopardize the health of a person in an emergency situation. A physician is qualified by experience and training to determine whether a person's health and safety are jeopardized. Therefore, the definition is reasonable because it is consistent with current standards of medical practice. A hospital is an institution which is appropriate for treatment of certain acute health conditions. These rules have provisions which apply specifically to the preadmission screening of persons being discharged from a hospital to a nursing home. Therefore, it is necessary and reasonable to clarify the use of the term "community" by excluding "hospital" because the clarification avoids confusion.

Subp. 20. Formal caregivers. This definition is necessary to clarify a term used in these rules and distinguish formal caregivers from informal caregivers. Public health and county social workers report that "formal caregiver" is in common usage by social work and health care professionals to refer to skilled providers of care who are employed by or under contract with local agencies. Thus, the definition is reasonable because it is consistent with community practice.

Subp. 21. Home health aide. This definition is necessary to clarify a term used in these rules and set a standard. Home health aides provide certain kinds of home health services. The definition is reasonable because it differentiates a home health aide from other persons who provide alternative care grant services or other services.

Subp. 22. Home health aide services. The definition is necessary to clarify a term used in these rules and set a standard. Home health aide services is a service that can be funded by an alternative care grant under Minnesota Statutes, section 256B.091, subdivision 8 and the waiver. The definition is reasonable because it differentiates home health aide services from other forms of care that may be funded with alternative care grants. It is consistent with Title 42, Code of Federal Regulations, section 440.180, which lists home and community based services, and Title XIX of the Social Security Act.

Subp. 23. Homemaker services. This definition is necessary to clarify a term used in these rule parts and set a standard. Homemaker services is a

service that can be funded by an alternative care grant under Minnesota Statutes, section 256B.091, subdivision 8 and the waiver. The definition is reasonable because it differentiates homemaker services from other forms of care that may be funded with alternative care grants. It is consistent with part 9565.1200 and with Title 42, Code of Federal Regulations, section 440.180, which lists home and community-based services. Furthermore, it agrees with common understanding. Including in the definition reporting and record keeping is consistent with the requirements established for providing community social services such as homemaker services under parts 9550.0010 to 9550.0092.

Subp. 24. Hospital. "Hospital" is a term used in these rules. A definition is necessary to set a standard. The cited statute establishes the definition "hospital" for purposes of licensure by the Minnesota Department of Health.

Subp. 25. Individual service plan. This definition is necessary to clarify a term used in these rules and set a standard. The term "plan of care" is a term generally accepted to refer to a medical management plan for an individual. However, Minnesota Statutes, section 256B.091 uses the term plan of care to refer to a community service plan which is designed to meet the health and social needs of the applicant or nursing home resident. It is reasonable to use the term "individual service plan" because this term removes possible confusion resulting from the use of the same term for two very different types of "plans of care."

Subp. 26. Individual treatment plan. This definition is necessary to clarify a term used in these rules and to set a standard. As used in these rules, an individual treatment plan sets out the medical management of personal care and home health aide services received by an ACG client. It is reasonable to use the term "individual treatment plan" rather than the term "plan of care," which is the generally accepted term for a medical management plan, in order to avoid confusion with the intended meaning of "plan of care" in Minnesota Statutes, section 256B.091. Because personal care services and home health aide services are medical in nature, it is reasonable to require an individual treatment plan for those services.

Subp. 27. Informal caregivers. This definition is necessary to clarify a term used in these rules and set a standard. The term is in common usage by social work and health care professionals to refer to persons who assist the elderly without the sponsorship of an agency or organization. Thus, the definition is reasonable because it is consistent with the common usage of health care and social work professionals.

Subp. 28. Local agency. "Local agency" is a term used in these rules. It is defined solely for identification purposes. It is the agency that administers the Medical Assistance Program on a day to day basis subject to the supervision of the Department of Human Services.

Subp. 29. Medical Assistance or MA. It is necessary to identify the particular program governed by these and related rules that govern

conditions of payment of the costs of health services to persons who are determined eligible for medical assistance. The definition is solely for purposes of identification.

Subp. 30. Mental illness. "Mental illness" is a term used in these rules. A definition is necessary to clarify its meaning and set a standard. The definition is consistent with statute.

Subp. 31. Nursing home. This definition is necessary to clarify a term used in these rules and to set a standard. It is reasonable to include skilled nursing facilities (SNF), intermediate care facilities (ICF), and boarding care homes in the definition of nursing home because this inclusion is consistent with the definition in Minnesota Statutes, section 256B.091 and section 256B.421, subdivision 7 which governs nursing homes reimbursement under the medical assistance program. It is reasonable to use the term "nursing home" as an abbreviation of SNF and ICF to shorten these rules.

Subp. 32. Nursing home resident. The definition is necessary to clarify a term used in these rules and to set a standard. Under Minnesota Statutes, section 256B.091, subdivision 8, and Title 42, Code of Federal Regulations, section 441, subpart G, alternative care grants may pay for community services only to persons who would otherwise need admission to a nursing home. (Under federal regulations, boarding care homes are nursing homes if they are certified as intermediate care facilities.) Furthermore, alternative care grants cannot be used to reimburse nursing home resident days unless the nursing home care is provided for respite care. The definition is, therefore, reasonable because it excludes persons living in a nursing home who are ineligible for funding of their nursing home care under these rules.

Subp. 33. Personal care services. This definition is necessary to clarify a term used in these rules and set a standard. Personal care service is a service that can be funded by an alternative care grant under Minnesota Statutes, section 256B.091, subdivision 8 and the waiver. The definition is consistent with Title 42, Code of Federal Regulations, section 440.180, which lists home and community based services.

Subp. 34. Personal care assistant. This definition is necessary to clarify a term used in these rules and set a standard. Personal care assistants provide personal care services under these rules. The definition is reasonable because it differentiates a personal care assistant from other persons who provide alternative care grant services.

Subp. 35. Person with mental retardation or related conditions. A definition is necessary to clarify a term used in these rules. The definition is consistent with the cited rule part which governs services for persons with mental retardation.

Subp. 36. Physician. Physician is a term used in these rules. The definition is necessary to clarify its meaning and set the standard. The definition is consistent with the statute.

Subp. 37. Preadmission screening. This definition is necessary to clarify a term used in these rules and to set a standard. The definition is consistent with Minnesota Statutes, section 256B.091.

Subp. 38. Preadmission screening document. This definition is necessary to clarify a term used in these rules. The term is consistent with the title printed on the document supplied by the commissioner.

Subp. 39. Preadmission screening team. The definition is necessary to clarify a term used in these rules and set a standard. The definition is consistent with Minnesota Statutes, section 256B.091.

Subp. 40. Primary caregiver. This definition is necessary to clarify a term used in these rules and to set a standard. The definition is reasonable because it is in common use among persons involved with health and human services.

Subp. 41. Public health nurse. The definition is necessary to clarify a term used in these rules and to set a standard. The definition is consistent with the cited statutes and certification procedures of the Department of Health.

Subp. 42. Public health nursing services. This definition is necessary to clarify a term used in these rules and set a standard. The definition is consistent with statute.

Subp. 43. Reassessment. The definition is necessary to clarify a term used in these rules and set a standard. Before providing services to an ACG client, an assessment of his or her financial, health, and social needs is performed. A client's needs may change over time and therefore a client may require another assessment. Thus, the definition is consistent with the requirements of Minnesota Statutes, section 256B.091, subdivisions 3 and 8, which require a county to reassess an ACG client's service needs and eligibility at least every six months.

Subp. 44. Recipient. "Recipient" is a term used in these rules. A definition is necessary to clarify its meaning. The definition is reasonable because it ensures consistency in use of the term in the medical assistance program by reference to the rule which establishes the medical assistance eligibility requirements and thus clearly distinguishes recipients from persons who would be eligible 180 days after admission to a nursing home and other persons.

Subp. 45. Registered nurse. The definition is necessary to clarify a term used in these rules and set a standard. The definition is consistent with the cited statutes.

Subp. 46. Representative. The definition is necessary to clarify a term used in these rules. It is consistent with the cited statutes.

Subp. 47. Rescreening. The definition is necessary to clarify a term that is used in these rules and set a standard. It is reasonable because it distinguishes an initial preadmission screening from a repetition of the procedure.

Subp. 48. Resident class. The definition is necessary to clarify a term that is used in these rules. It is consistent with the rule part cited within it.

Subp. 49. Resident day. The definition is necessary to clarify a term used in these rules and set a standard. The definition is consistent with part 9549.0020, subpart 42. Parts 9549.0010 to 9549.0080 establish the policies and procedures applicable to determining payment rates for all Minnesota nursing homes enrolled in the medical assistance program.

Subp. 50. Respite care services. This definition is necessary to clarify a term used in these rules and set a standard. Respite care service is a service that can be funded by the ACG program under Minnesota Statutes, section 256B.091, subdivision 8 and the waiver. The definition is reasonable because it differentiates respite care from other forms of care that may be funded with alternative care grants. It is consistent with Title 42, Code of Federal Regulations, section 440.180, which lists home and community based services.

Subp. 51. Room and board costs. Under these rules and the waiver, room and board costs are not reimbursable except when respite care is provided away from the client's home. It is necessary to define "room and board costs" to inform the providers and the local agencies which costs are unallowable so that they can accurately estimate, measure, and bill for costs that are allowable. The definition is reasonable because it is consistent with the provisions defining room and board costs found in other department rules such as part 9535.2400, subpart 3 and 9525.0950, subpart 8.

Subp. 52. Skilled nursing service. "Skilled nursing service" is a term used in these rules. A definition is necessary to clarify its meaning. The definition is consistent with a federal regulation applicable to the ACG program.

Subp. 53. Social worker. The definition is necessary to clarify a term used in these rules and to set a standard. Minnesota Statutes, section 256B.091, subdivision 2 specifies that a social worker from the local agency must be a member of the established local screening team. Therefore, it is reasonable that a social worker meet the employment qualifications of the local agency. The definition is consistent with statute.

Subp. 54. Unscreened applicant. The definition is necessary to clarify a term used in these rules and to set a standard. The definition is reasonable because it pertains to a person for whom preadmission screening has not been completed according to Minnesota Statutes, section 256B.091 and these rules.

Subp. 55. Waiver. The definition is necessary to clarify a term used in these rules. The term is consistent with Title 42, Code of Federal Regulations, Part 441, Subpart G.

Subp. 56. Working day. The definition is necessary to clarify a term used in these rules and to set a standard. Since the local agency is responsible for implementing the preadmission screening/alternative care grant program, it is reasonable that the term be limited to the hours when the local agency is open.

9505.2396 COMPUTATION OF THE INTERVALS TO MEET NOTICE REQUIREMENTS

Parts 9505.2390 to 9505.2500 establish several time requirements for specific actions such as the time when notices must be given. Therefore, a standard is necessary to ensure consistency and statewide uniformity in giving the notices. The computation is consistent with Minnesota Statutes, section 645.15 and other rules of the department.

9505.2400 PREADMISSION SCREENING REQUIREMENT

Subpart 1. Coverage, is needed to clarify who is responsible for completing preadmission screening and who must be screened. Minnesota Statutes, section 256B.091, subdivision 2 specifies that each local agency must establish a screening team to assess the health and social needs of certain applicants.

Minnesota Statutes, section 256B.091, subdivision 3, establishes the screening team's responsibilities. Minnesota Statutes, section 256B.092 specifies other screening requirements for a person with mental retardation or related conditions. Thus, persons with mental retardation or related conditions who are applicants to intermediate care facilities for the mentally retarded are not screened under the provisions of parts 9505.2390 to 9505.2500. However, if a person with mental retardation or related conditions is an applicant to a nursing home, the person will have a screening conducted under parts 9505.2390 to 9505.2500 and also conducted under 9525.0015 to 9525.0165. (See the definition of nursing home in part 9525.2395, subpart 31.) Minnesota Statutes, sections 245.461 to 245.486, the Comprehensive Mental Health Act specifies services that must be provided for a person with mental illness. Thus, persons with mental illness are screened according to the requirements of Comprehensive Mental Health Act, Minnesota Statutes, section 245.476. Including this citation is necessary and reasonable to inform affected persons and facilitate a coordinated screening effort. This subpart is consistent with the cited statutes.

Subp. 2. Exemptions, is needed to clarify who is not subject to preadmission screening. Minnesota Statutes, section 256B.091, subdivision 4 specifies the exemptions to preadmission screening. Items A, B, G, H, I, and J are consistent with statute.

It is reasonable to exempt the persons under items D, E, and F because they have been screened and therefore it is reasonable to assume that their care needs can no longer be met by community services and that nursing home admission is necessary to their appropriate care.

It is reasonable to exempt persons under item C whose are already residents of a nursing home from preadmission screening because the staff of the nursing home is responsible for assessing their condition and providing appropriate care on an ongoing basis.

9505.2405 INFORMATION REGARDING AVAILABILITY OF PREADMISSION SCREENING

Minnesota Statutes, section 256B.091 specifies that it is the responsibility of the local agency to inform the public about the PAS program. This part is necessary to clarify what information the local agency must provide, and how and when it is to be provided.

Items A and B are necessary and reasonable because they provide information the general public needs in order to understand and use the PAS program. It is reasonable that the newspaper be the medium for providing information as it is available to the general public. Requiring use of the newspaper that has the largest circulation in the geographic area served by the local agency is reasonable because it informs the greatest number of potential applicants in an administratively effective manner. An annual notice is reasonable because it provides a systematic means of ensuring that potential users are made aware of the program and its requirements. The annual notice is reasonable because Minnesota Statutes, section 256B.091, subdivision 3 requires the local agency to provide information to the general public about the availability of the screening program.

9505.2410 ESTABLISHMENT OF PREADMISSION SCREENING TEAM

Minnesota Statutes, section 256B.091, subdivision 2 requires that each local agency establish a preadmission screening team and specifies the composition of the team. The statute also allows the local agency to contract with a hospital to have the hospital's discharge planners perform the screening of patients in that hospital.

Subpart 1. Establishment. This subpart is necessary to inform affected persons of statutory requirements. It is consistent with Minnesota Statutes, section 256B.091.

Subp. 2. Composition of preadmission screening team. This subpart is necessary and reasonable to inform affected persons about the composition of the screening team. Subitems A to C are consistent with the requirements of Minnesota Statutes, section 256B.091.

It is reasonable to require the local board of health or the entity under contract with the local agency to provide public health nursing services to designate the public health nurse by name because this information enables the local agency to verify that the person so designated meets the standard required in part 9505.2395, subpart 40.

Subp. 3. Number of preadmission screening team members present at screening. This subpart is necessary as a standard. Requiring both members to be present at the screening is reasonable to assess both the health needs (by the public health nurse) and the social needs (by the social worker) of the applicant. Allowing the physician to participate in the preadmission screening of his or her patient is reasonable because the physician has primary responsibility to identify and meet the health needs of his or her patient.

Subp. 4. Physician notification of preadmission screening. Minnesota Statutes, section 256B.091, subdivision 2 specifies that an individual's physician may be included on the screening team if the physician chooses to participate. This subpart is necessary to ensure that the physician knows about the screening and is given a choice to participate as a member of the screening team. It is reasonable to require that the physician be verbally notified on the date that the PAS team schedules the screening to allow time for the physician to arrange her or his schedule to include the screening. It is also reasonable that the notice be written to serve as a record verifying that the notice was made and as a second invitation to the physician to participate as a member of the screening team. To be consistent with other notices required in these rules, it is reasonable that the written notice be sent within ten working days of the verbal notice.

Subp. 5. Preadmission screening by public health nurses. This subpart is necessary to specify that preadmission screening may be performed by one member of the screening team, in consultation with the other member, under certain circumstances. Minnesota Statutes, section 256B.091, subdivision 2 states that "[i]ndividuals not eligible for medical assistance who are being transferred from a hospital to a nursing home may be screened by only one member of the screening team in consultation with the other member."

A local agency's screening team is composed of a public health nurse and a social worker. In addition to assessing the health and social needs of the person being screened, the team members complete the Quality Assurance Review (QA and R) required under part 9549.0059, subpart 1. The QA and R assesses the person's physical needs. Therefore, it is reasonable that the public health nurse perform the preadmission screening because a public health nurse is qualified by training and experience to make judgments about physical and social needs. Furthermore, it is reasonable to require consultation with the social worker because a social worker is qualified by training and experience to make judgments about social needs and because Minnesota Statutes, section 256B.091, subdivision 2 mandates consultation with the other screening team member.

The American Heritage Dictionary defines "consultation" as "1. The act or procedure of consulting," and, "2. A conference at which advice is given or views are exchanged." The definition of "consultation" in this subpart is consistent with the accepted usage and is therefore reasonable.

Subp. 6. Physician consultant to preadmission screening team. Minnesota Statutes, section 256B.091, subdivision 2, states that "each screening team shall have a physician available for consultation." This subpart is necessary to specify the responsibility of the local agency to designate such a physician. This subpart is consistent with the cited statute. Requiring the local agency to designate the physician consultant is reasonable because the local agency is responsible for implementing the preadmission screening program under Minnesota Statutes, section 256B.091.

9505.2413 CONTRACTS FOR PREADMISSION SCREENING TEAM MEMBERS FOR APPLICANTS DISCHARGED FROM HOSPITAL

Minnesota Statutes, section 256B.091, subdivision 2 states "the county agency may contract with an acute care facility to have the facility's discharge planners perform the functions of a screening team with regard to individuals discharged from the facility." (An acute care facility is a hospital.) This part is consistent with the cited statute. This part is necessary and reasonable to define the circumstances under which a local agency may contract with hospitals to provide members of a screening team. Specifying the contents of contracts is necessary to clarify the working relationship between the local agency and the contracted hospitals to ensure uniform administration of the preadmission screening program and to establish the standards to which the contracted hospital will be held accountable.

Items A, B, D, G, I, J, K, and L are provisions included in contracts entered into by the state as required under Minnesota Statutes, Chapter 16B. Therefore, requiring these items in a contract is reasonable because the local agency's administration of the program is subject to the department's supervision under Minnesota Statutes, section 256B.091.

Item C is consistent with Minnesota Statutes, section 256B.091, subdivision 2.

Item E requires that the contracted team members comply with these rules. Minnesota Statutes, section 256B.091, subdivision 2 specifies that contracted team members "perform the functions of screening team." The functions of the screening team are specified in cited rule parts. Item E is therefore reasonable.

Items F and H are consistent with Minnesota Statutes, section 256B.091, subdivision 2.

9505.2415 HOSPITAL NOTICE REQUIREMENTS

Subpart 1. Notification of preadmission screening team. As a means of preventing inappropriate nursing home placements of applicants being discharged from a hospital, preadmission screenings should be performed before the applicants are discharged from the hospital. This subpart is necessary to define the role of a hospital discharge planner in the preadmission screening.

The hospital discharge planner's function involves coordinating the development of a plan of care for patients being discharged. (See 42 CFR 405.1034 (a)(4).) It is, therefore, reasonable that the hospital discharge planner notify the preadmission screening team of persons who require screenings. Because the screening team needs time to schedule and coordinate the screenings, it is reasonable that the oral notice be given at least three working days before discharge to allow the screening team time to schedule and prepare for the screenings.

It is reasonable that a follow-up notice be written because a written notice serves as a record verifying that the oral notice was made.

Items A to C are reasonable because they provide the screening team necessary client information.

Information obtained from item D enables the screening team to determine if a 30-day delay of screening may be requested (see part 9505.2420, subpart 4), if a "short term" nursing home stay under the medical assistance program is expected, or if the person will be in a nursing home less than or longer than 180 days. Obtaining this information is reasonable as the length of residency impacts the financial resources of nursing home residents and thereby might affect the resident's eligibility for medical assistance and the alternative care grant program. For example, persons who are ineligible for medical assistance may be granted a 30-day delay of screening under part 9505.2420, subpart 5, and persons who would be eligible for medical assistance if they were in a nursing home for 180 days may be eligible for ACG services under part 9505.2455.

Minnesota Statutes, section 256B.091, subdivision 3, states that "local screening teams shall seek cooperation from public and private agencies in the community which offer services to the disabled and elderly." It further specifies that information on the preadmission screening program must be provided to the general public. Item E is consistent with the cited statute.

Minnesota Statutes, section 256B.091, subdivision 2, states that "if the individual is being discharged from an acute care facility, a discharge planner from that facility may be present, at the facility's request, during the screening team's assessment of the individual and may participate in discussions." Item F is consistent with that statute.

Subp. 2. Exception to notice required of hospital. This subpart is necessary to clarify a circumstance under which a hospital may discharge an applicant before completing preadmission screening. A hospital patient remains in a hospital only during the time that in-hospital services are medically necessary. This period may be shorter than three working days. Such a short period of hospitalization is not long enough for a hospital discharge planner to notify the screening team and for the screening team to perform a screening before discharge. However, a screening must be performed if the patient is an applicant to a nursing home. Retaining the patient in the hospital when in-hospital services are not medically necessary is inconsistent with parts 9505.0500 to 9505.0540 and the

requirements of Minnesota Statutes, section 256B.04, subdivision 15. It is therefore reasonable that the patient be discharged from the hospital before the screening is completed. Furthermore, it is reasonable that the hospital discharge planner notify the preadmission screening team before the patient is discharged so that the screening team receives the information necessary to carry out the screening within the time requirements of part 9505.2420, subpart 2.

9505.2420 TIME REQUIREMENTS FOR PREADMISSION SCREENING

Subp. 1. General time requirements. This subpart is necessary to define the period of time in which the local screening team must schedule and perform a preadmission screening in order to establish a standard for timely action. The screening team must schedule a preadmission screening within five working days of receiving the request. The final decision on whether to recommend a nursing home admission or alternative living arrangement must be made by the screening team in a timely manner consistent with other rules related to nursing home admissions and without placing an unworkable time limit on the team. Part 9549.0059, subpart 1, item C requires the case mix classification to be determined within ten days before or ten days after admission to a nursing home. It is reasonable to require the screening team to complete the screening within the same time period required under part 9549.0059, subpart 1, item C because the Quality Assurance and Review (QA and R) form completed pursuant to that item is an essential ingredient of the preadmission screening assessment under parts 9505.2390 to 9505.2500. However, because not all persons screened will be admitted to a nursing home, it is reasonable to use the date of the applicant's request as the parameter of compliance.

Subp. 2. Preadmission screening of hospital patients. This subpart is necessary to explain an exception to the preadmission screening time lines of applicants who are hospital patients. Historical experience of preadmission screening teams indicates that prior to the implementation of the 1985 legislative amendment which mandated screenings of all applicants, it was possible to complete screenings of applicants within three working days of receiving a notice. Statutory amendments enacted in 1985 greatly increased the number of people being screened. Consequently, local agency screening teams are sometimes unable to complete all screenings requested by hospital discharge planners within three working days of receipt of a request. Therefore, while it is important that screenings occur within this three-day period, as explained in the statement of need and reasonableness for part 9505.2415, it is reasonable that preadmission screening may be delayed by the local agency when a screening team cannot complete the screening during this period of time due to increased number of requests it has received.

Because nursing homes that admit unscreened applicants are penalized under part 9505.2450, it is reasonable that the local agency notify the nursing home of the delay of screening and the agency's approval of the delay so that a nursing home will not deny an unscreened applicant admission because of the penalty attached to such an admission under part

9505.2420. It is also reasonable to require the local agency to inform the nursing home of the scheduled screening so that the nursing home will be ready to make the applicant available to the team. To be consistent with the general time line for preadmission screening specified in subpart 1, and part 9549.0059, subpart 1, item D, it is reasonable that the preadmission screening team completes the screening within ten working days of the applicant's admission to the nursing home.

According to Minnesota Statutes, section 256B.091 local agencies must establish a preadmission screening team to screen applicants to nursing homes. Thus, each local agency has a screening team. A hospitalized applicant may choose to enter a nursing home in another county. In this circumstance the local agency may grant a delay of screening because its preadmission screening team cannot complete the screening before the person's discharge from the hospital. Therefore, requiring the local agency located in the same county as the nursing home to perform screening is reasonable because it facilitates PAS in an efficient manner and avoids placing the undue burden of travel on the team of the county in which the hospital is located.

If the nursing home and the local agency which granted the delay of screening (i.e., initial local agency) are located in different counties, it is reasonable that the initial local agency notify the local agency of the county where the nursing home is located. To be consistent with the general preadmission screening time requirements under subpart 1, it is reasonable that the preadmission screening team complete the screening within ten days after the applicant's admission to the nursing home.

Subp. 3. Emergency admission. This subpart is necessary to specify requirements applicable to an emergency admission that is required by the person's condition. Item A is consistent with the definition of "emergency" admission in part 9505.2395, subpart 19. It is reasonable that the physician certifies the reason for the emergency admission in the resident's medical record because the record is written evidence that the circumstances were determined to be an emergency.

Because Minnesota Statutes, section 256B.091, subdivision 4 requires a person seeking nursing home admission to be screened before admission, it is necessary and reasonable that nursing home admission staff determine before they admit an applicant whether the applicant has been screened. In order to prevent inappropriate prolonged nursing home placement, it is necessary that preadmission screening be performed as soon as possible after an emergency admission. Therefore, it is reasonable that the nursing home notify the preadmission screening team within two working days after the date of admission so that the preadmission screening team's recommendation is obtained in a timely manner.

The final decision on whether to recommend a nursing home admission or alternative living arrangement must be made by the screening team in a timely manner consistent with other rules related to nursing home admission and without placing an unworkable time limit on the team. Part 9549.0059, subpart 1, item C requires the case-mix classification to be

performed within ten days before or ten days after admission. The requirement of ten working days after receipt of the oral or written request is current practice and is consistent with the other time requirements for screenings throughout parts 9505.2390 to 9505.2500.

Subp. 4. Thirty-day exemption from preadmission screening. This subpart is necessary to specify requirements of a 30-day exemption from preadmission screening. Minnesota Statutes, section 256B.091, subdivision 4 exempts from preadmission screening a person who is not eligible for medical assistance and whose length of stay in the nursing home is expected to be 30 days or less based on a physician's certification. To obtain a 30-day exemption from screening, the statute also requires that the nursing home notify the screening team of the applicant's admission and of the applicant's discharge plans. The statute also requires the nursing home to provide an update to the preadmission screening team in 30 days. Items A and B are consistent with the cited statute. Under Title 42, Code of Federal Regulations, sections 456.280 and 456.380, nursing home residents must have a written plan of care which includes plans for discharge. It is, therefore, reasonable that the individual's plan of care state that discharge is planned for within 30 days of admission. To be consistent with subpart 1, it is reasonable that preadmission screening is completed within ten working days after the 30th day. If the applicant leaves the nursing home during these ten days and is not an applicant to another nursing home, preadmission screening is not required under Minnesota Statutes, section 256B.091. It is, therefore, reasonable that under these circumstances preadmission screening is not required. However, if the person is an applicant to another nursing home, the preadmission screening team is required to perform a screening. It is reasonable to inform nursing homes about the 30-day exemption of an applicant from preadmission screening because the nursing home will incur the penalty set out under part 9505.2450 when the applicant's screening does not occur within the time established in subpart 1.

Subp. 5. Nursing home applicant admitted to a hospital from a nursing home before completion of preadmission screening. This subpart is necessary to specify an exception to the preadmission screening time requirements under subparts 2 to 4. Local agency screening teams report that, under certain circumstances, the preadmission screening time requirements may negatively affect applicants and their families. The negative impact is especially true for the nursing home resident who is an unscreened applicant and who is hospitalized after admission to a nursing home. In order to comply with the time requirements specified in subparts 2 to 4, the preadmission screening team is required to complete the screening while the nursing home resident is hospitalized. Completion of preadmission screening of the hospitalized nursing home resident may heighten the concern of the resident's family for the resident at a very difficult time and, thus, be unduly burdensome to the resident and the resident's family. Without the exemption, the resident's family may find it impossible to accommodate the schedule of the preadmission screening team in a timely manner. Furthermore, such a screening might lead to an inaccurate determination and recommendation as the resident's condition may be significantly different from that when the resident was admitted to

the nursing home. Thus, the assessment would have little or no bearing on the appropriateness of the nursing home admission or the level of care that will be required after the resident returns to the nursing home upon being discharged from the hospital. Because completion of the screening under these circumstances may be burdensome and inaccurate, it is reasonable that the screening occurs when the resident is readmitted to the nursing home. Furthermore, it is necessary and reasonable to specify this exemption because the nursing home may be reluctant to permit the resident who is an unscreened applicant to return to the nursing home because of the penalty imposed on the nursing home under part 9505.2450, for admitting an unscreened applicant.

Subp. 6. Applicant from another state. This subpart is necessary to specify an exception to the preadmission screening time requirements defined in subparts 1 to 4.

Under part 9505.2400, subpart 1, preadmission screening applies to applicants who are Minnesota residents or would become Minnesota residents upon admission to a nursing home. An applicant from another state, however, cannot be screened prior to admission to a nursing home as a local agency screening team does not have the authority to screen a resident of another state. Therefore, screening of an applicant from another state must occur after the applicant is admitted to the nursing home even if the applicant is present in Minnesota as a nonresident before the nursing home admission. Thus, it is necessary and reasonable to set time requirements because they facilitate the nursing home's and local agency's compliance with screening requirements.

As stated in subpart 3, nursing home admission staff determine before they admit an applicant whether the applicant has been screened. In order to prevent inappropriate prolonged nursing home placement it is necessary that preadmission screening be performed as soon as possible after an admission of an applicant from another state. Therefore, it is reasonable that the nursing home notify the preadmission screening team within two working days after the date of admission so that the preadmission screening team's assessment and recommendation are completed in a timely manner.

In order to be consistent with subpart 1, it is reasonable that the preadmission screening team complete the screening within ten days after an applicant's admission to a nursing home.

9505.2425 SCREENING AND ASSESSMENT PROCEDURES REQUIRED DURING PREADMISSION SCREENING

Subp. 1. General requirements. This subpart is necessary to specify the general requirements for the assessment that the preadmission screening team performs. Minnesota Statutes, section 256B.091, subdivision 2, mandates that the preadmission screening team must assess the health and social needs of all applicants. It is reasonable that the assessment form be supplied by the commissioner to facilitate an assessment which is based on the requirements of statutes and these rules and to ensure a uniform,

statewide standard for determining appropriateness of placement and collection of data.

Requiring the preadmission screening team to ask whether the person being screened has been determined eligible for or is receiving medical assistance is reasonable because if the person is eligible for medical assistance, ACG services to the person might be funded under the waiver. (See part 9505.2395, subpart 45, for the definition of "waiver".) It is possible that a person being screened may be unable to pay for nursing home care but unaware that medical assistance will pay for nursing home care of persons who meet the medical assistance eligibility standards. Therefore, requiring the preadmission screening team to give the person information about making a medical assistance application is necessary and reasonable because it informs the person of a resource for eligible persons.

Subp. 2. Assessment interview. This subpart is necessary to specify a uniform standard for the interview used to assess the person. The subpart is reasonable because a face-to-face assessment allows the screening team to observe and assess the person's functional abilities in the setting where the person is or will be living. For example, the screening team cannot accurately assess the person's ability to walk while talking over the phone with the person.

When a person being screened has a representative, including the representative in the interview is reasonable because the representative has legal authority to make decisions for the person.

Subp. 3. Information given to persons being screened by screening team during preadmission screening. This subpart is necessary to implement Minnesota Statutes, section 256B.091, subdivisions 3 and 5 and to ensure that the person being screened understands her or his statutory rights.

Items A and B are consistent with Minnesota Statutes, section 256B.091. Items C, D, and E are consistent with the statutes cited in those items.

It is reasonable that the forms documenting compliance with this subpart are supplied by the commissioner to ensure that all persons being screened are given consistent, uniform, and current information on the preadmission screening and alternative care grant program and their rights related to the program.

It is reasonable that the screening team members sign the forms and that the forms are retained in the person's records at the local agency, because the signed forms are evidence that the screening team met the requirements of this subpart.

Subp. 4. Access to medical records. Preadmission screening requires an assessment of a person's health and social needs. This information must come from all knowledgeable sources so that the preadmission screening team is fully aware of the factors affecting the person when it recommends nursing home admission or an alternative care setting in the community. A key source of information is the medical information about the person.

Under Minnesota Statutes, section 13.42, some medical information is medical data (medical records) and is private and may be released only to the subject of the data unless the subject has given "an informed consent" to authorize disclosure as required under Minnesota Statutes, section 13.05, subd. 4 (d). Release of other types of medical information and welfare data is not covered by Minnesota Statutes, section 13.05, subdivision 4 (d) but it is reasonable to request the person to authorize access to this information because such a request protects the rights of the person to be informed and to choose whether to authorize access. Including this subpart is necessary and reasonable to inform affected persons of their rights and responsibilities and to enable the screening team to obtain necessary and pertinent information. Requiring the person's signature on the authorization forms is reasonable because it provides evidence the person has authorized the access.

Subp. 5. Preadmission screening team recommendations. This subpart is necessary to ensure that the screening team makes the required types of recommendations following completion of an assessment.

Item A. Title 42, Code of Federal Regulations, section 441.302(e) states that the state must assure HCFA that "the average per capita fiscal year expenditures under the waiver will not exceed the average per capita expenditures for the level of care provided in an SNF [or] ICF, . . . under the state plan." Parts 9549.0050 to 9549.0059, known as the "case mix rule," requires assignment of a nursing home resident to one of eleven classifications depending upon the resident's care needs. Furthermore, under parts 9549.0050 to 9549.0059, an annual monthly statewide average payment for nursing home care can be calculated for each of the eleven classifications. One of the preadmission screening team's responsibilities under subpart 13 and part 9549.0058 is to estimate the person's case mix score from the team's assessment of the person's health and social functioning. To comply with the terms of the waiver granted by the federal government, the average payment for community services to a resident or an applicant cannot exceed the average payment associated with the estimated resident class. If the cost of community services exceeds the average payment associated with the estimated resident class, it is reasonable that the screening team recommend nursing home care because the recommendation is consistent with the federal waiver and Minnesota Statutes, section 256B.091 and with operating the medical assistance program in a cost-effective manner as required by Minnesota Statutes, section 256B.04, subdivisions 2 and 15.

However, if services needed by the person are not available in the community but could be provided in a nursing home, it is reasonable that the team recommend nursing home placement so that the person will be able to have the necessary services.

Item B. According to Minnesota Statutes, section 256B.091, subdivision 1, a purpose of the preadmission screening and alternative care grant program is to prevent inappropriate nursing home placement by providing grants to local agencies to pay costs of cost effective alternative care. Therefore, it is reasonable that the screening team recommends using

community services when the needed services are available and the cost of the services is less than the total annual monthly statewide average payment calculated from payments made for the resident class that the person would be assigned because the recommendation is consistent with the purpose of the preadmission screening and alternative care grant program.

Item C. Minnesota Statutes, section 256B.04, subdivision 15 authorizes the department to "safeguard against unnecessary or inappropriate use of medical assistance services." Therefore, it is reasonable that the preadmission screening team recommends that the person live in the community without community services if the person does not need either nursing home care or care provided by community services because the care would be neither cost-effective nor necessary.

Items D and E. These items are necessary because persons with mental retardation or related conditions and persons with mental illness who are applicants are subject to preadmission screening under parts 9505.2390 to 9505.2500.

Items D and E require a preadmission screening team that believes the applicant is mentally ill or has a condition of mental retardation or a related condition to refer the applicant to services appropriate to the applicant's condition. These items are necessary and reasonable to inform the screening team of its responsibilities and to ensure that persons believed to be mentally retarded or mentally ill are appropriately served. Parts 9525.0015 to 9525.0165 establish the screening, service, and case management standards for mentally retarded persons. The Comprehensive Mental Health Act, Minnesota Statutes, sections 245.461 to 245.486, establish the requirements for services to mentally ill persons.

Subp. 6. Required ACG application. This subpart is necessary to clarify the process for choosing the use of community services provided under the ACG. It is reasonable to require the person being screened or the person's representative to sign an application for community services provided by ACG because the signed application provides evidence that the person made the choice. Requiring the application to be on a form prescribed by the commissioner is reasonable because use of a standard form is consistent with Minnesota Statutes, section 256.01, subdivision 4, and ensures implementation of these rules in a uniform manner.

Subp. 7. Use of directory of services during preadmission screening. Minnesota Statutes, section 256B.091, subdivision 8, requires that the individual have the freedom to choose among available qualified providers, both public and private. This subpart is necessary to specify how to identify qualified providers of community services. Requiring the screening team to use a directory is reasonable because the directory enables the team to review services available in the community and, thereby, facilitates informed choices. (See part 9505.2395, subpart 12 and its SNR for the definition of community services.)

Requiring the local agency to make the directory available not only to the preadmission screening team but also the person being screened and other

persons present at the screening is reasonable because it is the local agency that is responsible for the preadmission screening program and the directory enables informed choices. An annual updating of the directory is reasonable because it facilitates accurate information about location, contacts for services, and type of service and, thus, access to needed services.

Subp. 8. Notification of preadmission screening team recommendation. This subpart is necessary to establish requirements regarding notification of the preadmission screening team's recommendation. Subpart 6 requires the preadmission screening team to recommend a service choice. It is reasonable that the team send a written notice of the recommendation to the persons being screened, or the person's representative, and the person's physician because these individuals should be informed and a written notice provides a record of the recommendation and, thus, avoids confusion.

Preadmission screening teams assess the health and social needs of the applicant. Physicians prescribe the health care services of their patients but are not always aware of their patient's social needs or the social services the client is receiving. Thus, the written notice will inform the physician of the assessment results as well as the range of services recommended to meet the patient's care needs.

Requiring the notice to be given or sent within ten working days after completing the screening is consistent with the general time requirement for preadmission screening under Part 9505.2420, subpart 1. Requiring the team to notify the county of financial responsibility is reasonable because the county will incur a financial obligation for ACG or nursing home services to the person.

Subp. 9. Individual service plan. The subpart is necessary to specify one of the responsibilities of the preadmission screening team. Minnesota Statutes, section 256B.091, subdivision 3(e)(2) states that one of the responsibilities of the screening team is to make "recommendations for individuals screened regarding maintenance in the community with specific service plans and referrals and designation of a lead agency to implement each individual's plan of care." The subpart is consistent with this statute.

Subp. 10. Submittal of ACG client information to county of financial responsibility. This subpart is necessary to specify a responsibility of the preadmission screening team. By definition the county of financial responsibility is the county responsible for paying for ACG services. Sometimes, the county of service is different from the county of financial responsibility. Under this circumstance, it is reasonable that the county of service give the county of financial responsibility the information necessary to support the individual service plan. (See also subpart 11, concerning approval or rejection of the plan.) Items A to D are documents that the preadmission screening team is required to complete or explain during the screening. It is therefore reasonable that the county of financial responsibility receives items A to D to know what services it is

likely to be asked to pay for. Requiring submission of the original individual service plan is reasonable because this document is needed if an ACG client appeals the decision of the local agency of the county of service under part 9505.2500.

Subp. 11. County of financial responsibility review of individual service plan. This subpart is necessary to specify the criteria for approval of the individual service plan and the time requirements for giving the approval.

Item A. According to Minnesota Statutes, section 256B.091, a local agency must establish a preadmission screening team composed of a social worker and a public health nurse. The statute also sets professional standards for the team members. Therefore, screening teams are qualified to perform the required assessment and to develop the individual service plan.

Screening teams, in using the directory of services under subpart 7, are familiar with community services available in their service area, the cost effectiveness of the services, and the requirements of these rules. Therefore, it is reasonable that the county of financial responsibility approve or reject an individual service plan based on cost limitations under subpart 5, item B to ensure consistency with these rules. The phrase "skilled nursing services provided by public health nursing services that are reimbursable under medical assistance" is consistent with the standard established in Minnesota Statutes, section 256B.091, subdivision 8 which permits the use of ACG funds to pay for "a home health service eligible for reimbursement under Titles XVIII and XIX of the federal Social Security Act . . . ." These skilled nursing services are not included in the definition of ACG services in part 9505.2395, subpart 6 (see part 9505.2395, subpart 50, for the definition of "skilled nursing service and part 9505.2455, subpart 8 and the SNRs for these parts.")

Item B. The individual service plan, by definition, is the plan that sets forth the combination of community services designed to meet the health and social needs of the ACG client. It is necessary for the county of financial responsibility to notify the county of service of its approval so that the county of service knows whether to begin implementing the plan. Once a screening identifies the ACG client's health and social needs, it is reasonable that services aimed at meeting the identified needs begin as soon as possible. At the same time, the local agency requires time to process and respond to the submitted individual service plan. Public Advisory Committee members agree that three working days following receipt of the plan is an adequate amount of time to process it. Because three working days may not be sufficient time for the county of financial responsibility to write a response to the preadmission screening team, and services ought to begin as soon as possible, oral notification is required. To serve as a written record of approval or rejection of the individual service plan and to be consistent with the general time requirement for preadmission screening under Part 9505.2420, subpart 1, it is reasonable that the county of financial responsibility send a written notice to the preadmission screening team stating its approval or rejection of the individual service plan within ten working days.

Item C. As explained in item B above, it is reasonable that needed services begin as soon as possible. Therefore, it is reasonable that the county of service implements the individual service plan upon oral notice of approval and specifying this in the rule is necessary to provide guidance to the local agency.

Item D. Rejection of an individual service plan by the county of financial responsibility shall occur only if cost limitations under subpart 6, item B are not met. It is necessary and reasonable that the county of financial responsibility explain the basis for rejecting the individual service plan as the explanation is necessary and reasonable to ensure that the preadmission screening team has the information needed to modify the plan.

The purpose of the preadmission screening/alternative care grant program is to prevent inappropriate nursing home placements. In order to accomplish this goal, community services are used instead of nursing home care. Therefore, if it is not possible for the county of service to provide community services to the ACG client within the cost limitations by making the correction defined in the notice of rejection, it is reasonable to require the preadmission screening team to revise the plan.

To serve as a written record of the revised individual service plan and to be consistent with other notification time requirements in this rule, it is reasonable that the revised individual service plan be sent to the county of financial responsibility within ten days of receiving the oral rejection.

Item E. Under item A, only an individual service plan which exceeds the cost limitations under subpart 6, item B, may be rejected by the county of financial responsibility. Therefore, if the revised individual service plan does not exceed the cost limitations, it is reasonable to require the county of financial responsibility to approve it.

As explained under item B above, a time limit on approving the plan is necessary and reasonable because it facilitates the provision of the identified services as soon as possible. The standard of three working days after receiving the revised plan has been accepted as reasonable by the Public Advisory Committee because it balances time required by the local agency to carry out its administrative review and the need of the client for timely service. To serve as a written record and to be consistent with notification time requirements in these rules, it is reasonable that the county of financial responsibility send a written notice to the preadmission screening team within ten working days of receipt of the revised plan.

Subp. 12. Sending of individual service plan to the county of service. This subpart is necessary to define the obligation the preadmission screening team has upon receiving approval of the individual service plan from the county of financial responsibility.

The preadmission screening team is not responsible for providing ACG services or contracting for these services. Its role is to perform the screening and make recommendations. The county of service provides the case manager and some direct services and contracts for other services. Therefore, it is reasonable that the preadmission screening team send the service plan to the county of service so that the county of service can implement the service plan. Oral approval and information has already been sent to the county of service. Providing a written individual service plan to the county of service verifies the oral information. Thus, a ten-day period is reasonable because it does not delay the plan's implementation but allows enough time for completing paper work and delivering the written record.

Subp. 13. Resident class assessment. This subpart is necessary to clarify when the preadmission screening team is responsible for completing the resident class assessment under parts 9549.0058 to 9549.0059. The subpart is consistent with the cited rules.

Subp. 14. Authorization to release information. This subpart sets out the items of information that must be on the form a person signs to authorize access to information. This subpart is necessary to establish a standard. It is reasonable to require the information to be on the form above the person's signature because its presence ensures the person has an opportunity to review the requested items and, therefore, is able to make an informed decision about authorizing access. Furthermore, requiring the information to be on the form limits the authorization to the specified material. Limiting the authorization is reasonable because such a limit protects the person's right to privacy. Items A to E are necessary and reasonable because they specify the information being requested. Item F is necessary and reasonable because it states how the information will be used and enables the person to make an informed decision about authorizing release of the information. Item G is necessary and reasonable because it safeguards the person's privacy by limiting access to a definite period of time. Requiring a separate form to be completed and signed for each authorization is necessary and reasonable to avoid confusion and inform the person authorizing the release and the person or persons who will provide the information. Limiting the authorization to one year is consistent with standards of the collection and use of data found in certain public documents as set forth in Minnesota Statutes, section 13.05. For example, these standards apply to hospitals which request patient authorization to release medical information. Information obtained from the Minnesota Department of Health indicates that approximately 70 percent of new admissions to nursing homes are applicants from hospitals. Furthermore, it is reasonable to have a single standard for the period of authorization in order to avoid confusion and promote efficiency. See also subpart 4 and its SNR, access to medical records.

9505.2426 APPLICANT'S AND NURSING HOME RESIDENT'S RIGHT TO CHOOSE COMMUNITY SERVICES

This part is consistent with Minnesota Statutes, section 256B.01 and 42 CFR 431.51 which require the MA program to provide each recipient a free choice of provider. This part is necessary and reasonable because it informs affected persons of requirements under federal and state law.

9505.2430 ESTABLISHMENT OF THE INDIVIDUAL SERVICE PLAN

Subp. 1. Individual service plan required. This subpart is necessary to establish who is responsible for the development of an individual service plan and who is to be consulted. Minnesota Statutes, section 256B.091, subdivision 3(e)(2) designates responsibility to the screening team to make recommendations regarding individual service plans. The Minnesota Long-Term Care Plan (October 1981, p. 20) states that "family members are the primary providers of long-term care" and that "when assistance is needed, it is to the family that the older person turns first for help. In cases where the elderly receive formally provided services, the family member may act as an intermediary, service broker, and/or provide services to augment the formal services." Because families are the main providers of long-term care, and are often the primary caregivers, it is reasonable that they have the opportunity to participate in the development of the elderly person's individual service plan. However, in some instances the family member's participation may not be desired by the person being screened. Therefore, it is reasonable to require the team to consult the person being screened about persons who may participate in order to protect the rights of the applicant or nursing home resident. Permitting the applicant or nursing home resident to designate other persons who may participate is reasonable because it is consistent with the applicant's or nursing home resident's right to choose.

Subp. 2. Request for Information about eligibility for medical assistance or 180-day eligibility determination. This subpart is necessary to specify a responsibility of the preadmission screening team. Minnesota Statutes, section 256B.091, subdivision 8 defines the eligibility criteria for alternative care grants. One criterion is that the person has been screened by the preadmission screening team. A second criterion is that the person is receiving medical assistance or would be eligible for medical assistance 180 days after admission to a nursing home. Therefore, it is reasonable to ask whether the person being screened receives medical assistance or would be eligible 180 days after admission because it is the standard for determining eligibility for alternative care grants. Assigning the preadmission screening team the responsibility to ask and, when necessary, to estimate the person's eligibility 180 days after nursing home admission is reasonable because the screening team is in direct contact with the person or the person's representative who is most knowledgeable about the person's financial status and thus the team can carry out the task in an administratively efficient manner. The financial information obtained by the screening team also is necessary to determine any sliding fee that must be paid for ACG services if the person would be eligible to receive medical assistance within 180 days after admission to a nursing home. See subpart 3 and its SNR. In order to avoid confusion and to standardize the estimation throughout the state, it is reasonable to require the team's use of a form provided by the commissioner.

Subp. 3. Individual service plan for person not eligible for ACG. Minnesota Statutes, section 256B.091, subdivision 3(c), requires the local agency responsible for the preadmission screening to assess the health and social needs of applicants and nursing home residents to identify services needed to maintain these persons in the "least restrictive environments." Therefore, the screening team must develop an individual service plan for all persons being screened who have chosen community services but who are ineligible for ACG services.

Item A is necessary and reasonable as it defines the status of the person for whom the plan is established. Items B to D are consistent with part 9505.2425, subparts 5 and 7. Item B is necessary and reasonable because it ensures that the affected person is informed and it is consistent with the purpose of preadmission screening and alternative care grants under Minnesota Statutes, section 256B.091.

Subp. 4. Individual service plan for a person who is eligible for an ACG. Under Minnesota Statutes, section 256B.091, subdivision 8, grants of state funds are used to pay the costs of providing alternative care to persons who meet the eligibility requirements. Furthermore, Minnesota Statutes, section 256B.091, subdivision 8 requires the local agency to ensure that a plan of care is established for each ACG client. This subpart is necessary to set a uniform standard of the components of an individual service plan for a person who is eligible for an ACG. It is reasonable that the person or the person's representative, if any, sign the individual service plan because the signature is evidence that the plan has been made available to the person or the person's representative. Requiring the preadmission screening team to give the person a copy of the plan is reasonable because it ensures the person has an opportunity to be informed and to monitor the plan's implementation.

Item A is necessary and reasonable as it defines the status of the person for whom the plan is established.

Item B. Subitem 1 is necessary to ensure that the person's plan includes the treatment prescribed by the person's physician. Subitems 2 and 4 of this item are necessary to comply with Minnesota Statutes, section 256B.091, subdivision 3, paragraphs (c), (d), (c)(2), and (f). Subitems 3, 5, 6 and 7 are reasonable as they contain information necessary to implement the individual service plan and meet the requirements of Minnesota Statutes, section 256B.091, subdivision 3(c)(2). Subitem 8 is necessary and reasonable as the total cost of the ACG services (together with the cost of skilled nursing services provided by a public health nursing service) is used in determining whether the cost of services exceeds the monthly limitation under 9505.2455, subpart 8. Subitem 9 is reasonable because an estimate of the total cost of community services which are comprised of ACG services and skilled nursing services must be made to determine whether the cost is within the limitations under part 9505.2425, subpart 6. (Skilled nursing service is eligible for medical assistance reimbursement if it meets requirements set forth in parts 9505.0170 to 9505.0470).

Item C is consistent with the requirement of Minnesota Statutes, section 256B.091, subdivision 8, that the local agency must document in a person's plan of care that the "most cost-effective alternatives available have been offered" to the person and that the person "was free to choose among available qualified providers. . ."

Item D. Minnesota Statutes, section 256B.091, subdivision 3 requires the participation of the person being screened and the person's representative, if any, in developing the individual service plan.

It is reasonable to require the PAS team to document that the person being screened or the person's representative has seen the plan because such documentation is evidence of compliance with the statutory requirement.

Subp. 5. Sliding fee information. This subpart is necessary to specify a responsibility of the preadmission screening team. Under this subpart, the team would apply the financial information obtained in subpart 2 to the sliding fee schedule set by the commissioner. It is reasonable to require the team to inform the person of the amount of the fee as the team is in direct contact with the person or the person's representative and has access to all the information necessary to carry out the task in an administratively efficient manner. The subpart is consistent with the statute cited in this subpart.

9505.2435 RESCREENING

This part is necessary to establish a standard for rescreening and payment for rescreening.

Subp. 1. Applicability. This subpart is necessary to clarify who is eligible for a rescreening. A rescreening is defined in part 9505.2395, subpart 44 as a completion of a preadmission screening after an initial screening.

A rescreening differs from a reassessment in that a rescreening of an applicant or nursing home resident is conducted by the preadmission screening team and occurs only when there is a change in the applicant's or resident's social or health status whereas an ACG client's reassessment is conducted by the client's case manager and must occur at least once every six months.

Minnesota Statutes, section 256B.091, subdivision 3(b) states that the preadmission screening team is responsible for accepting referrals from individuals. Because a rescreening involves the same purpose and procedure as a screening, it is reasonable to require the preadmission screening team also to accept referrals for rescreenings. However, to avoid unnecessary rescreenings, which may unduly burden the county or the preadmission screening team, it is reasonable to require that the person requesting a rescreening explain the reasons for the request, the changes in health and social needs, and to limit the circumstances justifying the rescreening to those where there are changed circumstances.

Subp. 2. Request for rescreening. This subpart is necessary to specify the details of the request for rescreening so that rescreening is done when it should be and resources are only used for necessary screenings. To assist the preadmission screening team in evaluating whether to perform a rescreening and in preparing for a rescreening, it is reasonable that the request for a rescreening include the information required in this subpart.

Subp. 3. Rescreening procedure. This subpart is necessary to establish the required procedures for rescreening. It is consistent with the definition of "rescreening" in these rules. It is reasonable to require the same procedure as is used for preadmission screening because the purpose of the rescreening is the same as that of preadmission screening.

Subp. 4. Reimbursement for rescreening. This subpart is necessary to clarify how the cost of a rescreening is reimbursed. Because rescreenings are the same procedure as the initial screening, it is reasonable that payment to the local agency for rescreenings is the same as the payment for preadmission screening. Thus, this subpart cites parts 9505.2440 to 9505.2445 which sets forth the reimbursement of preadmission screening.

9505.2440 PREADMISSION SCREENING RATE

Under Minnesota Statutes, section 256B.091, the commissioner must set the maximum rates for screenings on a statewide basis and for each county. Accordingly, the reimbursement rates for preadmission screening were first established in 1982, the first year of a statewide preadmission screening program. The rates have been adjusted annually since then. This subpart is necessary to clarify how the preadmission screening rates are to be adjusted. Preadmission screening must be completed by a public health nurse and a social worker according to Minnesota Statutes, section 256B.091. Therefore, it is reasonable to require the commissioner to base the rates on the cost of the preadmission screening team's work because this basis is consistent with avoiding excess payment as required by Minnesota Statutes, section 256B.04, subdivision 15 and with avoiding an undue financial burden for the county. It is also reasonable that the rates not include the cost of implementing the individual service plan because the local agency, not the screening team, implements the plan. The department has chosen to use the change in the CPI-U (Consumer Price Index Urban) to annually adjust the rate because it is in common use as a means to adjust reimbursement rates to be consistent with cost changes. The rationale for using the CPI-U is discussed in the SNR for part 9505.2490, subpart 2.

It is necessary to specify when and how the commissioner must notify local agencies of the established preadmission screening rate. Minnesota Statutes, section 256B.091, subdivision 4 requires the county to annually submit a monthly cost estimate for preadmission screening to the state and to each nursing home within the county by February 15. To fulfill this requirement, the county needs to know the state approved preadmission screening rate. Specifying the time of January 15 is reasonable because

it gives a county the necessary time to compute the estimate and to comply with the statutory requirement.

9505.2445 REIMBURSEMENT FOR PREADMISSION SCREENING

Subp. 1. Determination of county of financial responsibility for preadmission screening of a recipient. Minnesota Statutes, section 256B.091, subdivision 4 requires medical assistance to pay the costs of screening applicants who are receiving medical assistance. Thus, this subpart is necessary to clarify which local agency is financially responsible for recipients so that medical assistance reimbursement can be made to the financially responsible agency. This subpart is consistent with Minnesota Statutes, chapter 256G, which defines county of financial responsibility in regard to medical assistance eligibility.

Subp. 2. Medical assistance reimbursement for preadmission screening of a recipient. Requiring the county of financial responsibility to submit the invoices for reimbursement is reasonable because this county is the one which will receive the reimbursement. Because medical assistance will pay the reimbursement rate for recipients' preadmission screenings, it is reasonable that the local agency adhere to the medical assistance billing standards of part 9505.0450, subpart 2 in order to obtain medical assistance funds and to avoid confusion about billing procedures. Medical assistance billing procedures require the county of financial responsibility to carry out required billings. Thus, if the county of service is different from the county of financial responsibility, the county of service will bill the county of financial responsibility which in turn bills the department for the medical assistance payment. This subpart is necessary to specify procedures for paying the costs of preadmission screening for a recipient. The subpart is consistent with the rule cited in this subpart.

Subp. 3. Reimbursement for preadmission screening of persons who are not recipients. This subpart is necessary to clarify procedures for paying the costs of preadmission screening for persons who are not recipients. This subpart is consistent with the cited statute.

Subp. 4. Required local agency estimate of the cost and number of preadmission screenings of persons other than recipients. Minnesota Statutes, section 256B.091, subdivision 4 requires the local agency to submit a monthly cost estimate of preadmission screenings of applicants who are not recipients for each nursing home in the county. The estimate must be submitted to the department. The subpart is consistent with the cited statute and is necessary to inform persons affected by the rule.

Subp. 5. Local agency's allocation of cost estimate to a nursing home. Minnesota Statutes, section 256B.091, subdivision 4 requires the local agency to submit a monthly cost estimate of preadmission screenings of applicants who are not recipients to each nursing home in the county. This subpart is consistent with cited statute and is necessary to inform persons affected by the rule.

Subp. 6. Reconciliation of estimate required in subpart 5 with actual cost. This subpart is necessary to adjust extimates of costs with the actual costs. The actual cost affects the rates each nursing home receives. Therefore, reconciliation of the estimate with the actual costs is reasonable because it ensures fiscal responsibility and prevents overpayment or underpayment.

9505.2450. PENALTIES

This part is necessary to define penalties imposed on nursing homes and counties for failure to comply with preadmission screening time lines.

Subpart 1. Penalty to nursing home for admission of an unscreened applicant. Clear delineation of responsibility is crucial to the success of the preadmission screening program. If the screening requirement is to be implemented as the statute requires, there must be consequences attached to noncompliance.

Item A. The financial consequence of loss of medical assistance payment for the period of noncompliance is reasonable because it is consistent with the requirement of Minnesota Statutes, section 256B.04, subdivisions 10 and 15, of safeguarding against unnecessary and inappropriate use of medical assistance services.

Item B. Minnesota Statutes, section 256B.091, subdivision 1 requires a determination of the appropriateness of nursing home placement before admission. The necessity and appropriateness of admission to a nursing home are determined in the preadmission screening. If the screening is not completed as required, the appropriateness and necessity of admission has not been determined. Thus, it is reasonable that an applicant who is not a recipient not be billed for resident days before the determination because the applicant has no assurance that admission is necessary and appropriate. Beginning reimbursement on the date of completion of the applicant's assessment is reasonable because it limits the penalty to the period of noncompliance and provides an incentive to comply quickly.

Item C requires the nursing home to report unreimbursed resident days in its resident day total for purposes of the department's rate calculation under parts 9549.0010 to 9549.0080. Including unreimbursed resident days in the total reported to the department is necessary to give the department an accurate count of the resident days provided by the nursing home. An accurate count is necessary and reasonable because this information affects the nursing home's payment rates.

Subp. 2. Penalty to county of service for late screening. This subpart is necessary to specify the consequences of a county's noncompliance with the preadmission screening time requirements. Minnesota Statutes, section 256B.091, subdivision 4 states:

> For all individuals regardless of payment source, if delay of screening time lines are not met because a county is late in screening an individual who meets the delay of screening criteria, the county is solely responsible for paying the cost of the preadmission screening.

This subpart is consistent with the statute.

9505.2455. ALTERNATIVE CARE GRANTS

Subp. 1. Preadmission screening determination of eligibility. This subpart is necessary to clarify who is responsible for determining if an applicant or nursing home resident is eligible for an alternative care grant and the procedures that must be used if eligibility is established. Under part 9505.2425, the preadmission screening team must develop an individual service plan which includes ACG services if the person is eligible for an alternative care grant. Therefore, it is reasonable that the PAS team determines eligibility for an alternative care grant because the PAS team will be in direct contact with the person and can obtain the required information without placing an additional burden on the person. Also under part 9505.2425, the preadmission screening team must submit the individual service plan, along with the completed forms provided by the commissioner to the county of financial responsibility to estimate whether the person would be eligible to receive medical assistance 180 days after admission to a nursing home and to determine the amount of the fee the person must pay according to the sliding fee schedule established by the commissioner. To submit the documents to the appropriate agency that is responsible for paying for the person's ACG services, it is necessary and reasonable that the team determines the county of financial responsibility.

Subp. 2. Eligibility criteria. This subpart is necessary to clarify who is eligible to receive an alternative care grant. The eligibility criteria are consistent with Minnesota Statutes, section 256B.091, subdivision 8. (See also the SNR for subpart 8.)

Subp. 3. Determination of county of financial responsibility for alternative care grants. This subpart is necessary to clarify the criteria the preadmission screening team shall use in determining the county of financial responsibility.

Item A is consistent with Minnesota Statutes, section 256B.091 and the cited statutes.

Item B. For purposes of this rule, there are no federal regulations or state statutes which define a county of financial responsibility for persons who are not eligible for medical assistance. However, it is necessary to establish a county of financial responsibility to ensure payment of services provided under the individual service plan. The ACG program serves elderly persons, many of whom move frequently. For example, an ACG client might periodically live with family members who live in counties other than the client's home county. Although the person's living place changes, the person's health and social needs must be met. It is reasonable that the county of financial responsibility for an ACG client who would be eligible for medical assistance within 180 days after admission to a nursing home is the same county as the county established under Minnesota Statutes, chapter 256G because the requirement

ensures continuity of care, continuity of review of the criteria for approving an individual service plan, an orderly procedure for payment of ACG services, and is consistent with the definition in the cited statutes.

Subp. 4. Use of alternative care grants. This subpart is necessary to specify services which can be reimbursed through the use of an alternative care grant. This subpart is consistent with Title 42, Code of Federal Regulations, section 440.180, with the waiver allowed by the federal government, and with Minnesota Statutes, section 256B.091, subd. 8.

The 30-day limit on reimbursement of respite care services is consistent with the waiver (see waiver section IV, 6). (For the definition of "respite care," see part 9505.2395, subpart 48 and its SNR.)

Subp. 5. Supplies and equipment. This subpart is necessary to specify that supplies and equipment may be funded under an alternative care grant, to clarify reimbursement sources for supplies and equipment, and to establish a criterion for prior authorization of supplies and equipment. Minnesota Statutes, section 256B.091, subdivision 8 states that "grants may be used for payment of costs of providing care-related supplies, equipment and services." Minnesota Statutes, section 256B.091, subdivision 8, also states that "the county agency shall provide documentation to the commissioner verifying that the individual's alternative care is not available at the time through any other public assistance or service program." Supplies and equipment are not funded under the waiver. However, some supplies and equipment are funded under the medical assistance program, Medicare, and third party payers. Therefore it is reasonable that supplies and equipment that are not funded under the medical assistance program, Medicare, or a third party payer may be funded under an alternative care grant because the funding is consistent with the statutory provisions.

It is not the intent of the ACG program that available ACG funds be used to purchase capital items of equipment or a several months supply of an item that may be needed for a limited period of time but rather that the funds be used to purchase only those items necessary to enable the client to live in community setting. The requirement of prior authorization for an expenditure for an item of supply costing more than $100 per month provides the department an opportunity to review the necessity of an item of supply or of equipment without placing an undue burden on the county or the client of justifying every expenditure. It should be noted that the limit is placed on an item of supply and not on the total amount of supplies purchased in a month. The limit is reasonable because it balances the local agency's ability to obtain supplies and equipment needed to maintain the client in a community setting and the department's responsibility to ensure that limited ACG funds are used in a manner consistent with the purpose of the program.

Subp. 6. Supervision costs. This subpart is necessary to clarify how the cost of supervision of ACG service providers will be paid. (See part 9505.2465, subpart 9 for requirements about supervision of personal care assistants and part 9505.2470, subpart 4, for requirements about

supervision of home health aides.) Under the waiver, supervision costs are reimbursable if they are included in the service rate. Home health aides and personal care assistants must be supervised by a registered nurse under these rules. Skilled nursing rates may include the cost of supervising home health aides and personal care assistants. To avoid duplicate reimbursements, it is necessary to specify that the rate for supervision cannot be included in the service rate if it is included in the skilled nursing rate. Therefore, this subpart is reasonable because it is consistent with the waiver.

Subp. 7. Unallowable costs. This subpart is necessary to specify unallowable costs under an alternative care grant. Items A, B, and D are consistent with Minnesota Statutes, section 256B.091, subdivision 8. Under 42 CFR, sections 433.135 to 433.138 medical assistance cannot be used to pay for services when a third party is liable to pay. Item B is consistent with those regulations and the cited rule. Item C is consistent with Title 42, Code of Federal Regulations, section 441.310(a)(3).

Subp. 8. Costs included within the monthly limitation of an alternative care grant to a client. This subpart sets a limit on the monthly expenditures for a client's ACG services. This limit applies to the total cost of ACG services for a client including skilled nursing services provided by public health nursing services if covered under medical assistance, and supplies and equipment.

Minnesota Statutes, section 256B.091, subdivision 8 requires the local agency to document to the commissioner that the most cost effective alternatives have been offered to the individual.

Furthermore, Minnesota Statutes, section 256B.091, subdivision 8 authorizes the department to set a limit on ACG rates for approved ACG services that include care-related supplies, equipment, and services such as home health services eligible for reimbursement under Medicare and Medicaid. Under the waiver and consistent with 42 CFR 441.301(3), the department can deny home and community-based services "when it is determined that nursing home care would be less costly." This subpart is necessary to set the limit and ensure a uniform standard. Items A to C are consistent with the waiver. It is reasonable to use the total statewide monthly average payment for the resident class that would be assigned the person, calculated from the payments for the classification, as this amount is based upon the cost of providing nursing home services to persons in the resident class.

Subp. 9. Criteria for reimbursement as an ACG provider. This subpart is necessary and reasonable to clarify criteria for selecting ACG providers.

Item A. A contract delineates responsibilities and obligations of the contractor and contractee. A signed contract serves as a record of agreement to hold the parties accountable for fulfilling the designated responsibilities.

Item A is necessary and reasonable because it clarifies who the contracting parties are. Minnesota Statutes, section 256B.091, subdivision 8 requires that ACG service providers be employed by or under contract with the county. This item is consistent with the cited statute.

Item B. Title 42 Code of Federal Regulations, section 441.302 (a) requires the department to assure the federal agency that:

> "necessary safeguards have been taken to protect the health and welfare of the recipients of the services. Those safeguards must include: (1) adequate standards for all types of providers who provide services under the waiver."

The regulation further specifies that a provider of services under the waiver must meet all applicable state licensure and certification requirements. Therefore, item B is consistent with the Code of Federal Regulations.

Subp. 10. Contract for ACG services. This subpart is necessary to specify the details of a contract between a provider and a local agency and thus establish a uniform statewide standard. Items A, B, D, E, and F are provisions commonly included in contracts for services. Their inclusion is reasonable because clarifying the terms between the contracting parties reduces the likelihood of dispute and confusion about the parties' obligations.

Item C requires that the contracted provider comply with these rules. Alternative care services are governed by these rule parts. Therefore, it is reasonable that a provider of alternative care services comply with these rules. Item G is consistent with the statute and rules cited in the item.

Subp. 11. Reassessment of ACG clients. This subpart is necessary to clarify when reassessments must be performed. Minnesota Statutes, section 256B.091, subdivision 8 requires that a local agency ensure that an ACG client's service needs and eligibility are reassessed at least every six months. The statute, therefore, establishes a minimum standard for reassessments and allows the commissioner to set further standards. A reassessment as defined in part 9505.2395, subpart 42 is a re-evaluation of an ACG client's financial, health, and social needs. It is required under Title 42, Code of Federal Regulations, section 441.303 (c). Individual service plans are developed to meet the health and social needs of the ACG client. If the plan no longer meets the client's needs, due to changes in the person's health and social needs or financial status, it is reasonable to revise the plan. To revise the individual service plan to better meet the ACG client's needs, a reassessment must be performed. Requiring an ACG client's case manager to notify the local agency of a different county to which the client moves is necessary and reasonable because the notification makes the county aware of a client who must be served. Furthermore, requesting the assignment of a case manager is reasonable because the case manager has the responsibility to adjust, monitor, and coordinate the services needed by the client to remain in a

community setting. Reassessment is necessary and reasonable to determine whether the ACG client's condition has changed and to identify the community services needed by the client to successfully remain in the community.

Subp. 12. Record of reassessment. This subpart is necessary to specify the components of reassessment. It is reasonable that the case manager use an assessment form supplied by the commissioner because use of this form ensures consistency and a uniform standard in determining the ACG client's health and social needs and financial status. (See the definition of "assessment form," part 9505.2395, subpart 8.) It is reasonable to require the form to be placed in client's case record because the form is evidence of the reassessment and its recommendations. Requiring the case manager to give an ACG client information required in part 9505.2425, subpart 1, items C to E is necessary and reasonable to ensure that the ACG client being reassessed understands his or her statutory rights. (See part 9505.2425, subpart 3 and its SNR.) Finally, requiring the case manager to carry out this task is reasonable because the case manager is responsible for the ACG client's case management services. (See part 9505.2395, subpart 9 and its SNR.)

Item A. Placing the completed assessment form in the client's case record is a reasonable requirement as the form is the record of the client's condition and need for services.

Item B. Subpart 11 defines when reassessments are required. To serve as a written record of compliance with subpart 11, it is reasonable that the case manager documents the reason for the reassessment in the client's chart.

Items C and G are consistent with Minnesota Statutes, section 256B.091, subdivision 8.

Item D. Part 9505.2430, subpart 1, requires the individual service plan to be established in consultation with the person being assessed or the person's representative and that the person's family, primary caregiver, and physician have an opportunity to be consulted about the plan. During a reassessment a revised individual service plan is developed. Therefore it is reasonable that the case manager document who was consulted as evidence of compliance with the consultation requirement.

Item E is consistent with Part 9505.2430, subpart 5, which specifies that an individual service plan must identify types, frequency, and cost of community services.

Item F. Part 9549.0059 requires that "the assessment of each applicant or newly admitted nursing home resident must be based on the Quality Assurance and Review (QA and R) procedures of the Department of Health . . . and must be recorded on the assessment form." A completed QA and R form includes an estimate of the person's case mix resident classification. Under subpart 8, total costs for ACG services cannot exceed the monthly average rate for the person's case mix classification. Therefore, it is

reasonable that a QA and R form is completed during a reassessment because a case mix classification is required to obtain the monthly limitation for total ACG service costs.

9505.2458 CASE MANAGER ACTION TO ASSURE SAFETY AND HEALTH OF ACG CLIENT WHO IS A VULNERABLE ADULT

ACG services are provided to ACG clients who live in the community, usually with their family members or alone in their homes or apartments. These settings and the provision of services to ACG clients are not necessarily supervised on a daily basis by qualified professionals. Furthermore, the ACG clients may be vulnerable adults because of their own physical or mental health status or because of their dependency on others for services. Thus, circumstances occur under which these clients may be abused or neglected. The ACG clients should be able to live and receive necessary services in conditions that are safe and healthful. If such conditions cannot be met under existing circumstances, it is necessary and reasonable to require the case manager to act in a manner that will protect the client and also provide the client's necessary services.This part is necessary to specify the procedure the case manager must follow if the case manager has reason to believe an ACG client is subject to abuse or neglect. Minnesota Statutes, section 626.557, governs the reporting of maltreatment of vulnerable adults. Some ACG clients fall within the definition of vulnerable adult set forth in subdivision 2, clause (c) of this statute. Subd. 2, clauses (d) and (e) of this statute define abuse and neglect as related to a vulnerable adult. Minnesota Statutes, section 626.577 specifies the requirements for reporting and investigating suspected abuse of vulnerable adults. This part is consistent with the statute cited within it.

9505.2460. LOCAL AGENCY SELECTION OF ACG PROVIDERS

Subpart 1. Public meeting to inform providers. Minnesota Statutes, section 256B.091, subdivision 8 states that:

> The county agency shall document to the commissioner that the agency made reasonable efforts to inform potential providers of the anticipated need for services under the alternative care grants program including a minimum of 14 days written advanced notice of the opportunity to be selected as a service provider and an annual public meeting with providers to explain and review the criteria for selection and that the agency allowed potential providers an opportunity to be selected to contract with the county board.

It is consistent with the statute cited to require that the local agency hold a public meeting. It is reasonable to require the local agency to set a specific date by which the meeting must be held and to clarify that the local agency may hold the public meeting at a time convenient to its schedule for completing service contracts to avoid placing an undue burden on the county.

It is reasonable that the local agency documents that the notice of opportunity to be selected was given and that the public meeting was held to serve as a record of compliance with the statutory requirements.

Subp. 2. Notice of annual public meeting. Minnesota Statutes, section 256B.091, subdivision 8 requires a local agency to hold "an annual meeting with providers to explain and review the criteria for selection." It is reasonable that the newspaper is the medium for the written notice as it is available to all providers and is an accepted community forum for announcements. Furthermore, it is reasonable to require the local agency to use the newspaper designated by the county board for official notices because persons in the community are familiar with the use of this paper for notices and its consistent use avoids confusion. It is reasonable that the notice is given at least 14 days before the public meeting because it gives sufficient time for providers to arrange their schedules so that they can attend the meeting. It is also reasonable that the notice contains the required details specified in this subpart because the details give potential providers information they need to respond to the opportunity to be selected as a provider of ACG services. Minnesota Statutes, section 256B.091, subdivision 8 specifies that a local agency must give providers a ". . . minimum of 14 days written advanced notice of the opportunity to be selected as a provider . . . ." This subpart is consistent with the statute cited.

Subp. 3. Selection criteria. Minnesota Statutes, section 256B.091, subdivision 8 requires the local agency to explain and review provider selection criteria at the annual public meeting under subpart 1. The selection criteria in subpart 4 are consistent with Minnesota Statutes, section 256B.091, subdivision 8.

Subp. 4. Written record of reason for not selecting a provider. Minnesota Statutes, section 256B.091, subdivision 8, specifies that "the county shall provide a written statement of the reasons for not selecting providers." This subpart is consistent with statute. Requiring the local agency to notify the provider of the reasons is reasonable because the notice informs the affected person, the provider.

9505.2465 STANDARDS FOR PERSONAL CARE SERVICES

Personal care services are an alternative care grant service and also are a medical assistance service. However, statutes specifically exempt personal care services provided under medical assistance from certain requirements applicable to personal care services provided under an ACG.

Minnesota Statutes, section 144A.43, subdivision 3 includes personal care services within the definition of home care services. Under Minnesota Statutes, section 144A.46, a provider of home care services must be licensed unless the provider is exempted from licensure under subdivision 2 of the cited statute. Clauses (2) and (3) of the cited statute exempt from licensure a personal care assistant and a provider who provides personal care services under medical assistance. Additionally, Minnesota Statutes, section 144A.43, subdivision 4, (clause 2) states that a home care provider does not include an individual who only provides home care services to a relative. Although medical assistance does not allow payment of a relative providing personal care services, the federal 2176

waiver for the elderly (applicable to ACG) does allow payment of a relative other than a spouse. Some, but not all, ACG clients are recipients. However, it is reasonable to have one standard applicable to the population to be served by the ACG program in order to ensure uniformity of service delivery and to avoid administrative confusion.

In deciding which standard to apply to the ACG program, the department considered the purpose for which the federal agency granted the waiver. This purpose is to enable the state to be less restrictive about accessibility to medical assistance services and, thereby, increase the scope of services available. Therefore, this part allows the local agency to contract with a person who only provides personal care services to a relative without meeting the requirements of licensure under Minnesota Statutes, sections 144A.43 to 144A.54. Except for this difference and the definitions of subpart 1 of part 9505.0335, which would also be inconsistent with the increased accessibility available under the federal waiver, the provisions of this part are consistent with the standards of eligibility set for medical assistance reimbursement in part 9505.0335, which became effective on January 1, 1988.

Subpart 1. Definitions. This subpart is necessary and reasonable because it clarifies terms used in this rule and informs persons affected by the rule.

Item A. The definition of "personal care provider" is reasonable because it sets a clear standard of who is eligible to be a personal care provider. The definition is consistent with the requirements of Minnesota Statutes (1987 supplement), section 144A.46 which requires licensure of providers unless the services are being provided under the medical assistance program. Some personal care services in ACG program are provided to persons who are not recipients. See also subpart 5 and its SNR.

Item B. Part 9505.0335, subpart 1, item E defines personal care service for purposes of eligibility for reimbursement in the medical assistance program. The definition in item B is consistent with that in part 9505.0335, subpart 1, item E. It is reasonable that item B be consistent with the MA program definition because personal care services are provided to ACG clients who may be recipients. Thus, consistency in use of the term in the two programs avoids confusion and is a condition for MA reimbursement of these services given to recipients who are ACG clients.

Subp. 2. Training requirements. Minnesota Statutes, section 256B.02, subdivision 8 (17) and 42 CFR 440.170 (f) require personal care services to be provided by an individual who is qualified to provide the services. Therefore, this subpart is necessary to establish who is qualified to be a personal care assistant. However, although neither the regulations nor the statute specifies the qualifications, the federal agency, the Health Care Financing Administration, recommended in its review of Minnesota's medical assistance program that minimum training requirements should be established. This recommendation is also supported by the Metropolitan Center for Independent Living Report: Living Independently. The federal

guidelines given in federal Medical Assistance Manual, Part 5 (5-140-00) at present set a minimum requirement of completion of a course of 40 hours of training in basic personal care procedures such as grooming, bowel and bladder care, food, nutrition, diet planning, etc., methods of making patients comfortable, care of the aged, care of the confused, first aid and health-oriented record keeping. Part 9505.0335, subpart 3 establishes training requirements for providing covered services in the medical assistance program. Items A to E are consistent with the training requirement established for the medical assistance program in part 9505.0335, subpart 3. Because the ACG program provides personal care services to ACG clients who may also be recipients, it is reasonable to ensure consistency with a requirement for obtaining medical assistance reimbursement. Furthermore, it is reasonable to have a single set of standards applicable to all persons providing personal care services to ACG clients regardless of the source of payment for the services because a single set of standards avoids confusion and promotes equity of service to clients.

Subp. 3. Personal care services. This subpart is necessary to specify the personal care services that can be provided in the ACG program. The services listed in items A to N are consistent with the services listed in part 9505.0335, subpart 8, which governs the medical assistance program. As discussed in the SNR for subparts 1 and 2, ensuring consistency with medical assistance program requirements is reasonable to obtain MA reimbursement for ACG clients who are recipients and to avoid confusion among affected persons.

Subp. 4. Employment of personal care assistants. This subpart is necessary to specify employment arrangements for personal care assistants. Under part 9505.0335, subpart 1, item C which establishes requirements for medical assistance reimbursement a personal care assistant must be an employee of or under contract to a personal care provider. The subpart is consistent with the medical assistance rule requirements. However not all ACG clients are recipients so it is too restrictive to limit personal care assistants to these clients to the assistants who meet medical assistance standards. Furthermore, Minnesota Statutes, section 144A.46, subdivisions 1 and 2 require licensure of home health providers including a local agency which functions as a provider of services to persons who are not recipients. (See the introduction to the SNR for this part.) The subpart is consistent with the statute cited in the subpart.

It is reasonable that the local agency employs or contracts with a personal care assistant to provide personal care services because the provision fixes the responsibility of the local agency to assure that the quality of care standards are met. It is reasonable that a personal care assistant contract or employment may be terminated if the case manager, on the recommendation of the supervising registered nurse, determines that the personal care assistant is not performing satisfactorily because it is consistent (1) with the purpose of the ACG program of providing needed services in an alternative community setting, (2) with the local agency's responsibility to assure quality of care, and (3) with subpart 9 which

requires the supervising nurse to evaluate the personal care assistant's work and document the action needed to correct any deficiencies.

Subp. 5. Personal care provider; eligibility. Local agencies have the responsibility under Minnesota Statutes, section 256B.091, subdivision 8 to employ or contract with personal care providers. There are 87 counties in Minnesota, all of which are participating in the ACG program. This subpart is necessary to set uniform eligibility standards for personal care providers who want ACG services contracts with local agencies in order to ensure equitable treatment of providers throughout the state. As discussed in the introduction to this part and the subparts preceding subpart 5, consistency with the standards for providers under the medical assistance program is necessary in order to obtain federal financial participation in the paying the cost of personal care services to recipients. This subpart is consistent with the medical assistance standards found in part 9505.0335, subpart 5. Using medical assistance standards is reasonable because the use complies with the requirement of Minnesota Statutes, section 256B.04, subdivision 4 to cooperate with the federal agency "in any reasonable manner as may be necessary to qualify for federal aid. . . ." For the exception provided in subpart 11, see the introduction to the SNR for this part and subpart 11.

Subp. 6. Personal care provider responsibilities. As stated in the SNR of subpart 5, there are 87 counties in Minnesota, all of which are participating in the ACG program. This subpart is necessary to set a uniform standard of a provider's duties throughout Minnesota. As discussed in the introduction to this part and subparts preceding subpart 6, consistency with the standards for providers under the medical assistance program is necessary in order to obtain federal financial participation in paying the cost of personal care services of recipients. This subpart is consistent with the medical assistance standards found in part 9505.0335, subpart 6. Using medical assistance standards is reasonable because the use complies with the requirement of Minnesota Statutes, section 256B.04, subdivision 4 to cooperate with the federal agency "in any reasonable manner as may be necessary to qualify for federal aid. . ."

Subp. 7. Employment prohibition. Personal care service involves direct contact between the personal care assistant and the ACG client within the client's residence. Sometimes no other person is in the residence while the service is being given. As discussed in the SNR for part 9505.2458, ACG clients may be vulnerable adults as defined under Minnesota Statutes, section 626.557, subdivision 2, clause (c). In the past, the department has been made aware of and has had to address abusive situations involving personal care assistants and their clients. Thus, the department believes that the potential exists for the occurrence of abusive situations. Therefore, this subpart is necessary to protect ACG clients from potentially abusive situations. This subpart is consistent with the employment prohibition applicable to personal care assistants employed in the medical assistance program under part 9505.0335, subpart 7. It is reasonable because it prohibits the employment of persons who have been identified as abusive, (items B and C), as not fully in control of their

actions, (item D), or as not meeting all the requirements of subpart 8, (item A). Furthermore, it is reasonable to allow the county to have a means to prohibit employment of persons who are abusive or neglectful because such action is necessary to protect the safety of the ACG client.

Subp. 8. Preemployment check of criminal history. As discussed in the SNR for previous subparts, personal care assistants in the ACG programs work with vulnerable adults, the ACG clients, usually in the client's residence, and perform the same duties as the personal care assistants under the medical assistance program. (See part 9505.0335, subpart 8.) The department's experience with personal care services in the medical assistance program includes circumstances where an individual previously convicted of abusive behavior while providing personal care services obtains further employment as a personal care assistant. Such further employment as a personal care assistant may subject another recipient to abusive behavior. Therefore, this subpart is necessary to protect ACG clients from possible abuse. The subpart is reasonable as it limits the disclosure to conviction and criminal history records of crimes related to the occupation in which the person is seeking employment or to the program through which the services will be reimbursed. The subpart is reasonable because the disclosure requirement protects the provider from having to hire anyone who fails to disclose and, thus, places the burden of disclosure on the applicant. The subpart is also reasonable because it supports the requirement placed on the provider in subpart 7.

Subp. 9. Supervision of personal care assistant. 42 CFR 440.170 (f) and Minnesota Statutes, section 256B.02, subdivision 8 (17), require a personal care assistant to be supervised by a registered nurse. Therefore, this subpart is consistent with the federal regulations and state law. This subpart is necessary to establish the components of supervision, thereby setting a standard and informing affected persons of what is expected. The federal guidelines in the federal Medical Assistance Manual part 5 (5-140-00-page 9) list some tasks and responsibilities that the supervising nurse should perform. They include providing the personal care assistant and the provider a list of the services required by the recipient, making periodic visits to assess the patient's health condition and the quality of personal care being given, reviewing the plan of care, reviewing the observations and notes of the personal care assistant, assessing the patient's health, and evaluating the interactions and relationship between the patient and assistant. The subpart is consistent with 42 CFR 440.170(f)(3) which requires supervision to be provided by a person other than a family member of the recipient receiving the personal care service. Items A to G specify the responsibilities and tasks of the supervising registered nurse. Items A to G are consistent with the supervisory responsibilities specified in part 9505.0335, subpart 4, for personal care services provided in the medical assistance program. Thus, a single standard of supervision of services to ACG clients who are recipients or are persons who would be eligible for medical assistance within 180 days after admission to a nursing home is necessary and reasonable to avoid administrative confusion and promote equity of services.

Subp. 10. Evaluation of services. This subpart is necessary to specify the frequency of evaluations by the supervising registered nurse. The federal agency recommended in its review of the personal care services component of the medical assistance program that a definite schedule be established and followed. The requirements in this subpart are consistent with those of the medical assistance program in part 9505.0335, subpart 4, items D and E. As discussed in the SNRs of the previous subparts of this part, it is necessary and reasonable that evaluation requirements placed on personal care services in the ACG program be consistent with the evaluation requirements in the medical assistance program in order to obtain federal aid in reimbursing the cost of these services to ACG clients who are recipients and because the ACG program and the medical assistance program provide similar personal care services to similar clients in similar circumstances.

It is reasonable to require the supervising nurse to record the evaluation and actions taken to correct deficiencies in the personal care assistant's work because such a record provides a means to determine whether the supervising nurse is carrying out her or his supervising responsibilities and whether the personal care assistant is following the plan of treatment.

Subp. 11. Employment and reimbursement of a relative for personal care services. This subpart is necessary to clarify the eligibility of an ACG clients relative to be employed and receive payment for providing the client's personal care services. Under the waiver, an ACG client's spouse may not receive payment for ACG services.

Item A is necessary to specify the agency authorized to hire or contract with an ACG client's relative. This item is consistent with the statute cited within it. It is reasonable to require the relative to be hired or under contract with a local agency because the local agency is responsible for the ACG program.

Item B. Sometimes personal care service is given to an ACG client by a relative. A relative providing this service may incur considerable financial hardship. For example, the time required to give the care may make it impossible for the relative to continue compensated employment outside the home or the relative may incur substantial expenses in making arrangements necessary to enable the relative to care for the client. When relatives have been unable or unwilling to incur such economic hardship, the necessary personal care services have been provided by compensated personal care assistants or the person may have had to leave the community and be admitted to a nursing home. Recognizing such financial hardship by paying for the relative-provided personal care services offers an incentive to relatives to give personal care, enabling the client to remain in the community. However, ACG funds are limited and not all relatives want payment or have suffered an economic hardship because of caring for an ACG client. Thus, limiting payment to situations involving financial hardship is reasonable because it balances the need to provide an incentive to relatives to care for the ACG clients, thereby enabling the clients to remain in the community, and the need to maximize the use of available ACG funds.

Item C is necessary and reasonable because it sets a single standard for personal care services and promotes equity of services.

Item D. Requiring that the local agency receive the department's approval of payment to a relative is reasonable because it provides the department an opportunity to determine whether the relative meets not only the personal care assistant qualifications but also financial hardship standards.

9505.2470 STANDARDS FOR HOME HEALTH AIDE SERVICES

Subpart 1. Employment of home health aide. 42 CFR 440.70 (b)(2) requires a home health agency to provide home health aide services as a condition of medical assistance eligibility. As discussed under part 9505.2465, it is necessary and reasonable to require ACG services to an ACG client who is a recipient to comply with medical assistance program standards in order to obtain federal funds to pay for the cost of the ACG services. This subpart is consistent with part 9505.0290, subpart 1, item B. This subpart is necessary to set a standard of the employment of home health aides to ensure uniform conditions throughout Minnesota. It is reasonable to choose the standard of the medical assistance program because both programs provide similar services to similar clients in similar circumstances and because the consistency ensures federal financial participation. Requiring the service to be under the supervision of a registered nurse is reasonable as the scope of practice of a registered nurse under Minnesota Statutes, section 148.171 includes the supervision and teaching of less qualified caregivers such as home health aides. Additionally, the requirement is consistent with 42 CFR 405.1227(b). Home health aide services are services of a paraprofessional nature and are less complex and less demanding than those requiring the training and skill of a registered or practical nurse. Thus, employing or permitting the employment of a registered or practical nurse to perform such paraprofessional tasks is not necessary as a registered or practical nurse is overqualified. Furthermore, if a registered or practical nurse were to perform such tasks it would be unreasonable to expect the nurse to be satisfied with the lower wage scale applicable to home health aides or to require the nurse to differentiate for billing purposes and the client's records between time spent in skilled nursing services and time spent in home health aide services. Thus prohibiting the employment of registered and practical nurses as home health aides is reasonable because it is consistent with their qualifications and the cost of their services and with operating the program in an administratively cost-effective manner.

Subp. 2. Eligible providers. Minnesota Statutes, sections 144A.43 to 144A.46 require a home health agency providing home health services other than under the medical assistance program to be licensed by the Minnesota Department of Health. Some home health services in the ACG program are provided to ACG clients who are not recipients and therefore the services are not medical assistance services. Thus, it is necessary and reasonable to require the provider of home health aide services under the ACG program to meet the licensure requirements of the statute cited within this

subpart. Minnesota Statutes, section 256B.091, subdivision 8 specifies that home health services must be eligible for reimbursement under titles XVIII and XIX of the federal Social Security Act in order to be eligible

subpart. Minnesota Statutes, section 256B.091, subdivision 8 specifies that home health services must be eligible for reimbursement under titles XVIII and XIX of the federal Social Security Act in order to be eligible payment through an ACG grant. Requiring the provider to be certified to participate under titles XVIII and XIX is consistent with the cited statute. Requiring the home health agency to be certified to participate under title XVIII (Medicare) also is consistent with part 9505.0290, subpart 2 which sets the standards for being a provider under the medical assistance program.

Subp. 3. Approval and supervision of home health aide services. As discussed in the SNR for part 9505.2465, consistency with medical assistance standards is necessary to obtain federal funds for paying the cost of ACG services to ACG clients. Requiring the supervising registered nurse's approval of the aide's performance of medically oriented tasks is consistent with the requirement of the medical assistance program in part 9505.0290, subpart 3, item B. Requiring the supervising registered nurse to be an employee of a home health agency that is a provider is reasonable because the home health agency is the provider who is responsible by contract with the local agency for the provision of home health services to the ACG client and thus is responsible to monitor and evaluate the work of the person actually performing the tasks.

Subp. 4. Record of home health services. Documentation of home health agency services including home health aide services is required by 42 CFR 440.70 (b)(1)(iii) for medical assistance eligibility for paying the cost of the services. As discussed in the SNRs for previous subparts in this part and in part 9505.2465, meeting medical assistance standards is necessary and reasonable to obtain federal funds to pay for services to ACG clients who are recipients. Requiring the copy to be sent to the home health agency is reasonable because it is the home health agency that is under contract with the local agency to provide home health services. Furthermore, a written record is reasonable because it provides information that can be used for billing and auditing purposes.

9505.2473 STANDARDS FOR HOMEMAKER SERVICES

Subpart 1. Qualified homemakers. A homemaker service is one of the services that may be provided through the alternative care grant program. This subpart is necessary to set a standard of who is qualified to give a homemaker service. Part 9565.1200, subpart 2, sets standards related to the recruitment, selection, duties, and training of homemakers who provide homemaker services purchased by a local agency. This subpart is consistent with the cited rule. It is reasonable to require the same standards as the standards are sufficient for this rule's purposes and the use of a single set of standards avoids confusion.

Subp. 2. Contracting homemaker services and supervision of a homemaker. The local agency has the responsibility to administer and monitor the ACG program and its services. Part 9565.1300 states responsibilities of the local social service agency (which is the same as the local agency) for purchasing and supervising homemaker services. It is reasonable to

require the same standards as the cited rule to ensure consistency and uniformity of local agency actions of providing homemaker services.

Subp. 3. Payment limitation; homemaker. Delineation of the homemaker tasks that are reimbursable under an ACG is necessary to set a standard, This subpart is consistent with part 9505.2395, subpart 23, which defines "homemaker services." Including this subpart in the rule is reasonable because it informs affected persons of the limitations. (See the SNR for part 9505.2395, subpart 23.)

9505.2475 ESTABLISHMENT OF THE INDIVIDUAL TREATMENT PLAN.

Subpart 1. Requirement. This subpart is necessary to set a standard and to clarify who is responsible for developing an individual treatment plan. Title 42, Code of Federal Regulations, section 409.42(d) refers to a plan of treatment required for the provision of home health services:

> The home health services must be furnished under a plan of treatment

require the same standards as the cited rule to ensure consistency and uniformity of local agency actions of providing homemaker services.

Subp. 3. Payment limitation; homemaker. Delineation of the homemaker tasks that are reimbursable under an ACG is necessary to set a standard, This subpart is consistent with part 9505.2395, subpart 23, which defines "homemaker services." Including this subpart in the rule is reasonable because it informs affected persons of the limitations. (See the SNR for part 9505.2395, subpart 23.)

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> The home health services must be furnished under a plan of treatment that is established and periodically reviewed by a doctor of medicine, or osteopathy...

It should be noted that the cited federal regulation, 42 CFR 409.42 (d), sets Medicare standards related to home health services. The population served by the ACG program serves a population similar to that of Medicare, that is, persons who are 65 years of age or older.

Title 42, Code of Federal Regulations, section 409.40(a) and (d) defines "home health services" to include "part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse," and "part-time or intermittent services of a home health aide." The development of an individual treatment plan for an ACG client who receives home health aide services is consistent with the cited code.

42 CFR 440.170(f) requires personal care services in a recipient's home to be provided by a qualified individual in accordance with the recipient's plan of treatment.

Because the ACG client or the client's representative must agree to the client's receiving personal care or home health aide services, it is reasonable that the ACG client is consulted during the development of the individual treatment plan. It is also reasonable that the supervising registered nurse and the home health aide or personal care assistant help in developing the plan as they are aware of what services and procedures they are able to provide to meet the client's needs. It is reasonable to require the supervising registered nurse to give a copy of the plan to the ACG client's case manager and the home health agency because the supervising registered nurse and the home health agency are responsible to monitor and evaluate the services and the case manager is responsible to identify, coordinate, and monitor the delivery of the services.

Subp. 2. Contents of the individual treatment plan. This subpart is necessary to specify details of an individual treatment plan and to set a

standard. The subpart is consistent with 42 CFR 405.1223 which establishes standards to obtain federal funds in reimbursing medical assistance program costs. It enables the state funded program to comply with the conditions of the waiver.

9505.2480 ALLOCATION OF STATE ACG FUNDS

Subpart 1. Formula for allocation of state ACG funds. Minnesota Statutes, section 256B.091, subdivision 8 states that "prior to July of each year, the commissioner shall allocate state funds available for care grants to each local agency." The statute goes on to specify how the allocation is made. The statute cited in this subpart also requires the commissioner to "establish by rule . . . procedures for determining grant allocations." This subpart is necessary to refer affected persons to the statute cited within it and to set the stage for the rest of this part. This subpart is consistent with the cited statute.

Subp. 2. Review of allocation; reallocation of state ACG funds. This subpart is consistent with the statute. This subpart is necessary to specify that unused portion of state ACG funds allocated to a local agency must be reallocated to another local agency. The amount of state ACG funds is allocated to the local agencies under subpart 1. To know if the state is maximizing the use of ACG funds, the department must have information on local agencies' projected and expended funds on a quarterly basis. It is reasonable to require the commissioner to reallocate ACG funds from a local agency which will not use the total allocation to a local agency which will use the additional funds, in order to maximize use of state ACG funds and to provide ACG services to a maximum number of ACG clients.

9505.2485 ALLOCATION OF THE NUMBER OF ACG CLIENTS TO BE SERVED UNDER THE WAIVER

Subpart 1. Local agency allocation of ACG clients under the waiver. This subpart is necessary to specify how counties are allocated the number of ACG clients they can serve under the waiver. Although the waiver specifies the number of ACG clients who are recipients aged 65 or older the state is to serve in a fiscal year, Minnesota Statutes, section 256B.091, subdivision 8 does not specify the basis for allocating the number of ACG clients. Specifying the basis is necessary to set a standard. Minnesota Statutes, section 256B.091, subdivision 8 does specify the basis the commissioner must use in allocating the state funds available for ACG grants. An allocation to a county based on the county's percentage of the statewide total number of recipients who are age 65 or older is reasonable because it ensures equitable treatment of both potential ACG clients who are recipients and the counties. This subpart is consistent with this statute. It is reasonable for the allocation of the number of clients to be served by a county to be consistent with the amount of funds allocated to the county because this consistency assures the county will be able to carry out its responsibility to serve ACG clients.

Subp. 2. Review of allocation; reallocation of number of ACG clients under the waiver. A limited number of persons in the state who are recipients aged 65 or older can be served under the waiver. If a county does not serve the allocated number of clients in a fiscal year, it is reasonable that the commissioner may decrease the county's allocation during the next fiscal year in order to serve a greater number of eligible persons in another county that used all of its allocation. Such action by the commissioner encourages counties to fulfill the purposes of the ACG program and Minnesota Statutes, section 256B.091, subdivision 8. This subpart is necessary to define the commissioner's authority to reallocate the number of clients to be served under the waiver and to set a standard. As explained in the SNR of subpart 1, the number of persons who may be served under the waiver is limited. To use the waiver to the maximum extent possible, and thereby obtain maximum federal participation, all allocations should be used during the fiscal year. Therefore, if a local agency determines that the total allocation of persons to be served will not be used, it is reasonable that the commissioner may reduce the county's allocation and reallocate the unused portion to another local agency.

Subp. 3. Notice to local agency. Standards for the time of notifying a local agency about its allocated number of ACG clients are necessary so that the agency can plan how to meet its responsibilities under parts 9505.2390 to 9505.2500. The standard of May 15 is reasonable because this date allows the information to be received by the local agency in time to use the information to prepare documents required under part 9505.2495, subpart 2.

9505.2486 LOCAL AGENCY ESTIMATION OF NUMBER OF PERSONS OTHER THAN RECIPIENTS TO BE SERVED AS ACG CLIENTS

Minnesota Statutes, section 256B.09, subdivision 8 states that "payment. . .is available. . .for individuals. . .(2). . .who would be eligible for medical assistance within 180 days of admission to a nursing home." (These individuals are not recipients.) However, the statute does not provide a basis for estimating the number of these individuals that a county must serve. This part is necessary to inform the county of its responsibility to estimate the number to be served. Money to pay for ACG services is provided to the counties from state funds. (See part 9505.2480 and its SNR.) The local agencies are in the best position to know the nature of the population eligible for service and the historical costs of these services. Therefore, it is reasonable to permit the local agency to plan and manage within the budgeted allocation. It is also necessary and reasonable to require the local agency to report the estimate to the department as the department has the responsibility under Minnesota Statutes, section 256B.091, subdivision 8 to audit the ACG program for fiscal and utilization control.

9505.2490 RATES FOR ACG SERVICES

Minnesota Statutes, section 256B.091, requires the commissioner to set limits on rates for payment of the cost of ACG services.

Subpart 1. Statewide maximum ACG service rate. This subpart is necessary to set the limits required by the statute cited above. Economic circumstances beyond the control of the state, county, or provider may vary from year to year in ways that affect the costs of providing services. Thus it is reasonable to require the commissioner to make an annual adjustment of the maximum ACG service rate in order to reflect the effect of cost increases beyond the provider's control. Basing the increase on the cost changes occurring from one year to the following year is reasonable because it ensures implementation of the ACG program in an economical and equitable manner. The index used to update the rates is the change in the all urban consumer price index (CPI-U) for Minneapolis-St. Paul new series between the two most recent Januarys prior to the rate year. Using the CPI-U is reasonable because it reflects cost changes in the market basket of goods that represent purchases by consumers. These changes, in turn, are generally based upon cost changes incurred in the production of the items included in the CPI-U market basket. Thus, although wages, for example, are not explicitly recognized as an item in the market basket, cost changes for wages are an implicit part of the costs of the individual items. The CPI-U is in common usage to adjust prices to be congruent with cost changes. The CPI-U is used in determining other rates set by the department and, in some instances, its use is required by the Legislature. The CPI-U for Minneapolis-St. Paul is published twice a year, January and July. Use of the CPI-U published in January is reasonable because it permits the most up-to-date information to be used and yet at the same time facilitates meeting the time requirements of part 9505.2480, subpart 6 of this part, and part 9505.2495. Using the Minneapolis-St. Paul CPI-U index is reasonable because this index reflecting the highest market basket item costs in Minnesota provides the commissioner the opportunity to adjust the rate in a manner that will recognize the higher costs inherent in services in some counties of Minnesota.

Subp. 2. Local agency maximum ACG service rate set by commissioner; general. Minnesota Statutes, section 256B.091, subdivision 8, requires the commissioner to "establish by rule . . . limits on rates for payment of approved services . . ." The cost of providing a given service is not uniform throughout Minnesota. This fact is recognized in other rules of the department and by the Legislature in requiring certain rates to be established on a geographic basis. Not all local agencies will find it necessary to pay the statewide maximum ACG service rate established under subpart 1 in order to contract with an ACG provider. Thus, this part is necessary to establish the basis for the maximum rate that a local agency may pay for an ACG service. (It should be noted that a local agency may pay less than the maximum set for the local agency by the commissioner but it cannot pay more than the maximum.) The subpart is consistent with the requirements of Minnesota Statutes, section 256B.091, subdivision 8. See the SNR of subpart 1 for a discussion of the need and basis for annual adjustments of these rates.

Subp. 3. Local agency maximum ACG service rate set by commissioner; new ACG service. The ACG program first was implemented in Minnesota in 1982.

ACG service rates were established at that time for the ACG services in the local agency's approved plan required under part 9505.2495, subpart 3. At the present time not all services included in the ACG program are offered in every county either because the service is a recently developed service or the county has not had a need for the service. However, a local agency may identify an ACG client whose individual treatment plan calls for a service that the local agency has not been providing. Such a local agency must contract for the service and the maximum rate for the service must be consistent with the requirements of Minnesota Statutes, section 256B.091, subdivision 8 and with this part. Therefore, this part is necessary to establish the basis for setting the maximum rate a local agency may pay for a service that has not been provided before the effective date of parts 9505.2390 to 9505.2500. The basis chosen is reasonable because it ensures equity of treatment of ACG providers who have been providing ACG services and new ACG providers whose contracts are established after these rules are effective.

Subp. 4. Notice to local agency. Under subparts 1 and 2, the commissioner annually sets maximum rates for ACG services on a statewide basis and for each county. Local agencies need to know these rates in order to prepare their county plans and budgets. This part is necessary to establish who is responsible to notify the local agencies and when the notice is to be made. It is reasonable to require the commissioner to notify the local agencies because the rates are established by the commissioner. Annual notice is a reasonable requirement because the rates are adjusted annually according to subparts 1 and 2. The time of May 15 is reasonable because it allows the local agencies to receive the information in time to use it in preparing the biennial plans which part 9505.2495, subpart 2 requires local agencies to submit by July 1.

Subp. 5. Local agency request to exceed county's maximum rate. In the more heavily populated counties of the state, there may be more than one provider of a particular service required under the ACG program that wants a contract to provide the ACG service and is willing to accept a rate within the limits set for a county under subpart 2. However, in the more sparsely settled areas of the state, there may be only one provider qualified to provide a service needed in the ACG program and the local agency may find it necessary to pay a rate higher than the allowable maximum in order to obtain the service. Furthermore, a particular provider type throughout the state may have experienced a sudden increase in costs that the provider can no longer absorb or is unwilling to absorb within a local agency's maximum allowable rate. Thus, this subpart is necessary to establish the requirements for requesting and approving a rate that exceeds the maximum rate allowed under subpart 2. It is reasonable to require the local agency to submit a request to the commissioner as the commissioner is required under Minnesota Statutes, section 256B.091, subdivision 8 to establish limits on the ACG service rates. Requiring the local agency to justify the need is reasonable because the rates already established by the commissioner have taken into account inflationary increases in costs as reflected in the percentage change in the CPI-U and the commissioner has the responsibility under Minnesota Statutes, section 256B.04, subdivision 2, to administer the

medical assistance program in a uniform manner throughout the state. The types of costs listed in this subpart are those which affect a provider's rate and which the local agency or provider may have limited ability to control. It is necessary to define the service area of the provider who is requesting the desired rate in order to set a uniform standard. Using the definition of "local trade area" set forth for the medical assistance program in part 9505.0175, subpart 22 is reasonable because ACG services to ACG clients who are medical assistance recipients then will meet one of the standards required for the service's eligibility for medical assistance payment including federal financial participation. Furthermore, it is reasonable to apply the same standard to all ACG providers because a uniform standard assures equitable treatment of providers.

Subp. 7. Local agency ACG service rate subject to audit and approval. Services reimbursed through the medical assistance program are subject to review under Minnesota Statutes, section 256B.04, subdivision 15 which requires the state agency to safeguard against excess payments. An audit is an "examination of records or accounts to check their accuracy" (The American Heritage Dictionary of the English Language). Requiring an audit and approval for a local agency ACG service rate or a request to exceed the local agency's maximum service rate is reasonable because the commissioner has the responsibility to ensure that the rates are not excessive. Thus, this subpart is consistent with the cited statute. Authorizing the commissioner to do the audit is also consistent with the cited statute.

9505.2495 LOCAL AGENCY REPORTS AND RECORDS

Subp. 1. Preadmission screening documents. This subpart is necessary to specify that preadmission screening documents must be submitted to the commissioner and the time frame for submitting them. Minnesota Statutes, section 256B.091, subdivision 3, states that it is the responsibility of the local agency to prepare reports which may be required by the commissioner. Subdivision 1 of the same statute states that one purpose of the program is "to gain further information about how to contain costs associated with inappropriate nursing home or boarding care home admissions." The preadmission screening document contains client specific information, as well as the screening team's recommendation and the placement decision made by the person being screened. Therefore, the commissioner can use information obtained from the screening document to, among other things, monitor and evaluate the appropriateness of nursing home placement, to assess the need for community services, and to determine the cost of maintaining persons in the community. The requirement therefore is consistent with the cited statute. Submission by the tenth of the month following completion of the screening or reassessment is reasonable because it provides sufficient time for the department to monitor the validity of a local agency's payment claims for the entire month and make payment adjustments required by part 9505.2450.

Subp. 2. Local agency biennial plans. This subpart is necessary to specify the contents and time of submission of a local agency's biennial

plan. Minnesota Statutes, section 256B.091, subdivision 8, requires the commissioner to establish rules governing submittal and approval of the local agency's biennial plans. It is reasonable that the local agency submit the biennial plan by July 1 of odd numbered years in order to receive funding for the next two fiscal years because July 1 is the beginning of the state fiscal year and July 1 of odd numbered years is the beginning of the state biennium.

Items A, B, and C are reasonable because they provide a way for the department to identify the county and the persons in the county who are responsible for the PAS/ACG program.

Item D helps the department identify the types of services available to ACG clients as well as gaps in the kinds of services. Consistent with the requirement of Minnesota Statutes, section 256B.04, subdivision 2, to implement the medical assistance program statewide in a uniform and impartial manner, the aggregate data collected from these items will assist the department in future program planning.

Item E. Minnesota Statutes, section 256B.091, subdivision 8 states that "grants to counties under this subdivision are subject to audit by the commissioner for fiscal and utilization control." The written record of the county's ACG budget is necessary for a fiscal audit. An ACG budget is based on the estimate of the number of persons to be served as ACG clients. Therfore it is necessary and reasonable to require the local agency to submit this information together with the proposed and actual budgets because the information aids the commissioner's audit.

Item F. It is reasonable that the plan contain the local agency's assurance of compliance as the assurance provides a clear record of the local agency's acceptance of conditions of participation and thus avoids misunderstandings.

Subp. 3. Commissioner approval of local agency biennial plan. This subpart is necessary to specify when the commissioner must respond to a submitted biennial plan. It is reasonable that the commissioner respond by August 15 of odd numbered years because it balances the time required for department review of the plans and the county's need to complete its budget cycle in a timely manner.

Subp. 4. ACG provider records. This subpart is necessary to specify the standard of maintaining program and fiscal records. Minnesota Statutes, section 256B.091, subdivision 8 grants the commissioner authority to audit local agencies for fiscal and utilization control. Separate files are necessary and reasonable because they aid the commissioner's audit of the program as required by the cited statute. Parts 9505.1750 to 9505.2150 cited in this subpart as standards for record maintenance and audit availability are applicable to all medical assistance programs, and so apply to services paid for through the waiver. This citation is reasonable to ensure consistency and coordination of rules.

9505.2496 CRITERION FOR DELAY IN SENDING REQUIRED NOTICES

Information that the commissioner needs to carry out actions required under Minnesota Statutes, section 256B.091 and parts 9505.2390 to 9505.2500 comes from many sources outside of the commissioner's control. Examples of necessary information include the amount of state funds appropriated by the Legislature, changes in the comsumer price index, and waiver conditions approved by the federal government. Therefore this part is necessary and reasonable because it allows the flexibility to delay the required actions until the necessary information is available.

9505.2500 APPEALS OF SCREENINGS, RESCREENINGS, AND REASSESSMENTS

This part covers the general provisions for appeals by ACG clients. Federal regulations, 42 CFR 431.200 to 431.250, require an appeal process

Information that the commissioner needs to carry out actions required under Minnesota Statutes, section 256B.091 and parts 9505.2390 to 9505.2500 comes from many sources outside of the commissioner's control. Examples of necessary information include the amount of state funds appropriated by the Legislature, changes in the comsumer price index, and waiver conditions approved by the federal government. Therefore this part is necessary and reasonable because it allows the flexibility to delay the required actions until the necessary information is available.

9505.2500 APPEALS OF SCREENINGS, RESCREENINGS, AND REASSESSMENTS

This part covers the general provisions for appeals by ACG clients. Federal regulations, 42 CFR 431.200 to 431.250, require an appeal process for recipients. Many ACG services are funded by medical assistance under the waiver and state appropriations and, thus, are considered public assistance services under Minnesota Statutes, section 256.045, subdivision 3. Minnesota Statutes, section 256.045 establishes the right of a person whose application for services under Minnesota Statutes, Chapter 256B, is denied or whose assistance [under Minnesota Statutes, Chapter 256B] is suspended, reduced, or terminated to contest that decision. Minnesota Statutes, section 256.045 also establishes the time limitations for submitting a written request for a hearing, the conduct of the hearing, who shall hear the appeal and who shall issue an order on the matter, and the right of a party aggrieved by the order to seek judicial review.

Subpart 1. Information about the right to appeal. Informing a person applying for an ACG about appeal rights is necessary and reasonable to inform the person of rights available under Minnesota Statutes, section 256.045. It is reasonable to require the preadmission screening team to inform the person being screened, rescreened, or reassessed as the preadmission screening team has direct contact with the person during the screening or reassessment. Requiring the information to state the grounds for an appealable action and the date for filing an appeal is necessary and reasonable to minimize confusion and assist the person's ability to appeal. Requiring written information to be given to the person is reasonable because it is evidence that the information was given and, furthermore, minimizes possible misunderstanding about the person's right to appeal.

Subp. 2. Appealable actions. See the introductory discussion about appeals under Minnesota Statutes, section 256.045 in the SNR for subpart 1.

Items A and B are consistent with Minnesota Statutes, section 256B.091, subdivision 5 which permits appeals from the screening team's recommendations and with subdivision 8 of the cited statute which requres a county to document that the most cost effective alternatives available have been offered to the individual and that the individual was free to choose among the available qualified providers.

Item C. An ACG client's case manager is responsible for reassessing an ACG client. (See part 9505.2455, subpart 11 and 12 and their SNRs.) From information learned in the reassessment, the case manager may determine to deny, reduce, suspend, or terminate ACG services. This action would have the same effect on the person's receipt of services as a similar recommendation by a preadmission screening team. Therefore, it is reasonable to provide the client the same remedy, the right to appeal, in both situations.

Including items A to C in the rule is necessary and reasonable to inform affected persons.

Subp. 3. Denial, reduction, suspension, or termination because of insufficient ACG funds or openings. There is no entitlement to ACG services. Eligibility for ACG services is limited by the availability of money from a combination of federal, state, and county sources. Minnesota Statutes, section 256B.091 specifies that "the commissioner shall provide grants to counties participating in the program to pay costs of providing alternative care . . ." Therefore, a county does not have control of the amount of funds available to provide ACG services. Consequently, it is possible that a county's funds are not sufficient to provide services to all eligible persons. Therefore, it is necessary and reasonable to permit denial, reduction, suspension, or termination of the services if the funds are insufficient to pay for the services.

As stated in part 9505.2458 and its SNR concerning the case manager's actions to assure the health and safety of the ACG client who is a vulnerable adult, the case manager may determine it is necessary to withdraw the client's ACG services. Therefore, it is necessary and reasonable to deny the right to appeal a withdrawal resulting from an action necessary to assure the health or safety of the ACG client because this denial is consistent with the concern for the client's health and safety and is based on recommendations of qualified professionals.

Subp. 4. Submission of appeals. Minnesota Statutes, section 256.045, subdivision 3 establishes the procedure for making an appeal concerning public assistance programs. This subpart is consistent with the cited statute. Including this information in the rule is necessary and reasonable because it informs affected persons.

Subp. 5. Appeal of action. This subpart is consistent with the statute cited within it. Including this information in the rule is necessary and reasonable because it informs affected persons.

Expert Witness

The department will not present expert witnesses to testify concerning the provisions of these proposed rules on behalf of the department.

2/23/88
Date

SANDRA S. GARDEBRING, Commissioner
Department of Human Services

SRF/EW

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF THE RULE OF THE STATE DEPARTMENT OF HUMAN SERVICES GOVERNING PREADMISSION SCREENING AND ALTERNATIVE CARE GRANTS, MINNESOTA RULES, PARTS 9505.2390 TO 9505.2500

AFFIDAVIT OF MAILING

Nancy Bishop, being first duly sworn, deposes and says:

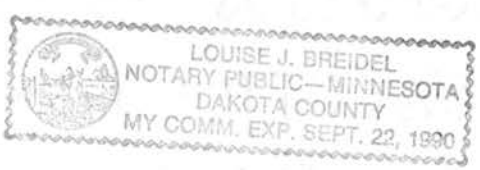
That on the 9 th day of March, 1988, at the City of St. Paul, County of Ramsey, State of Minnesota, I mailed the attached Notices by depositing in the State of Minnesota Central Mail System for first class mailing, a copy thereof, properly enveloped, with postage prepaid, to all persons and associations who have requested that their names be placed on file with the Department of Human Services for the purpose of receiving notice of hearing by this Department.

Nancy Bishop

Subscribed and sworn to before me

this 9 day of March, 1988

Louise J. Breidel



STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption of Department of Human Services Rules Governing Preadmission Screening and Alternative Care Grants, Minnesota Rules, Parts 9505.2390 to 9505.2500

NOTICE OF HEARING AND NOTICE OF INTENT TO CANCEL HEARING IF FEWER THAN TWENTY-FIVE PERSONS REQUEST A HEARING IN RESPONSE TO NOTICE OF INTENT TO ADOPT RULES WITHOUT A PUBLIC HEARING

NOTICE IS HEREBY GIVEN that a public hearing on the above-entitled matter will be held in Rooms 1 A and 1 B, First Floor, 444 Lafayette Road, St. Paul, MN 55155 on April 28, 1988 commencing at 9:00 a.m. and continuing until all interested or affected persons have an opportunity to participate. The proposed rules may be modified as a result of the hearing process. Therefore, if you are affected in any manner by the proposed rules, you are urged to participate in the rule hearing process.

PLEASE NOTE, HOWEVER, THAT THE HEARING WILL BE CANCELLED IF FEWER THAN TWENTY-FIVE PERSONS REQUEST A HEARING IN RESPONSE TO THE NOTICE OF INTENT TO ADOPT THESE SAME RULES WITHOUT A PUBLIC HEARING PUBLISHED IN THIS STATE REGISTER AND MAILED TO PERSONS REGISTERED WITH THE DEPARTMENT OF HUMAN SERVICES. To verify whether a hearing will be held, please call the Department of Human Services between April 14 and April 27, 1988 at (612) 297 4301.

Following the agency's presentation at the hearing, all interested or affected persons will have an opportunity to participate. Such persons may present their views either orally at the hearing or in writing at any time prior to the close of the hearing record. All evidence presented should be pertinent to the matter at hand. Written material not submitted at the time of the hearing which is to be included in the hearing record may be mailed to Peter Erickson, Administrative Law Judge, Office of Administrative Hearings, 500 Flour Exchange Building, 310 Fourth Avenue South, Minneapolis, Minnesota 55415; telephone (612) 341 7606, either before the hearing or within five working days after the public hearing ends. The Administrative Law Judge may at the hearing, order the record be kept open for a longer period not to exceed 20 calendar days. The comments received during the comment period shall be available for review at the Office of Administrative Hearings. Following the close of the comment period the agency and all interested persons have three business days to respond in writing to any new information submitted during the comment period. During the three-day period, the agency may indicate in writing whether there are amendments suggested by other persons which the agency is willing to adopt. No additional evidence may be submitted during the three-day period. The written responses shall be added to the rulemaking record. Upon the close of the record the Administrative Law

Judge will write a report as provided for in Minnesota Statutes, sections 14.15 and 14.50. The rule hearing is governed by Minnesota Statutes, sections 14.14 to 14.20 and by Minnesota Rules, parts 1400.0200 to 1400.1200. Questions about procedure may be directed to the Administrative Law Judge.

Minnesota Rules, Parts 9505.2390 to 9505.2500 establish the procedures that govern preadmission screening (PAS) for nursing home applicants and residents who request a screening, and alternative care (ACG) grants for eligible persons who choose to remain in the community with community services. The rules provide a framework for counties to: 1) maintain preadmission screening teams; 2) administer preadmission screening; 3) determine individual service plans which will enable persons to remain in the community; 4) select providers for alternative care grant services; 5) set standards for alternative care grant providers; 6) authorize services for reimbursement; 7) bill the department for reimbursement of eligible services; 8) provide for allocation and reallocation of the number of ACG clients a county may serve and the funds for the services; 9) establish penalties on counties and nursing homes that fail to provide preadmission screenings within required time limits; 10) establish standards for home health aide , homemaker, and personal care services that are provided under ACG grants; 11) require case managers to act to assure safety and health of ACG clients who are vulnerable adults; 12) establish limits on rates for services including screenings; and 13) set forth the conditions for appealing decisions resulting from screenings, rescreenings, and reassessments. The proposed rules, if adopted, will repeal the present rule, parts 9505.2250 to 9505.2380, and are necessary in order to ensure consistency with state and federal laws and regulations and the federal waiver granted under section 2176 of the Social Security Act which allows the state to use federal Medicaid funds to provide home and community-based services otherwise not allowed under the Medicaid program.

The agency's authority to adopt the proposed rules is contained in Minnesota Statutes, section 256B.091, subdivisions 1 to 9. Adoption of these rules will not result in additional spending by local public bodies in excess of $100,000 per year for the first two years following adoption under the requirements of Minnesota Statutes, section 14.11.. A fiscal note prepared according to the requirements of Minnesota Statutes, section 3.98, subdivision 2, estimating the fiscal impact of the rule is available upon request from:

Eleanor Weber
Rules Division
Department of Human Services.
444 Lafayette Road
St. Paul, MN 55155-3816
(612) 297 4301

Copies of the proposed rules are now available and at least one free copy may be obtained by writing to:

Eleanor Weber
Rules Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816

This rule is also available for viewing at each of the county welfare or human service agencies in the State of Minnesota.

Additional copies will be available at the hearing. If you have any questions on the content of the rule contact Mary Bruns, (612) 297 2243.

NOTICE: Any person may request notification of the date on which the Administrative Law Judge'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. If you desire to be notified, you may so indicate at the hearing. After the hearing, you may request notification by sending a written request to the Administrative Law Judge. Any person may request notification of the date on which the rules were adopted and filed with the secretary of state. The notice must be mailed on the same day the rules are filed. If you want to be so notified you may so indicate at the hearing or send a request in writing to the agency at any time prior to the filing of the rules with the secretary of state.

NOTICE IS HEREBY GIVEN that a Statement of Need and Reasonableness is now available for review at the agency and at the Office of Administrative Hearings. The Statement of Need and Reasonableness includes a summary of all the evidence and argument which the agency anticipates presenting at the hearing justifying both the need for and reasonableness of the proposed rules. Copies of the Statement of Need and Reasonableness may be reviewed at the agency or the Office of Administrative Hearings and copies may be obtained from the Office of Administrative Hearings at the cost of reproduction.

Minnesota Statutes, chapter 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 Minnesota Statutes, section 10A.01, subdivision 11, 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 travel expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communication or urging others to communicate with public officials; or

(b) who spends more than $250, not including 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, 625 North Robert Street, St. Paul, Minnesota 55101, telephone (612) 296-5148.

SANDRA S. GARDEBRING
Commissioner

Dated: 2/23/86

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption of Rules of the State Department of Human Services Governing Preadmission Screening and Alternative Care Grants, Minnesota Rules, Parts 9505.2390 to 9505.2500

NOTICE OF INTENT TO ADOPT A RULE WITHOUT A PUBLIC HEARING AND NOTICE OF INTENT TO ADOPT A RULE WITH A PUBLIC HEARING IF TWENTY-FIVE OR MORE PERSONS REQUEST A HEARING

Notice is hereby given that the State Department of Human Services proposes to adopt the above-entitled rule without a public hearing following the procedures set forth in Minnesota Statutes, section 14.22 to 14.28. The specific statutory authority to adopt the rule is Minnesota Statutes, section 256B.091, subdivisions 1 to 9.

Persons interested in this rule shall have 30 days in which to submit comment in support of or in opposition to the proposed rule or any part or subpart of the rule and comment is encouraged. Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rule within the 30-day comment period. If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. If a public hearing is required, the agency will proceed pursuant to Minnesota Statutes, section 14.131 to 14.20. PLEASE NOTE THAT IF TWENTY-FIVE OR MORE PERSONS SUBMIT WRITTEN REQUESTS FOR A PUBLIC HEARING WITHIN THE 30-DAY COMMENT PERIOD, A HEARING WILL BE HELD ON APRIL 28, 1988, UNLESS A SUFFICIENT NUMBER WITHDRAW THEIR REQUEST, IN ACCORDANCE WITH THE NOTICE OF PUBLIC HEARING ON THESE SAME RULES PUBLISHED IN THIS STATE REGISTER AND MAILED TO PERSONS REGISTERED WITH THE DEPARTMENT OF HUMAN SERVICES. To verify whether a hearing will be held, please call the Department of Human Services between April 14, 1988 and April 27, 1988 at (612) 297 4301.

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

Eleanor Weber
Rules Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816

Comments or requests for a public hearing must be received by the Department by 4:30 p.m. on April 13, 1988.

The proposed rule may be modified if the modifications are supported by data and views and do not result in a substantial change in the proposed rule as noticed.

A free copy of this rule is available upon request for your review from:
Eleanor Weber
Rules Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816
(612) 297 4301

A copy of the proposed rule may be viewed at any of the county welfare or human service agencies in the State of Minnesota.

Minnesota Rules, Parts 9505.2390 to 9505.2500 establish the procedures that govern preadmission screening (PAS) for nursing home applicants and residents who request a screening, and alternative care (ACG) grants for eligible persons who choose to remain in the community with community services. The rules provide a framework for counties to: 1) maintain preadmission screening teams; 2) administer preadmission screening; 3) determine individual service plans which will enable persons to remain in the community; 4) select providers for alternative care grant services; 5) set standards for alternative care grant providers; 6) authorize services for reimbursement; 7) bill the department for reimbursement of eligible services; 8) provide for allocation and reallocation of the number of ACG clients a county may serve and the funds for the services; 9) establish penalties on counties and nursing homes that fail to provide preadmission screenings within required time limits; 10) establish standards for home health aide , homemaker, and personal care services that are provided under ACG grants; 11) require case managers to act to assure safety and health of ACG clients who are vulnerable adults; 12) establish limits on rates for services including screenings; and 13) set forth the conditions for appealing decisions resulting from screenings, rescreenings, and reassessments. The proposed rules, if adopted, will repeal the present rule, parts 9505.2250 to 9505.2380, and are necessary in order to ensure consistency with state and federal laws and regulations and the federal waiver granted under section 2176 of the Social Security Act which allows the state to use federal Medicaid funds to provide home and community-based services otherwise not allowed under the Medicaid program.

A Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relied upon to support the proposed rule has been prepared and is available upon request from:
Eleanor Weber
Rules Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816
9612) 297 4301

Adoption of these rules will not result in additional spending by local public bodies in the excess of $100,000 per year for the first two years following adoption under the requirements of Minnesota Statutes, section

14.11. A fiscal note prepared according to the requirements of Minnesota Statutes, section 3.98, subdivision 2, estimating the fiscal impact of the rule is available upon request from:

Eleanor Weber
Rules Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816
(612) 297 4301

If no hearing is required upon adoption of the rule, the rule and the required supporting documents will be delivered to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to:

Eleanor Weber
Rules Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155

State of Minnesota

SANDRA S. GARDEBRING, Commissioner
Department of Human Services

Dated: 2/25/88

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF THE RULE OF THE STATE DEPARTMENT OF HUMAN SERVICES GOVERNING PREADMISSION SCREENING AND ALTERNATIVE CARE GRANTS, MINNESOTA RULES, PARTS 9505.2390 TO 9505.2500

AFFIDAVIT OF ADDITIONAL MAILING

Nancy Bishop, being first duly sworn, deposes and says:

That on the 9 th day of March, 1988, at the City of St. Paul, County of Ramsey, State of Minnesota, I mailed the attached Notices by depositing in the State of Minnesota Central Mail System for first class mailing, a copy thereof, properly enveloped, with postage prepaid to the following parties:

.The 87 Minnesota County Human Services Agencies

.Certified nursing homes and boarding care homes

.Public advisory committee members

.Public health nursing service agencies

.Community health service agencies, directors/administrators

.County preadmission screening program administrators

.Hospital social service administrators and other interested parties

Nancy Bishop

Subscribed and sworn to before me

this 9 day of March, 1988

Louise J. Breidel

LOUISE J. BREIDEL
NOTARY PUBLIC—MINNESOTA
DAKOTA COUNTY
MY COMM. EXP. SEPT. 22, 1990

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption of Rules of the State Department of Human Services Governing Preadmission Screening and Alternative Care Grants, Minnesota Rules, Parts 9505.2390 to 9505.2500

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Persons interested in this rule shall have 30 days in which to submit comment in support of or in opposition to the proposed rule or any part or subpart of the rule and comment is encouraged. Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rule within the 30-day comment period. If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. If a public hearing is required, the agency will proceed pursuant to Minnesota Statutes, section 14.131 to 14.20. PLEASE NOTE THAT IF TWENTY-FIVE OR MORE PERSONS SUBMIT WRITTEN REQUESTS FOR A PUBLIC HEARING WITHIN THE 30-DAY COMMENT PERIOD, A HEARING WILL BE HELD ON APRIL 28, 1988, UNLESS A SUFFICIENT NUMBER WITHDRAW THEIR REQUEST, IN ACCORDANCE WITH THE NOTICE OF PUBLIC HEARING ON THESE SAME RULES PUBLISHED IN THIS STATE REGISTER AND MAILED TO PERSONS REGISTERED WITH THE DEPARTMENT OF HUMAN SERVICES. To verify whether a hearing will be held, please call the Department of Human Services between April 14, 1988 and April 27, 1988 at (612) 297 4301.

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

Eleanor Weber
Rules Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816

Comments or requests for a public hearing must be received by the Department by 4:30 p.m. on April 13, 1988.

The proposed rule may be modified if the modifications are supported by data and views and do not result in a substantial change in the proposed rule as noticed.

A free copy of this rule is available upon request for your review from:
Eleanor Weber
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444 Lafayette Road
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(612) 297 4301

A copy of the proposed rule may be viewed at any of the county welfare or human service agencies in the State of Minnesota.

Minnesota Rules, Parts 9505.2390 to 9505.2500 establish the procedures that govern preadmission screening (PAS) for nursing home applicants and residents who request a screening, and alternative care (ACG) grants for eligible persons who choose to remain in the community with community services. The rules provide a framework for counties to: 1) maintain preadmission screening teams; 2) administer preadmission screening; 3) determine individual service plans which will enable persons to remain in the community; 4) select providers for alternative care grant services; 5) set standards for alternative care grant providers; 6) authorize services for reimbursement; 7) bill the department for reimbursement of eligible services; 8) provide for allocation and reallocation of the number of ACG clients a county may serve and the funds for the services; 9) establish penalties on counties and nursing homes that fail to provide preadmission screenings within required time limits; 10) establish standards for home health aide , homemaker, and personal care services that are provided under ACG grants; 11) require case managers to act to assure safety and health of ACG clients who are vulnerable adults; 12) establish limits on rates for services including screenings; and 13) set forth the conditions for appealing decisions resulting from screenings, rescreenings, and reassessments. The proposed rules, if adopted, will repeal the present rule, parts 9505.2250 to 9505.2380, and are necessary in order to ensure consistency with state and federal laws and regulations and the federal waiver granted under section 2176 of the Social Security Act which allows the state to use federal Medicaid funds to provide home and community-based services otherwise not allowed under the Medicaid program.

A Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relied upon to support the proposed rule has been prepared and is available upon request from:
Eleanor Weber
Rules Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816
9612) 297 4301

Adoption of these rules will not result in additional spending by local public bodies in the excess of $100,000 per year for the first two years following adoption under the requirements of Minnesota Statutes, section

14.11. A fiscal note prepared according to the requirements of Minnesota Statutes, section 3.98, subdivision 2, estimating the fiscal impact of the rule is available upon request from:

Eleanor Weber
Rules Division
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444 Lafayette Road
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If no hearing is required upon adoption of the rule, the rule and the required supporting documents will be delivered to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to:

Eleanor Weber
Rules Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155

State of Minnesota

SANDRA S. GARDEBRING, Commissioner
Department of Human Services

Dated: 2/23/88

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption of Department of Human Services Rules Governing Preadmission Screening and Alternative Care Grants, Minnesota Rules, Parts 9505.2390 to 9505.2500

NOTICE OF HEARING AND NOTICE OF INTENT TO CANCEL HEARING IF FEWER THAN TWENTY-FIVE PERSONS REQUEST A HEARING IN RESPONSE TO NOTICE OF INTENT TO ADOPT RULES WITHOUT A PUBLIC HEARING

NOTICE IS HEREBY GIVEN that a public hearing on the above-entitled matter will be held in Rooms 1 A and 1 B, First Floor, 444 Lafayette Road, St. Paul, MN 55155 on April 28, 1988 commencing at 9:00 a.m. and continuing until all interested or affected persons have an opportunity to participate. The proposed rules may be modified as a result of the hearing process. Therefore, if you are affected in any manner by the proposed rules, you are urged to participate in the rule hearing process.

PLEASE NOTE, HOWEVER, THAT THE HEARING WILL BE CANCELLED IF FEWER THAN TWENTY-FIVE PERSONS REQUEST A HEARING IN RESPONSE TO THE NOTICE OF INTENT TO ADOPT THESE SAME RULES WITHOUT A PUBLIC HEARING PUBLISHED IN THIS STATE REGISTER AND MAILED TO PERSONS REGISTERED WITH THE DEPARTMENT OF HUMAN SERVICES. To verify whether a hearing will be held, please call the Department of Human Services between April 14 and April 27, 1988 at (612) 297 4301.

Following the agency's presentation at the hearing, all interested or affected persons will have an opportunity to participate. Such persons may present their views either orally at the hearing or in writing at any time prior to the close of the hearing record. All evidence presented should be pertinent to the matter at hand. Written material not submitted at the time of the hearing which is to be included in the hearing record may be mailed to Peter Erickson, Administrative Law Judge, Office of Administrative Hearings, 500 Flour Exchange Building, 310 Fourth Avenue South, Minneapolis, Minnesota 55415; telephone (612) 341 7606, either before the hearing or within five working days after the public hearing ends. The Administrative Law Judge may at the hearing, order the record be kept open for a longer period not to exceed 20 calendar days. The comments received during the comment period shall be available for review at the Office of Administrative Hearings. Following the close of the comment period the agency and all interested persons have three business days to respond in writing to any new information submitted during the comment period. During the three-day period, the agency may indicate in writing whether there are amendments suggested by other persons which the agency is willing to adopt. No additional evidence may be submitted during the three-day period. The written responses shall be added to the rulemaking record. Upon the close of the record the Administrative Law

Judge will write a report as provided for in Minnesota Statutes, sections 14.15 and 14.50. The rule hearing is governed by Minnesota Statutes, sections 14.14 to 14.20 and by Minnesota Rules, parts 1400.0200 to 1400.1200. Questions about procedure may be directed to the Administrative Law Judge.

Minnesota Rules, Parts 9505.2390 to 9505.2500 establish the procedures that govern preadmission screening (PAS) for nursing home applicants and residents who request a screening, and alternative care (ACG) grants for eligible persons who choose to remain in the community with community services. The rules provide a framework for counties to: 1) maintain preadmission screening teams; 2) administer preadmission screening; 3) determine individual service plans which will enable persons to remain in the community; 4) select providers for alternative care grant services; 5) set standards for alternative care grant providers; 6) authorize services for reimbursement; 7) bill the department for reimbursement of eligible services; 8) provide for allocation and reallocation of the number of ACG clients a county may serve and the funds for the services; 9) establish penalties on counties and nursing homes that fail to provide preadmission screenings within required time limits; 10) establish standards for home health aide , homemaker, and personal care services that are provided under ACG grants; 11) require case managers to act to assure safety and health of ACG clients who are vulnerable adults; 12) establish limits on rates for services including screenings; and 13) set forth the conditions for appealing decisions resulting from screenings, rescreenings, and reassessments. The proposed rules, if adopted, will repeal the present rule, parts 9505.2250 to 9505.2380, and are necessary in order to ensure consistency with state and federal laws and regulations and the federal waiver granted under section 2176 of the Social Security Act which allows the state to use federal Medicaid funds to provide home and community-based services otherwise not allowed under the Medicaid program.

The agency's authority to adopt the proposed rules is contained in Minnesota Statutes, section 256B.091, subdivisions 1 to 9. Adoption of these rules will not result in additional spending by local public bodies in excess of $100,000 per year for the first two years following adoption under the requirements of Minnesota Statutes, section 14.11.. A fiscal note prepared according to the requirements of Minnesota Statutes, section 3.98, subdivision 2, estimating the fiscal impact of the rule is available upon request from:

Eleanor Weber
Rules Division
Department of Human Services.
444 Lafayette Road
St. Paul, MN 55155-3816
(612) 297 4301

Copies of the proposed rules are now available and at least one free copy may be obtained by writing to:

Eleanor Weber
Rules Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816

This rule is also available for viewing at each of the county welfare or human service agencies in the State of Minnesota.

Additional copies will be available at the hearing. If you have any questions on the content of the rule contact Mary Bruns, (612) 297 2243.

NOTICE: Any person may request notification of the date on which the Administrative Law Judge'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. If you desire to be notified, you may so indicate at the hearing. After the hearing, you may request notification by sending a written request to the Administrative Law Judge. Any person may request notification of the date on which the rules were adopted and filed with the secretary of state. The notice must be mailed on the same day the rules are filed. If you want to be so notified you may so indicate at the hearing or send a request in writing to the agency at any time prior to the filing of the rules with the secretary of state.

NOTICE IS HEREBY GIVEN that a Statement of Need and Reasonableness is now available for review at the agency and at the Office of Administrative Hearings. The Statement of Need and Reasonableness includes a summary of all the evidence and argument which the agency anticipates presenting at the hearing justifying both the need for and reasonableness of the proposed rules. Copies of the Statement of Need and Reasonableness may be reviewed at the agency or the Office of Administrative Hearings and copies may be obtained from the Office of Administrative Hearings at the cost of reproduction.

Minnesota Statutes, chapter 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 Minnesota Statutes, section 10A.01, subdivision 11, 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 travel expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communication or urging others to communicate with public officials; or

(b) who spends more than $250, not including 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, 625 North Robert Street, St. Paul, Minnesota 55101, telephone (612) 296-5148.

SANDRA S. GARDEBRING
Commissioner

Dated: 2/23/86

A. If a recipient requests a conciliation conference, the service provider shall provide the conference within 30 days after receiving the recipient's written request for a conference. The service provider shall notify the recipient of the conference date at least ten days before the date of the conference.

B. The local agency shall reimburse the recipient for the recipient's reasonable and necessary child care and transportation expenses incurred as a result of the recipient's attendance of the conciliation conference.

C. The service provider shall hold the conciliation conference during regular working hours at the service provider's office. If the service provider and the recipient agree, the conciliation conference may be conducted over the telephone.

D. If a conciliation conference is not requested or if the dispute is not resolved at the conference, the service provider shall provide to the local agency and to the recipient written notification of its determination that the recipient failed or refused without good cause to participate in employment search or accept employment.

Subp. 7. **Final determination before sanction.** When WIN does not sanction a recipient for failure to accept employment assigned by WIN or participate in an employment and training service provided through WIN, a local agency shall not apply sanctions for the same failure. The local agency shall make a final determination of whether the recipient has failed, without good cause, to accept employment that has not been assigned by WIN or to participate in employment search program that has not been provided through WIN. Upon final determination of failure to participate or accept employment, the local agency shall apply the sanctions under part 9500.2730.

9500.2730 SANCTIONS FOR FAILURE TO PARTICIPATE IN A MANDATORY EMPLOYMENT AND TRAINING SERVICE OR ACCEPT EMPLOYMENT.

Subpart 1. **Notice.** If a local agency is notified of WIN deregistration under part 9500.2726, subpart 3, or if a local agency determines under part 9500.2728, subpart 7, that a recipient has failed, without good cause, to participate in employment search or accept employment, the local agency shall notify the recipient that the local agency will impose the sanctions of subpart 2, beginning with the first payment month following deregistration or noncompliance in which notification and appeal rights under part 9500.2740, subparts 5 to 10, allow application of those sanctions.

Subp. 2. **Sanctions.** The following sanctions apply to recipients who do not comply with WIN, employment search, or employment requirements:

A. When a recipient is also the principal wage earner under part 9500.2300, the entire assistance unit is ineligible for three payment months for the first failure to comply or for six payment months for later failures to comply. When, during the period of sanction, the principal wage earner leaves the home or when either parent becomes incapacitated and eligibility is established under parts 9500.2180 to 9500.2260, the sanction period ends for the remaining members of the assistance unit.

B. When a recipient in an assistance unit that qualifies under part 9500.2300 is the parent who is not the principal wage earner, or when the recipient is a parent caretaker in an assistance unit that qualifies under part 9500.2180, 9500.2220, or 9500.2260, the parent caretaker shall be removed from the assistance unit. The parent caretaker shall be ineligible for a period of three payment months for the first failure to comply or for six payment months for later failures to comply. Protective or vendor payments shall be issued for the needs of the remaining members of the assistance unit under part 9500.2680, subpart 2, item A until the period of the sanction ends or the recipient who is under sanction is no longer a member of the assistance unit.

C. When a recipient who is under sanction is a caretaker relative other than a parent or is one of several dependent children, that person must be removed from the assistance unit for three payment months for the first failure to comply or for six payment months for subsequent failures to comply. When the recipient is the only dependent child in the assistance unit, the assistance unit shall be ineligible for AFDC for three payment months following the first occasion of noncompliance or for six payment months following later occasions of noncompliance.

REPEALER. *Minnesota Rules*, part 9500.2700, subparts 13, 14, 15, 16, 17, 18, and 19, are repealed.

Department of Human Services

Proposed Permanent Rules Relating to Preadmission Screening and Alternative Care Grants

Notice of Intent to Adopt a Rule Without a Public Hearing and Notice of Intent to Adopt a Rule With a Public Hearing if Twenty-five or More Persons Request a Hearing

Notice is hereby given that the State Department of Human Services proposes to adopt the above-entitled rule without a public hearing following the procedures set forth in *Minnesota Statutes*, section 14.22 to 14.28. The specific statutory authority to adopt the rule is *Minnesota Statutes*, section 256B.091, subdivisions 1 to 9.

Persons interested in this rule shall have 30 days in which to submit comment in support of or in opposition to the proposed rule or any part or subpart of the rule and comment is encouraged. Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rule within the 30-day comment period. If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. If a public hearing is required, the agency will proceed pursuant to *Minnesota Statutes*, section 14.131 to 14.20. PLEASE NOTE THAT IF TWENTY-FIVE OR MORE PERSONS SUBMIT WRITTEN REQUESTS FOR A PUBLIC HEARING WITHIN THE 30-DAY COMMENT PERIOD, A HEARING WILL BE HELD ON APRIL 28, 1988, UNLESS A SUFFICIENT NUMBER WITHDRAW THEIR REQUEST, IN ACCORDANCE WITH THE NOTICE OF PUBLIC HEARING ON THESE SAME RULES PUBLISHED IN THIS *STATE REGISTER* AND MAILED TO PERSONS REGISTERED WITH THE DEPARTMENT OF HUMAN SERVICES. To verify whether a hearing will be held, please call the Department of Human Services between April 14, 1988 and April 27, 1988 at (612) 297-4301.

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

Eleanor Weber
Rules Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816

Comments or requests for a public hearing must be received by the Department by 4:30 p.m. on April 13, 1988.

The proposed rule may be modified if the modifications are supported by data and views and do not result in a substantial change in the proposed rule as noticed.

A free copy of this rule is available upon request for your review from:

Eleanor Weber
Rules Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816
(612) 297-4301

A copy of the proposed rule may be viewed at any of the county welfare or human service agencies in the State of Minnesota.

Minnesota Rules, Parts 9505.2390 to 9505.2500 establish the procedures that govern preadmission screening (PAS) for nursing home applicants and residents who request a screening, and alternate care (ACG) grants for eligible persons who choose to remain in the community with community services. The rules provide a framework for counties to: 1) maintain preadmission screening teams; 2) administer preadmission screening; 3) determine individual service plans which will enable persons to remain in the community; 4) select providers for alternative care grant services; 5) set standards for alternative care grant providers; 6) authorize services for reimbursement; 7) bill the department for reimbursement of eligible services; 8) provide for allocation and reallocation of the number of ACG clients a county may serve and the funds for the services; 9) establish penalties on counties and nursing homes that fail to provide preadmission screenings within required time limits; 10) establish standards for home health aide, homemaker, and personal care services that are provided under ACG grants; 11) require case managers to act to assure safety and health of ACG clients who are vulnerable adults; 12) establish limits on rates for services including screenings; and 13) set forth the conditions for appealing decisions resulting from screenings, rescreenings, and reassessments. The proposed rules, if adopted, will repeal the present rule, parts 9505.2250 to 9505.2380, and are necessary in order to ensure consistency with state and federal laws and regulations and the federal waiver granted under section 2176 of the Social Security Act which allows the state to use federal Medicaid funds to provide home and community-based services otherwise not allowed under the Medicaid program.

A Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rule

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.

and identifies the data and information relied upon to support the proposed rule has been prepared and is available upon request from:

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Sandra S. Gardebring, Commissioner
Department of Human Services

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Eleanor Weber
Rules Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155

Sandra S. Gardebring, Commissioner
Department of Human Services

Rules as Proposed (all new material)

9505.2390 SCOPE AND EFFECT.

Subpart 1. **Scope.** Parts 9505.2390 to 9505.2500 establish the standards and procedures applicable to the preadmission screening and alternative care grant program. The preadmission screening program screens persons who are applicants for admission to a nursing home or nursing home residents who request a screening as required under part 9505.2435, subpart 2. An alternative care grant pays for some community services in lieu of nursing home admission or continued nursing home resident status for persons who meet the requirements of parts 9505.2390 to 9505.2500.

Parts 9505.2390 to 9505.2500 must be read in conjunction with *Minnesota Statutes*, sections 256B.04, subdivision 2, 256B.05, 256B.091, subdivisions 1 to 9, and Code of Federal Regulations, title 42, sections 440.180 and 441.300 to 441.310. Unless otherwise specified, citations of Code of Federal Regulations, title 42, refer to the code amended as of October 1, 1986.

Parts 9505.2390 to 9505.2500 also must be read in conjunction with the requirements of the waiver obtained by the state from the United States Department of Health and Human Services.

Subp. 2. **Effect.** References to the waiver and waiver provisions that occur in parts 9505.2390 to 9505.2500 shall continue in effect only as long as the waiver from the United States Department of Health and Human Services remains in effect in Minnesota.

9505.2395 DEFINITIONS.

Subpart 1. **Applicability.** The definitions in this part apply to parts 9505.2390 to 9505.2500.

Subp. 2. **Adult day care services.** "Adult day care services" means services provided to alternative care grant clients by adult day care programs established under *Minnesota Statutes*, sections 245A.01 to 245A.17, including adult day care centers licensed under parts 9555.9600 to 9555.9730.

Subp. 3. **Adult foster care services.** "Adult foster care services" means supervised living arrangements for adults in an adult foster care home licensed under parts 9555.5105 to 9555.6265.

Subp. 4. **Alternative care grant or ACG.** "Alternative care grant" or "ACG" means funds allocated to a local agency by the commissioner under *Minnesota Statutes,* section 256B.091 to pay for alternative care services.

Subp. 5. **Alternative care grant client or ACG client.** "Alternative care grant client" or "ACG client" means a person who has been determined eligible to receive or is receiving services funded by an alternative care grant.

Subp. 6. **Alternative care grant services.** "Alternative care grant services" means the services listed in items A to G provided to ACG clients:

A. case management services;

B. respite care services;

C. homemaker services;

D. home health aide services;

E. adult foster care services;

F. adult day care services; and

G. personal care services.

Subp. 7. **Applicant.** "Applicant" means a person who is seeking admission to a nursing home or who has been admitted to a nursing home but has not yet been screened by the preadmission screening team as required in part 9505.2420.

Subp. 8. **Assessment form.** "Assessment form" means the form supplied by the commissioner that is used to record the information required under parts 9505.2425, subpart 1 and 9505.2455, subpart 12.

Subp. 9. **Case management services.** "Case management services" means services that identify, acquire, authorize, and coordinate services for an ACG client; monitor the delivery of services to the ACG client; and adjust services to the needs of the ACG client.

Subp. 10. **Case manager.** "Case manager" means a social worker employed by or under contract with the local agency or a registered nurse who is employed by the local public health department and under contract with the local agency to provide case management services. "Local agency" in this subpart refers to the county of service.

Subp. 11. **Commissioner.** "Commissioner" means the commissioner of the Minnesota Department of Human Services or the commissioner's authorized representative.

Subp. 12. **Community services.** "Community services" means home and community-based services including services provided under the ACG as specified in part 9505.2430, subpart 4, item B, subitem (3), that can be used to meet the health or social needs of an ACG client.

Subp. 13. **County of financial responsibility.** "County of financial responsibility" means the county responsible for paying for preadmission screening of a recipient or the county responsible for paying for ACG services under part 9505.2455, subpart 3.

Subp. 14. **County of service.** "County of service" means the county whose local agency performs preadmission screening of an applicant or nursing home resident or arranges case management services for an ACG client. The county of service may be the same as or different from the county of financial responsibility.

Subp. 15. **Delay of screening.** "Delay of screening" means that preadmission screening has not been completed for an applicant but will be completed according to the time requirements established for:

A. emergency admission under part 9505.2420, subpart 3;

B. preadmission screening of hospital patients under part 9505.2420, subpart 2;

C. 30-day exemption from screening under part 9505.2420, subpart 4; or

D. admission of an applicant from another state under part 9505.2420, subpart 6.

Subp. 16. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 17. **Directory of services.** "Directory of services" means the list of all community services available in a geographic area that is developed under part 9505.2425, subpart 7.

Subp. 18. **Discharge planner.** "Discharge planner" means a person qualified as a public health nurse or a social worker who is employed by a hospital to coordinate the development of an individual service plan of a person who no longer needs the services of the hospital.

Subp. 19. **Emergency admission.** "Emergency admission" means the admission of an applicant from the community to a nursing home before completion of preadmission screening when a physician has determined that the delay in admission needed for preadmission screening would adversely affect the applicant's health and safety. For purposes of this definition, "community" does not include a hospital.

Subp. 20. **Formal caregivers.** "Formal caregivers" means persons or entities providing ACG services who are employed or who are under contract with a local agency, or other agency or organization, public or private.

Subp. 21. **Home health aide.** "Home health aide" means a person who meets the requirements of part 9505.2470 and provides home health aide services to an ACG client.

Subp. 22. **Home health aide services.** "Home health aide services" means services provided under part 9505.2470 that are written in the individual treatment plan. Home health aide services include the performance of procedures as an extension of therapy services, personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the ACG client's condition and needs, and completing necessary records.

Subp. 23. **Homemaker services.** "Homemaker services" means services that assist an ACG client as set forth in items A to G:

A. performing house cleaning activities;

B. laundering, ironing, and mending;

C. meal planning, preparation, and cleanup;

D. assisting with money management;

E. providing companionship, emotional support, and social stimulation;

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F. observing and evaluating home safety practices and seeking to improve these practices where appropriate; and

G. performing essential errands and shopping.

Subp. 24. **Hospital.** "Hospital" has the definition given in *Minnesota Statutes*, section 144.696, subdivision 3.

Subp. 25. **Individual service plan.** "Individual service plan" means the written plan of a community service or a combination of community services designed to meet the health and social needs of an applicant or nursing home resident screened according to part 9505.2430. The individual service plan is the plan of care referred to in *Minnesota Statutes*, section 256B.091.

Subp. 26. **Individual treatment plan.** "Individual treatment plan" means the written treatment plan of care for providing personal care and home health aide services under part 9505.2475 to an ACG client.

Subp. 27. **Informal caregivers.** "Informal caregivers" means family, friends, neighbors, or others who provide services and assistance to the elderly without the sponsorship of an agency or organization.

Subp. 28. **Local agency.** "Local agency" means the county or multicounty agency that is required under *Minnesota Statutes*, section 256B.05, to administer the medical assistance program.

Subp. 29. **Medical assistance or MA.** "Medical assistance" or "MA" means the program established under title XIX of the Social Security Act and *Minnesota Statutes*, chapter 256B.

Subp. 30. **Mental illness.** "Mental illness" means an illness as defined in *Minnesota Statutes*, section 245.462, subdivision 20, clause (2).

Subp. 31. **Nursing home.** "Nursing home" means a facility licensed under *Minnesota Statutes*, chapter 144A or sections 144.50 to 144.56, that is certified to participate in the medical assistance program as a skilled nursing facility or an intermediate care facility. This definition includes boarding care homes.

Subp. 32. **Nursing home resident.** "Nursing home resident" means a person who resides, and expects to continue to reside, in a nursing home for more than 30 days. For purposes of parts 9505.2390 to 9505.2500, "nursing home resident" does not include a person who is in a nursing home for respite care.

Subp. 33. **Personal care services.** "Personal care services" means services meeting the requirements of part 9505.2465.

Subp. 34. **Personal care assistant.** "Personal care assistant" means a person who provides personal care services under part 9505.2465 and meets the training requirements of part 9505.2465, subpart 2.

Subp. 35. **Person with mental retardation or related conditions.** "Person with mental retardation or related conditions" means a person as defined in part 9525.0015, subpart 20.

Subp. 36. **Physician.** "Physician" means a person who is authorized to practice medicine under *Minnesota Statutes*, chapter 147.

Subp. 37. **Preadmission screening.** "Preadmission screening" means the activities performed by a preadmission screening team under *Minnesota Statutes*, section 256B.091, and parts 9505.2390 to 9505.2500. This definition does not include the activities of teams authorized under *Minnesota Statutes*, section 256B.092, and established in parts 9525.0015 to 9525.0165 and under the Minnesota Comprehensive Mental Health Act, *Minnesota Statutes*, sections 245.461 to 245.486.

Subp. 38. **Preadmission screening document.** "Preadmission screening document" means the document required in part 9505.2495, subpart 1, and supplied by the commissioner.

Subp. 39. **Preadmission screening team.** "Preadmission screening team" means the team authorized in *Minnesota Statutes*, section 256B.091, and required by part 9505.2410, to assess the financial, health, and social needs of an applicant or a nursing home resident.

Subp. 40. **Primary caregiver.** "Primary caregiver" means the informal caregiver who customarily provides care to the ACG client and cooperates with the case manager in assuring the provision of services by the formal caregivers.

Subp. 41. **Public health nurse.** "Public health nurse" means a registered nurse certified by the Minnesota Department of Health as a public health nurse and employed by a local board of health under *Minnesota Statutes*, sections 145.08 to 145.123.

Subp. 42. **Public health nursing services.** "Public health nursing services" means the nursing services provided by a board of health under *Minnesota Statutes*, sections 145.911 to 145.92.

Subp. 43. **Reassessment.** "Reassessment" means the reevaluation of an ACG client's financial, health, and social needs under part 9505.2455, subparts 11 and 12.

Subp. 44. **Recipient.** "Recipient" means a person who has been determined by the local agency to be eligible for medical assistance under parts 9505.0010 to 9505.0150.

Subp. 45. **Registered nurse.** "Registered nurse" means a person licensed under *Minnesota Statutes*, section 148.211.

Subp. 46. **Representative.** "Representative" means a person appointed by the court as a guardian or conservator under *Minnesota Statutes*, sections 252A.01 to 252A.21 or 525.539 to 525.6198 or a parent of a child under age 18 unless the parent's parental rights have been terminated.

Subp. 47. **Rescreening.** "Rescreening" means the completion of the activities in part 9505.2435, subpart 3, after an initial preadmission screening.

Subp. 48. **Resident class.** "Resident class" refers to the case mix classification required under *Minnesota Statutes*, section 256B.091, subdivision 2, and assigned to a person as required under parts 9549.0058, subpart 2, and 9549.0059.

Subp. 49. **Resident day.** "Resident day" means a day for which nursing services in a nursing home are rendered or a day for which a nursing home bed is held.

Subp. 50. **Respite care services.** "Respite care services" means short-term supervision, assistance, and care provided to an ACG client due to the temporary absence or need for relief of the ACG client's primary caregiver. Respite care services may be provided in the client's home or in a facility approved by the state such as a hospital, nursing home, foster home, or community residential facility.

Subp. 51. **Room and board costs.** "Room and board costs" means costs associated with providing food and shelter to a person, including the directly identifiable costs of:

A. private and common living space;

B. normal and special diet food preparation and service;

C. linen, bedding, laundering, and laundry supplies;

D. housekeeping, including cleaning and lavatory supplies;

E. maintenance and operation of the building and grounds, including fuel, electricity, water, supplies, and parts and tools to repair and maintain equipment and facilities; and

F. allocation of salaries and other costs related to items A to E.

Subp. 52. **Skilled nursing service.** "Skilled nursing service" refers to the term described in Code of Federal Regulations, title 42, section 405.1224.

Subp. 53. **Social worker.** "Social worker" means a person who has met the minimum qualifications of a social worker under the Minnesota Merit System or a county civil service system in Minnesota.

Subp. 54. **Unscreened applicant.** "Unscreened applicant" means an applicant for whom preadmission screening has not been completed under parts 9505.2390 to 9505.2500.

Subp. 55. **Waiver.** "Waiver" means the approval given by the United States Department of Health and Human Services which allows the state to pay for home and community-based services authorized under Code of Federal Regulations, title 42, section 441, subpart G. The term includes all amendments to the waiver including any amendments made after the effective date of parts 9505.2395 to 9505.2500, as approved by the United States Department of Health and Human Services.

Subp. 56. **Working day.** "Working day" means the hours of a day, excluding Saturdays, Sundays, and holidays, when a local agency is open for business.

9505.2396 COMPUTATION OF TIME INTERVALS TO MEET NOTICE REQUIREMENTS.

For purposes of parts 9505.2390 to 9505.2500, a required time interval to meet notice requirements must be computed to exclude the first and include the last day of the prescribed interval of time. The term "day" includes Saturday, Sunday, and holidays unless it is modified as "working day."

9505.2400 PREADMISSION SCREENING REQUIREMENT.

Subpart 1. **Coverage.** The preadmission screening team established by the local agency must complete the preadmission screening of all applicants except individuals who are exempt under subpart 2 and the preadmission screening of current nursing home residents who request a screening. The preadmission screening team shall complete the screening as specified in part 9505.2425, except in the cases of persons with mental retardation or related conditions. Persons with mental retardation or related conditions must be

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provided services according to parts 9525.0015 to 9525.0165. Persons with mental illness must be provided services according to the Minnesota Comprehensive Mental Health Act, *Minnesota Statutes*, sections 245.461 to 245.486.

Subp. 2. **Exemptions.** The following individuals are exempt from the requirement of subpart 1:

A. a nursing home resident who transfers from one nursing home located within Minnesota directly to another nursing home located within Minnesota, regardless of the location of either nursing home;

B. a nursing home resident who is admitted to a hospital from a nursing home and who returns to a nursing home;

C. a nursing home resident who changes certified levels of care within the same nursing home;

D. an applicant for whom preadmission screening was completed within the previous three months;

E. an applicant who has been screened and who is currently receiving ACG services;

F. an applicant who has been screened and who is currently receiving services from a certified home health agency;

G. an applicant who is not eligible for medical assistance and whose length of residency in a nursing home is expected to be 30 days or less as determined under part 9505.2420, subpart 4;

H. an applicant whose nursing home care is paid for indefinitely by the United States Veterans Administration;

I. an applicant who enters a nursing home administered by and for the adherents of a recognized church or religious denomination described in *Minnesota Statutes*, section 256B.091, subdivision 4; and

J. an applicant to a nursing home described in *Minnesota Statutes*, section 256B.431, subdivision 4, paragraph (c).

9505.2405 INFORMATION REGARDING AVAILABILITY OF PREADMISSION SCREENING.

The local agency must annually publish a notice that preadmission screening is available to persons in the area served by the local agency. At a minimum, the notice must appear in the newspaper that has the largest circulation within the geographic area served by the local agency. The notice must:

A. explain the purpose of preadmission screening as stated in *Minnesota Statutes*, section 256B.091, subdivision 1;

B. instruct the public how to contact the preadmission screening team; and

C. state who is subject to and who may request preadmission screening under *Minnesota Statutes*, section 256B.091, subdivisions 2 and 4, and part 9505.2400.

9505.2410 ESTABLISHMENT OF PREADMISSION SCREENING TEAM.

Subpart 1. **Establishment.** A local agency must establish at least one preadmission screening team to complete preadmission screening of applicants and nursing home residents. In addition, a local agency may contract with a nonprofit hospital to perform the functions of a preadmission screening team under part 9505.2413 for applicants being discharged from the hospital. If a nonprofit hospital performs the functions of a preadmission screening team under contract with a local agency, the hospital's discharge planner shall not be a member of the team unless the applicant is a person being discharged from the hospital. If a nonprofit hospital does not have a contract with the local agency to perform the functions of a screening team, the hospital's discharge planner may be present at the preadmission screenings and may participate in the discussions but not in making the screening team's recommendations.

Subp. 2. **Composition of preadmission screening team.** A preadmission screening team must be composed as specified in items A to C.

A. The preadmission screening team must include a social worker and a public health nurse. The team must also include the applicant's or nursing home resident's physician if the physician chooses to participate.

B. The social worker of the local agency's preadmission screening team must be employed by or under contract with the local agency and must be designated by name as a member of the preadmission screening team.

C. If a local agency has a human services board organized under *Minnesota Statutes*, sections 402.01 to 402.10, the local agency must designate by name the public health nurse member of the preadmission screening team. If a local agency does not have a human services board organized under *Minnesota Statutes*, sections 402.01 to 402.10, the local agency must contract with the board of health organized under *Minnesota Statutes*, section 145.913, or a public or nonprofit agency under contract with the local agency to provide public health nursing services to provide the public health nurse member of the preadmission screening team. The local board of health or a public or nonprofit agency under contract with the local agency to provide public health nursing services must designate by name the public health nurse member of a preadmission screening team.

Subp. 3. **Number of preadmission screening team members present at screening.** Except as provided in subpart 5, the social worker and the public health nurse designated as members of the preadmission screening team must be present at a preadmission

screening. The applicant's or nursing home resident's physician may be present if the physician chooses to participate in the preadmission screening.

Subp. 4. **Physician notification of preadmission screening.** The local agency must notify the physician of the applicant or nursing home resident being screened, by telephone, of the date, time, and place the person's preadmission screening is to take place. The telephone notice must be made on the day that the preadmission screening team schedules the screening. The notice must state the physician's right to participate as a member of the preadmission screening team. No later than ten working days after the telephone notice, the local agency must send the physician a written notice that contains the information given in the telephone notice.

Subp. 5. **Preadmission screening by public health nurse.** Preadmission screening may be completed by the public health nurse member of the team, in consultation with the social worker, for applicants who are being admitted to a nursing home from a hospital and who are not eligible for medical assistance under parts 9505.0010 to 9505.0150. For the purpose of this subpart, "consultation" means a meeting or telephone conversation between the public health nurse and the social worker that takes place after the public health nurse has completed the preadmission screening. The purpose of the consultation is to discuss the assessment, the recommendation, and, as appropriate, the applicant's individual service plan or the applicant's plans for discharge from the nursing home.

Subp. 6. **Physician consultant to preadmission screening team.** A local agency must designate a physician who practices within the local agency's service area to serve as a consultant to the preadmission screening teams designated under subpart 2.

9505.2413 CONTRACTS FOR PREADMISSION SCREENING TEAM MEMBERS FOR APPLICANTS DISCHARGED FROM HOSPITALS.

The local agency may contract with a nonprofit hospital to provide one or both members of a preadmission screening team to screen applicants being discharged from the nonprofit hospital and to make recommendations for the screened applicants about nursing home admission and community services necessary for the applicant's individual service plan. The contract between the local agency and the nonprofit hospital must:

A. set beginning and ending dates of the contract;

B. specify the duties and responsibilities of the local agency and the nonprofit hospital;

C. specify that a member of the preadmission screening team to be provided by the hospital must be a discharge planner;

D. designate by name the person or persons to be provided by the hospital;

E. require the designated preadmission screening team member or members to comply with parts 9505.2390 to 9505.2500;

F. specify that the member or members of the preadmission screening team under contract will screen only applicants being discharged from that nonprofit hospital;

G. designate the person employed by the hospital and the person employed by the local agency who are responsible for proper performance under the contract;

H. state that the nonprofit hospital must complete a preadmission screening for an applicant before the applicant's discharge from the nonprofit hospital;

I. require that a member of the nonprofit hospital's screening team have no direct or indirect financial or self-serving interest in a nursing home or other referral such that it would not be possible for the member to consider each case objectively;

J. specify the amount the local agency must pay the nonprofit hospital for carrying out the terms of the contract;

K. specify the person employed by the hospital who is responsible for implementing appropriate data practices; and

L. specify reports and records to be kept by the nonprofit hospital.

9505.2415 HOSPITAL NOTICE REQUIREMENTS.

Subpart 1. **Notification of preadmission screening team.** Except as indicated under subpart 2, the discharge planner of a hospital must notify the preadmission screening team about a hospital patient who is an applicant. Oral and written notices must be given. The oral notice must be given to the preadmission screening team at least three working days before discharge of the applicant. The hospital must document the oral notice by sending the preadmission screening team a written notice within ten working days after the oral notice. The notice must:

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A. provide the name of the applicant;

B. provide the name of the nursing home that the applicant is considering;

C. provide the applicant's primary diagnosis;

D. indicate the interval in which the applicant is expected to be discharged from the nursing home. The intervals are: less than 30 consecutive days; 30 days but less than three months; three months but less than six months; or six months or more;

E. indicate that the discharge planner gave information to the applicant about the purpose of preadmission screening and community services; and

F. indicate if the discharge planner wants to participate in the preadmission screening.

Subp. 2. **Exception to notice required of hospital.** If the applicant is in the hospital for less than three working days and preadmission screening is not completed, the hospital may discharge the applicant to a nursing home, but the hospital discharge planner must contact the preadmission screening team by telephone or in person before the applicant's discharge and complete the notice required under subpart 1.

9505.2420 TIME REQUIREMENTS FOR PREADMISSION SCREENING.

Subpart 1. **General time requirements.** Except as provided in subparts 2 to 6, the local agency must schedule a preadmission screening within five working days of receiving a request for the preadmission screening from an applicant or an applicant's representative. Except as provided in subparts 2 to 6, the preadmission screening must be completed within the period of ten working days following the applicant's request for preadmission screening.

Subp. 2. **Preadmission screening of hospital patients.** Notwithstanding subpart 1, the local agency must complete the preadmission screening of an applicant who is a hospital patient within three working days of receiving oral notice from the discharge planner under part 9505.2415, subpart 1. However, the local agency may delay the preadmission screening of an applicant who is a hospital patient when, based on information given in the oral notice, the preadmission screening cannot be completed before discharge from the hospital and the applicant's discharge plan indicates that the applicant must be admitted to a nursing home. If preadmission screening is delayed and the local agency and the nursing home are located in the same county, the local agency must notify the nursing home orally and in writing of the scheduled date for the preadmission screening and perform the preadmission screening within ten working days after the applicant's admission to the nursing home.

If preadmission screening is delayed and the nursing home and the local agency are located in different counties, the local agency of the county in which the nursing home is located must be responsible for the preadmission screening. The local agency of the county in which the hospital is located must send an oral and a written notice of the applicant's discharge plan to the local agency in the county where the nursing home is located. Oral notice must be given on the day that the local agency of the county in which the hospital is located delays preadmission screening. The written notice must be sent within ten working days after the oral notice. The written notice must include a copy of the delay-of-screening form completed by the local agency of the county in which the hospital is located and a copy of the hospital's discharge notice. The preadmission screening team from the local agency in the county where the nursing home is located must then notify the nursing home orally and in writing of the scheduled date for the preadmission screening and perform the preadmission screening within ten working days after the applicant's admission to the nursing home.

Subp. 3. **Emergency admission.** When preadmission screening is not completed due to an emergency admission, the procedures in items A to C must be followed.

A. The attending physician must certify the reason for the emergency in the applicant's medical record.

B. The nursing home must orally notify the preadmission screening team within two working days after the date of the emergency admission.

C. The preadmission screening team must complete the preadmission screening of the applicant within ten working days of the date of the applicant's admission to the nursing home or within ten working days after receiving the oral referral for preadmission screening, whichever is earlier.

Subp. 4. **Thirty-day exemption from preadmission screening.** A local agency must grant a 30-day exemption from preadmission screening to applicants who are not eligible for medical assistance if the requirements in items A and B are met.

A. The nursing home must notify the local agency of the applicant's admission no later than the day of the applicant's admission to the nursing home. The notice must include information stating that the requirements of item B have been met.

B. The attending physician must certify in the applicant's medical record in the nursing home that the applicant's expected length of stay in the nursing home will be 30 consecutive days or less.

The preadmission screening team of the local agency that has determined that the applicant's request for a 30-day exemption from preadmission screening meets the requirements in items A and B must complete and send the nursing home a form supplied by the

commissioner authorizing the 30-day exemption and at the same time must send a copy of the form to the applicant.

The nursing home must provide an update to the preadmission screening team before or on the 30th day of the applicant's stay if the applicant will continue to live in the nursing home for more than 30 consecutive days. The local agency must complete preadmission screening within ten working days after the 30th day unless the applicant is discharged within these ten working days, does not return to the nursing home, and does not become an applicant to a different nursing home.

Subp. 5. **Nursing home applicant admitted to a hospital from a nursing home before completion of preadmission screening.** The local agency must complete preadmission screening of a nursing home applicant who has been admitted to a nursing home within the periods required under subparts 1 to 4 unless the nursing home applicant is admitted to a hospital during these periods. If a nursing home applicant is admitted to a hospital during the periods under subparts 1 to 4, the preadmission screening time requirements begin again on the date of readmission to the nursing home.

Subp. 6. **Applicant from another state.** When an applicant from another state is admitted to a nursing home in Minnesota, the nursing home must notify the preadmission screening team within two working days after the date of the admission. The notice may be oral or written. The preadmission screening team must then complete the preadmission screening of the applicant within ten working days after the date of admission to the nursing home.

9505.2425 SCREENING AND ASSESSMENT PROCEDURES REQUIRED DURING PREADMISSION SCREENING.

Subpart 1. **General requirements.** The preadmission screening team must assess the health and social needs of the applicant or nursing home resident being screened using the assessment form provided by the commissioner. The preadmission screening team must carry out the responsibilities specified in subparts 2 to 14 and the duties listed in part 9505.0295, subpart 3, item C. The preadmission screening team must ask whether the person being screened has been determined eligible for or is receiving medical assistance and must give a person whose eligibility for medical assistance has not been determined information about making a medical assistance application.

Subp. 2. **Assessment interview.** The preadmission screening team must conduct the assessment in a face-to-face interview with the person being screened and the person's representative, if any.

Subp. 3. **Information given to person being screened by screening team during preadmission screening.** The preadmission screening team must give the person being screened or the person's representative the form or forms supplied by the commissioner containing the information specified in items A to E:

A. the purpose of the preadmission screening and alternative care grant program under *Minnesota Statutes*, section 256B.091;

B. the person's freedom to accept or reject the recommendation of the preadmission screening team;

C. the person's right to confidentiality under the Minnesota Government Data Practices Act, *Minnesota Statutes*, chapter 13;

D. the person's right to appeal the preadmission screening team's recommendation under part 9505.2500 and *Minnesota Statutes*, sections 256.045, subdivisions 2 and 3 and 256B.091, subdivision 5; and

E. if the person is not a recipient, the right of the person and the person's spouse to retain liquid assets up to the amount specified in *Minnesota Statutes*, sections 256B.14, subdivision 2; 256B.17; and 256B.48.

The preadmission screening team must document compliance with this subpart by signing and placing in the local agency's records of the person being screened the forms supplied by the commissioner that state the required information was given to the person being screened.

Subp. 4. **Access to medical records.** The preadmission screening team must ask the person being screened or the person's representative to sign forms necessary to authorize the team's access to the person's medical records. Furthermore, a nursing home or a hospital's discharge planner that conducts a preadmission screening must ask the person being screened or the person's representative to sign forms necessary to authorize the team's access to information that is needed to complete preadmission screening for the person. If the person or the person's representative agrees to sign the forms, the authorization must be completed as prescribed in subpart 14.

Subp. 5. **Preadmission screening team recommendations.** After completing the assessment form required in subpart 1, the preadmission screening team must offer the person being screened or the person's representative the most cost-effective alternatives available to meet the person's needs and must recommend one of the choices specified in items A to E.

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A. The preadmission screening team must recommend admission to a nursing home for an applicant or continued stay for a nursing home resident when the assessment indicates that the applicant or nursing home resident requires community services that are not available or that the anticipated cost of providing the required community services would exceed the annual monthly statewide average payment of the resident class under parts 9549.0050 to 9549.0059 that would be applicable to the person being screened if the person were placed in a nursing home, calculated from the payments made for that resident class in the previous fiscal year.

B. The preadmission screening team must recommend use of community services when the assessment indicates that the community services needed by the person are available and the anticipated cost of providing the community services is less than the total annual statewide monthly average payment of the resident class under parts 9549.0050 to 9549.0059 that would be applicable to the person if the person were placed in a nursing home, calculated from the payments made for that resident class in the previous fiscal year.

C. The preadmission screening team must recommend that the person live in the community without community services if the assessment indicates that the person does not need either admission to a nursing home or community services.

D. A preadmission screening team that has reason to believe that a person being screened has or may have a diagnosis of mental retardation or related conditions must refer the person for services including screening, development of the individual service plan, and case management services according to parts 9525.0015 to 9525.0165.

E. A preadmission screening team that has reason to believe that a person being screened has been diagnosed or may be diagnosed as mentally ill must refer the person for a diagnostic assessment as defined in *Minnesota Statutes*, section 245.462, subdivision 9. If the person is determined by the diagnostic assessment to have serious and persistent mental illness as defined in *Minnesota Statutes*, section 245.462, subdivision 20, and the person chooses community services under an ACG, the preadmission screening team must establish the individual service plan as required in part 9505.2430, subpart 4, and assure the assignment of a case manager as specified in part 9505.2430, subpart 6. The case manager shall incorporate the person's individual community support plan as defined in *Minnesota Statutes*, section 245.462, subdivision 12, into the person's individual service plan and shall coordinate the person's services that are specified in the Comprehensive Mental Health Act, *Minnesota Statutes*, sections 245.461 to 245.486.

Subp. 6. **Required application for ACG services.** If the person being screened chooses to remain in the community with community services the preadmission screening team must request the person or the person's representative to sign an application for the community services under the ACG. To be eligible to receive the community services under the ACG, the person being screened or the person's representative must sign the application. The application shall be on a form prescribed by the commissioner.

Subp. 7. **Use of directory of services during preadmission screening.** The preadmission screening team must use a directory of services provided by the local agency during the preadmission screening in determining the individual service plan of a person being screened. The local agency must make a directory of services available to the preadmission screening team, the person being screened, and other persons present at a screening. The local agency may compile its own directory of services or use a directory prepared by a community resource. In either event, the directory must be one that is updated annually.

Subp. 8. **Notification of preadmission screening team recommendation.** The preadmission screening team must give or send a written notice stating the team's recommendation to the person being screened, the person's representative, if any, and the person's physician. The preadmission screening team must also send the written notice to the county of financial responsibility. Both types of notice must be given or sent within ten working days after the date of the request for the preadmission screening.

Subp. 9. **Individual service plan.** The preadmission screening team must develop an individual service plan according to part 9505.2430 when the person or the person's representative chooses to use community services.

Subp. 10. **Submittal of ACG client information to county of financial responsibility.** If the county of service is different from the county of financial responsibility for an ACG client, the county of service must submit client information to the county of financial responsibility for approval of the individual service plan. The information must include items A to D:

A. the original preadmission screening assessment form, including the original individual service plan;

B. the original signed application if required under subpart 6;

C. the original preadmission screening document; and

D. a copy of the completed financial information form required in part 9505.2455, subpart 1, item C.

Subp. 11. **County of financial responsibility review of individual service plan.** The county of financial responsibility for an ACG client under part 9505.2455, subpart 3, must approve or reject the proposed individual service plan under items A to E and part 9505.2455, subpart 2.

A. If the costs of ACG services, together with the costs of skilled nursing services provided by public health nursing services that are reimbursable under medical assistance, if applicable, do not exceed the cost limitations in subpart 5, item B, the county of

financial responsibility must approve the proposed individual service plan. If the cost of ACG services together with the costs of skilled nursing services provided by public health nursing services that are reimbursable under medical assistance exceeds the cost limitations in subpart 5, item B, the county of financial responsibility must reject the individual service plan. Rejection of an individual service plan by the county of financial responsibility shall occur only if cost limitations of subpart 5, item B, are not met. If the county of financial responsibility and the county of service are the same, the county shall not reject the individual service plan prepared by the county's preadmission screening team if the individual service plan falls within the cost limitations of subpart 5, item B.

B. The county of financial responsibility must orally notify the preadmission screening team of the approval or rejection of the individual service plan within three working days after receiving the plan from the county of service. The county of financial responsibility must mail a written notice to the preadmission screening team within ten working days after receiving the individual service plan.

C. If the individual service plan is approved by the county of financial responsibility, the county of service must implement the plan upon oral notice of approval from the county of financial responsibility.

D. If the individual service plan is rejected by the county of financial responsibility because it exceeds the cost limitations in subpart 5, item B, the oral and written notice of rejection sent to the preadmission screening team must explain the reasons for the rejection and define the corrections needed to obtain approval. The preadmission screening team must develop a revised individual service plan for an ACG client whose initial individual service plan was rejected by the county of financial responsibility. The preadmission screening team must send the revised individual service plan to the county of financial responsibility within ten days after receiving the oral rejection.

E. If the revised individual service plan includes ACG services that meet the cost limitations in subpart 5, item B, the county of financial responsibility must approve the individual service plan and orally notify the preadmission screening team of the approval within three working days after receiving the revised plan. The county of financial responsibility must send a written notice of approval to the preadmission screening team within ten working days after receiving the revised plan.

Subp. 12. **Sending individual service plan to county of service.** If the county of financial responsibility approves an individual service plan, the preadmission screening team must send the written individual service plan to the county of service within ten working days after the approval.

Subp. 13. **Resident class assessment.** The preadmission screening team must complete the resident class assessment of the applicant required under parts 9549.0058 and 9549.0059 for an applicant who is not exempt from preadmission screening under part 9505.2400, subpart 5, or 9549.0059, subpart 1, item A, subitem (2). The resident class assessment shall be completed concurrently with preadmission screening performed within the time requirements of part 9505.2420.

Subp. 14. **Authorization to release information.** When a preadmission screening team, nursing home, or hospital's discharge planner asks a person being screened or the person's representative to sign forms needed to have access to information necessary to complete the preadmission screening, the following information must be on the form above the person's signature:

A. the person's name;

B. the date;

C. the information authorized;

D. who is authorized to give the information;

E. to whom the information is to be given;

F. the information's use during the screening to determine the appropriateness of nursing home admission or continued nursing home placement or use of community services for the person; and

G. the date of expiration of the authorization.

A separate form must be completed and signed for each authorization of access to a medical record. The period of the authorization must not exceed one year.

9505.2426 APPLICANT'S AND NURSING HOME RESIDENT'S RIGHT TO CHOOSE COMMUNITY SERVICES.

After completion of the preadmission screening required under part 9505.2425, subpart 5, or the rescreening required under part

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9505.2435, the applicant, nursing home resident, or the representative of the applicant or nursing home resident shall decide whether to accept or reject the recommendations of the preadmission screening team. If the applicant, nursing home resident, or the representative of the applicant or nursing home resident who is eligible for ACG services decides to receive the ACG services identified in his or her individual service plan, the applicant, nursing home resident, or the representative of the applicant or nursing home resident shall have the freedom to choose among the ACG providers under contract with the local agency to provide the identified ACG services.

9505.2430 ESTABLISHMENT OF INDIVIDUAL SERVICE PLAN.

Subpart 1. **Individual service plan required.** The preadmission screening team must establish an individual service plan for each applicant or nursing home resident who requests preadmission screening and who has been assessed under part 9505.2425, and who has chosen community services except persons referred under part 9505.2425, subpart 5, items D and E. The preadmission screening team must consult the applicant or nursing home resident or the person's representative in establishing the plan. Additionally, the preadmission screening team must ask the applicant or the nursing home resident or the representative of the applicant or nursing home resident whether he or she chooses to have other persons consulted about the plan. The preadmission screening team must consult the persons that the applicant, nursing home resident, or the representative of the applicant or nursing home resident has designated by name to be consulted about the plan.

Subp. 2. **Request for information about eligibility for medical assistance or 180-day eligibility determination.** The preadmission screening team must ask the applicant, nursing home resident, or the representative of the applicant or nursing home resident whether the applicant or nursing home resident receives medical assistance, is a recipient, or would be eligible to receive medical assistance within 180 days after admission to a nursing home. If the preadmission screening team has reason to believe the person being screened would be eligible to receive medical assistance within 180 days after admission to a nursing home, the preadmission screening team must estimate what the person's financial eligibility would be 180 days after admission using a form prescribed by the commissioner.

Subp. 3. **Individual service plan for a person not eligible for an ACG.** The individual service plan prepared by the preadmission screening team for a person being screened who is not eligible for an ACG must document compliance with items A to D:

A. the preadmission screening team determined that the person is not eligible for community services funded by an ACG under part 9505.2455, subpart 2;

B. the preadmission screening team discussed with the person the community services identified as needed in the assessment under part 9505.2425;

C. the preadmission screening team told the person what information is available in the directory of services; and

D. the preadmission screening team gave a copy of the individual service plan to the person.

Subp. 4. **Individual service plan for a person who is eligible for an ACG.** The individual service plan prepared by the preadmission screening team for a person being screened who is eligible for an ACG must document compliance with items A to D. The person or the person's representative and a member of the preadmission screening team must sign the individual service plan. The preadmission screening team must give the person or the person's representative a copy of the individual service plan.

A. The preadmission screening team has determined that the person being screened is eligible for community services funded by an ACG under part 9505.2455, subpart 2.

B. Recommendation of an individual service plan that identifies:

(1) any treatment prescribed by the individual's attending physician as necessary and any follow-up treatment as necessary;

(2) the community services needed by the person;

(3) the available providers of the identified community services including ACG service providers under contract with or employed by the local agency and informal support networks such as family, friends, volunteers, and church groups;

(4) the needed frequency of the services;

(5) the initial date on which each service must begin;

(6) the funding sources for the community services;

(7) the estimated cost of skilled nursing services provided by public health nursing services;

(8) the total cost of the ACG services;

(9) an estimate of the total cost of the community services; and

(10) the name of the case manager assigned by the county of service.

C. The preadmission screening team allowed the person or the person's representative to choose among the available providers listed in the directory of services who are under contract with or employed by the county of service.

D. The preadmission screening team reviewed the individual service plan with the person or the person's representative at the time of the completion of the preadmission screening.

Subp. 5. **Sliding fee information.** The preadmission screening team must tell the person being screened who would be eligible to receive medical assistance within 180 days after admission to the nursing home about the amount of the sliding fee that the person is required to pay for alternative care grant services according to the sliding fee schedule established by the commissioner under *Minnesota Statutes*, section 256B.091, subdivision 8, if the person will be receiving ACG services under an individual service plan developed under subpart 4.

Subp. 6. **Assignment of case manager.** Upon completion of the individual service plan, the local agency of the county of service shall assign a case manager to implement the individual service plan prepared for an ACG client under subpart 4.

9505.2435 RESCREENING.

Subpart 1. **Applicability.** The preadmission screening team must conduct a rescreening when the local agency receives either a written or oral request under subpart 2 suggesting that a recommendation resulting from a rescreening would differ from the recommendation given by the preadmission screening team at the last preadmission screening. Rescreenings must be conducted for all persons who meet the above criteria except ACG clients.

Subp. 2. **Request for rescreening.** The applicant, nursing home resident, or person's representative must submit a request to the local agency to be rescreened when the applicant or nursing home resident meets the criteria in subpart 1. The request may be oral or written and must state the date and location of the person's last preadmission screening and any changes in the person's health and social needs that have occurred since the last screening.

Subp. 3. **Rescreening procedure.** The rescreening must be conducted according to the procedures for preadmission screening in parts 9505.2390 to 9505.2450.

Subp. 4. **Reimbursement for rescreening.** Reimbursement to the local agency for rescreening must be the same as reimbursement of a preadmission screening under parts 9505.2440 and 9505.2445.

9505.2440 PREADMISSION SCREENING RATE.

For rate years beginning on January 1 following the effective date of parts 9505.2390 to 9505.2500, the commissioner shall annually establish the maximum statewide rate allowed for reimbursement of preadmission screening and the maximum reimbursement rate of a local agency for preadmission screening. The maximum statewide rate and the maximum reimbursement rate of a local agency shall not exceed the prior year's rate by more than the percentage change between the two previous Junes in the all urban consumer price index (CPI-U) for Minneapolis-St. Paul new series index (1967 = 100) as published by the Bureau of Labor Statistics, United States Department of Labor. The CPI-U is incorporated by reference and is available from the Minitex interlibrary loan system. The CPI-U is subject to frequent change. By January 15 of each year, the commissioner must send a written notice of the maximum reimbursement rate to a local agency.

9505.2445 REIMBURSEMENT FOR PREADMISSION SCREENING.

Subpart 1. **County of financial responsibility for preadmission screening of a recipient.** The county of financial responsibility for a recipient is as defined in *Minnesota Statutes*, chapter 256G.

Subp. 2. **Medical assistance reimbursement for preadmission screening of a recipient.** The medical assistance program must reimburse a local agency for the preadmission screening of a recipient if the local agency has complied with the time requirements of part 9505.2420. The local agency of the county of financial responsibility shall submit invoices for reimbursement of preadmission screening costs for a recipient to the department at the times and as required in part 9505.0450, subpart 2.

Subp. 3. **Reimbursement for preadmission screening of persons who are not recipients.** Reimbursement for the preadmission screening of persons who are not recipients must be made according to *Minnesota Statutes*, section 256B.091, subdivision 4.

Subp. 4. **Required local agency estimate of the cost and number of preadmission screenings of persons other than recipients.** Annually by February 15, a local agency must prepare and submit to the department an estimate for the following state fiscal

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year of the number and costs of preadmission screenings of persons who are not recipients and who will be applicants or nursing home residents for whom the county will provide preadmission screening.

Subp. 5. **Local agency's allocation of cost estimate to a nursing home.** Using the annual estimate of the number and costs of preadmission screenings required in subpart 4, a local agency must calculate the monthly amount to be paid by a nursing home to the local agency for preadmission screenings performed by the local agency for the following state fiscal year. The amount must be based on the nursing home's percentage of the number of licensed beds in nursing homes in the county of the local agency. The local agency must submit the amount to the nursing home by February 15.

Subp. 6. **Reconciliation of estimate required in subpart 4 with actual cost.** Annually by January 15, the department shall reconcile its estimated cost of a nursing home's number of preadmission screenings of persons who are not recipients as calculated under subpart 4 with the actual cost of preadmission screenings of these persons performed in the previous state fiscal year. The department shall notify the local agency of the amount of the overpayment or underpayment that the local agency must use in completing the calculation required under subpart 4.

9505.2450 PENALTIES.

Subpart 1. **Penalty to nursing home for admission of an unscreened applicant.** A nursing home that admits an unscreened applicant who is subject to the preadmission screening requirement under part 9505.2400 or that fails to notify the preadmission screening team about an emergency admission as required under part 9505.2420, subpart 3, item B, is subject to the penalties in items A to C.

A. If the applicant is a recipient, the nursing home must not be reimbursed by medical assistance for the applicant's resident days that preceded the date of completion of the applicant's assessment by the preadmission screening team under part 9505.2425. Furthermore, the nursing home must not bill an unreimbursed resident day to the unscreened applicant who is a recipient.

B. If the applicant is not a recipient, the nursing home must not bill the applicant for the applicant's resident days that preceded the date of completion of the applicant's assessment by the preadmission screening team under part 9505.2420.

C. The nursing home must include an unreimbursed resident day in the nursing home's resident day total reported to the department for the purpose of rate calculation under parts 9549.0010 to 9549.0080.

Subp. 2. **Penalty to county of service for late screening.** A county of service required to act within the time requirements in part 9505.2420 that fails to act within the time requirements shall not receive reimbursement for the preadmission screening under part 9505.2445, subparts 2 and 3, from medical assistance in the case of a recipient or from the nursing home in the case of a person who is not a recipient. Under these circumstances, the county of service shall be solely responsible for the costs of the preadmission screening. Nevertheless, the county of service must complete the preadmission screening as required in parts 9505.2400 and 9505.2425.

9505.2455 ALTERNATIVE CARE GRANTS.

Subpart 1. **Preadmission screening determination of eligibility.** The preadmission screening team must determine if the applicant or nursing home resident is eligible for an ACG under the criteria in subpart 2. If the person being screened is eligible for an ACG, the preadmission screening team must:

A. determine the county of financial responsibility according to subpart 3;

B. determine the county of service; and

C. determine the amount of the fee to be paid by the person if the person would be eligible to receive medical assistance within 180 days after admission to a nursing home. The amount of the sliding fee must be determined according to the sliding fee schedule established by the commissioner under *Minnesota Statutes*, section 256B.091, subdivision 8, and on forms provided by the commissioner.

Subp. 2. **Eligibility criteria.** A person is eligible for an ACG if the person meets the criteria in items A to G:

A. the person has been screened by the preadmission screening team;

B. the person is 65 years or older;

C. the person is a recipient or is eligible for medical assistance under parts 9505.0010 to 9505.0150 or would be eligible to receive medical assistance within 180 days after admission to a nursing home;

D. the person would require nursing home care if community services were not available;

E. the person is an applicant who chooses to remain in the community and use community services or a nursing home resident who chooses to leave the nursing home and receive community services;

F. the person requires community services that cannot be provided by services funded by sources other than alternative care grants;

G. the person has completed an application for community services; and

H. the cost of an ACG is within the monthly limitation specified in subpart 8.

Subp. 3. **Determination of county of financial responsibility for alternative care grants.** The preadmission screening team must determine the county of financial responsibility for an ACG client according to item A or B.

A. The county of financial responsibility for an ACG client who is a recipient is the county as defined in *Minnesota Statutes*, chapter 256G.

B. When ACG services begin, the county of financial responsibility for an ACG client who would be eligible to receive medical assistance within 180 days after admission to a nursing home is the county of financial responsibility as defined in *Minnesota Statutes*, chapter 256G for medical assistance recipients.

Subp. 4. **Use of alternative care grants.** ACG services may be reimbursed through an ACG if the person is eligible under subpart 2 and if the services are identified as needed in the ACG client's individual service plan and if the services are subject to the rates established in part 9505.2490. However, reimbursement for respite care services is limited to payment for 30 days of service in one state fiscal year.

Subp. 5. **Supplies and equipment.** If the ACG client is a recipient and the supplies and equipment are covered services under part 9505.0310, the cost of the supplies and equipment shall be paid as provided in the medical assistance program under parts 9505.0170 to 9505.0475 to the extent that reimbursement of the cost is not available from Medicare and a third party payer as defined in part 9505.0015, subpart 46. A local agency shall use ACG money to buy or rent care-related supplies and equipment for an ACG client as specified in items A to C.

A. If the supplies and equipment are not covered services under part 9505.0310 or the ACG client is not a recipient and the cost of the supplies and equipment for the ACG client is not more than $100 per month, the local agency shall authorize the use of ACG funds.

B. If the supplies and equipment are not covered services under part 9505.0315 or the ACG client is not a recipient and the cost of the supplies and equipment exceeds $100 per month, the local agency must obtain prior authorization from the department to use ACG funds to pay the cost of the supplies and equipment. For purposes of this subpart, "prior authorization" means written approval and authorization given by the department to the local agency before the purchase or rental of the supply or equipment.

C. The department shall have the right to determine whether the supplies and equipment are necessary to enable the client to remain in the community. If the department determines that the supplies and equipment are necessary to enable the ACG client to remain in the community and if the cost of the supplies and equipment together with all other ACG services and skilled nursing services provided by public health nursing services is less than the limitation in subpart 8, the department shall authorize the use of the ACG funds to pay the cost.

Subp. 6. **Supervision costs.** The cost of supervising a home health aide or personal care assistant must be included in the rate for home health aide or personal care services, unless payment for the cost of supervision is included in the rate for skilled nursing service. If the cost of supervising a home health aide or personal care assistant is included in the rate for skilled nursing service, the cost must not be included in the payment for a home health aide or personal care assistant. The cost of supervising an alternative care grant service other than a personal care service or a health aide service must be included in the rate for the service.

Subp. 7. **Unallowable costs.** Alternative care grants must not be used:

A. to establish community services for which funding sources are available through other programs;

B. to pay for community services that can be reimbursed through other funding sources including Medicare and third party payers as defined in part 9505.0015, subpart 46;

C. to pay for room and board costs except for respite care provided outside of the ACG client's residence; or

D. to pay providers that are not under contract with the local agency under *Minnesota Statutes*, section 256B.091, subdivision 8.

Subp. 8. **Costs included within the monthly limitation of an ACG to an ACG client.** In a calendar month, the total cost of an ACG to an ACG client must not exceed the total statewide monthly average payment of the resident class to which the ACG client would be assigned under parts 9549.0050 to 9549.0059, calculated from the payments made for that resident class in the previous fiscal year. The following costs must be included in determining the total costs of an ACG:

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A. cost of all ACG services;

B. cost of skilled nursing services provided by public health nursing services and reimbursable under parts 9505.0170 to 9505.0475; and

C. cost of supplies and equipment funded by an ACG.

Subp. 9. **Criteria for selection as an ACG provider.** A provider who provides ACG services must meet the criteria in items A and B.

A. The provider must be employed by or have contracted with the local agency to provide ACG services.

B. The provider must meet all licensure requirements and professional standards established in *Minnesota Statutes*, *Minnesota Rules*, and the Code of Federal Regulations that apply to the services provided.

Subp. 10. **Contract for ACG services.** If the local agency contracts with a provider under subpart 9, the contract must:

A. set beginning and ending dates for the term of the contract;

B. specify the duties and responsibilities of the local agency and the provider;

C. require the provider to comply with parts 9505.2390 to 9505.2500;

D. specify the amount that the local agency must reimburse the provider for the services;

E. specify reports and record retention required of the provider by the local agency;

F. specify the conditions under which the local agency shall terminate the provider's contract; and

G. specify documentation of an individual abuse prevention plan that complies with parts 9555.8000 to 9555.8500 if such a plan is required of the provider by *Minnesota Statutes*, section 626.557.

Subp. 11. **Reassessment of ACG clients.** A face-to-face reassessment of an ACG client must be conducted by the case manager at least once every six months after ACG services have begun. The case manager must also reassess an ACG client when the case manager determines that changes in the health and social needs or the financial status of the ACG client require revisions in the individual service plan. When an ACG client leaves the county of service and establishes residence in another Minnesota county, the case manager responsible for implementing the ACG client's individual service plan must notify the local agency of the other county about the client's change in residence and request the other county to assign a case manager and conduct a reassessment.

Subp. 12. **Record of reassessment.** At the time of an ACG client's reassessment, the case manager must complete an assessment form and give the ACG client an information form or forms supplied by the commissioner containing the information required in part 9505.2425, subpart 3, items C to E. The case manager must document in the ACG client's case record that the client received the required information. The ACG client's case record of reassessment shall contain at least the information in items A to G:

A. the completed assessment form;

B. the reason for the reassessment;

C. a redetermination of financial eligibility for the ACG client;

D. the names and relationship to the client of the persons consulted during the reassessment;

E. any revisions of the individual service plan that will occur in type, frequency, and cost of ACG services resulting from the reassessment;

F. a completed quality assurance and review (QA&R) form, as required by part 9549.0059, with an estimate of the client's resident class; and

G. a recomputed sliding fee for the client who would be eligible to receive medical assistance within 180 days after admission to a nursing home.

9505.2458 CASE MANAGER ACTIONS TO ASSURE SAFETY AND HEALTH OF ACG CLIENT WHO IS A VULNERABLE ADULT.

A case manager who has reason to believe an ACG client who is a vulnerable adult is or has been subject to abuse or neglect as defined in *Minnesota Statutes*, section 626.557, subdivision 2, that occurs at the client's residence or the place where the client receives the ACG service shall immediately comply with the reporting and other actions required under *Minnesota Statutes*, section 626.557, and shall determine how to assure the client's health and safety during the local agency's investigation. The case manager shall determine whether to withdraw the services, provide another living arrangement for the client, or arrange for the services of another ACG provider. When the case manager receives the findings of the local agency's investigation, the case manager shall amend the ACG client's individual service plan as needed to assure the client's health and safety.

9505.2460 LOCAL AGENCY SELECTION OF ACG PROVIDERS.

Subpart 1. **Public meeting to inform providers.** The local agency must hold an annual public meeting with possible providers of ACG services to inform providers about the criteria for provider selection as listed in subpart 4 and the date by which requests to be an ACG provider must be submitted to the local agency. The local agency may hold the annual public meeting at a time convenient to its schedule for completing service contracts to be included in its annual plan. The local agency must document that the notice required in subpart 2 was given and that the public meeting was held.

Subp. 2. **Notice of annual public meeting.** The local agency must place a notice of the public meeting required under subpart 1 in the newspaper that is the official newspaper designated by the county board of commissioners of the local agency under *Minnesota Statutes*, section 279.08. The notice must appear at least 14 days before the public meeting and must state the date, time, and place of the meeting, the type of services for which a need is anticipated, the criteria in subpart 3 for selection as an ACG provider, the date by which the local agency will complete its selection of ACG providers, and the name, telephone number, and address of the local agency's contact person who can provide information about the criteria for selection and contract terms.

Subp. 3. **Selection criteria.** The local agency must select providers for ACG contracts as required in *Minnesota Statutes*, section 256B.091, subdivision 8, using the criteria in items A to G and other criteria established by the local agency that are consistent with items A to G:

A. the need for the particular service offered by the provider;

B. the service needs of the ACG clients of the local agency including the number of ACG clients to be served, the length of time service will be provided, and the health status of the ACG clients;

C. the geographic area to be served;

D. the quality assurance methods to be used by the provider including compliance with required licensures, certifications, or standards and supervision of employees as required by parts 9505.2390 to 9505.2500;

E. the rate for each service or unit of service;

F. evaluation of services previously or currently provided by the provider; and

G. the provider's previous compliance with contract provisions and future ability to comply with contract provisions including billing requirements, and terms related to contract cancellation and indemnification. The local agency must evaluate the ACG services that it provides to ACG clients using the criteria in this subpart.

Subp. 4. **Written record of reason for not selecting a provider.** A local agency must keep a written record of the reason a provider who requests a contract to provide ACG services was not selected and must notify the provider of the reasons.

9505.2465 STANDARDS FOR PERSONAL CARE SERVICES.

Subpart 1. **Definitions.** For purposes of this part, the following terms have the meanings given them.

A. "Personal care provider" means a home health agency that meets the requirements of subpart 5 and is under contract to the local agency to provide personal care assistants or a local agency licensed as a home health agency under *Minnesota Statutes*, sections 144A.43 to 144A.47.

B. "Personal care service" means a service listed in subpart 3 that is ordered by a physician and provided by a personal care assistant to an ACG client to maintain the ACG client in his or her residence.

Subp. 2. **Training requirements.** Personal care services must be provided by a personal care assistant who has successfully completed one of the training requirements in items A to E:

A. a homemaker or home health aide preservice training program using a curriculum recommended by the Minnesota Department of Health;

B. a nursing assistant training program or its equivalent for which competency as a nursing assistant is determined according to a test administered by the State Board of Vocational Technical Education;

C. an accredited educational program for registered nurses or licensed practical nurses;

D. a training program that provides the personal care assistant with skills required to perform the services specified in subpart 3; or

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E. determination by the supervising registered nurse that the personal care assistant has, through training or experience, the skills required to perform the duties specified in subpart 3.

Subp. 3. **Personal care services.** The duties specified in items A to N are components of personal care services:

A. bowel and bladder care;

B. skin care done to maintain the health of the skin, including prophylactic routine and palliative measures such as exposure to air, use of nondurable medical equipment, application of lotions, powders, ointments, and treatments such as heat lamp and foot soaks;

C. range of motion exercises;

D. respiratory assistance;

E. transfers;

F. bathing, grooming, and hairwashing necessary for personal hygiene;

G. turning and positioning;

H. assistance with furnishing medication that is ordinarily self-administered;

I. application and maintenance of prosthetics and orthotics;

J. cleaning equipment;

K. dressing or undressing;

L. assistance with food, nutrition, and diet activities;

M. accompanying an ACG client to obtain medical diagnosis or treatment and to attend other activities such as church if the personal care assistant is needed to provide personal care services while the recipient is absent from his or her residence; and

N. performing other services essential to the effective performance of the duties in items A to M.

Subp. 4. **Employment of personal care assistants.** A personal care assistant who provides personal care services under the ACG program is not an employee of the ACG client but must be employed by or under contract with a personal care provider. A personal care assistant employed by a personal care provider must meet the training requirements in subpart 2. The personal care provider shall terminate the personal care assistant's employment or assignment to an ACG client if the supervising registered nurse determines that the personal care assistant is not performing satisfactorily.

Subp. 5. **Personal care provider; eligibility.** Except as provided in subpart 11, a local agency that is not licensed as a home health agency under *Minnesota Statutes*, sections 144A.43 to 144A.47, and that wants to provide personal care services under the ACG program must contract with a personal care provider to provide the personal care services. To be eligible to contract with the local agency as a personal care provider, the provider must meet the criteria in items A to K. The local agency must assure the provider's compliance with the criteria in items A to K:

A. be licensed as a home health agency under *Minnesota Statutes*, sections 144A.43 to 144A.47;

B. possess the capacity to enter into a legally binding contract;

C. possess demonstrated ability to fulfill the responsibilities in this subpart and subpart 6;

D. demonstrate the cost effectiveness of its proposal for the provision of personal care services;

E. demonstrate a knowledge of, sensitivity to, and experience with the special needs, including communication needs, and the condition of the ACG client;

F. provide a quality assurance mechanism;

G. demonstrate the financial ability to produce a cash flow sufficient to cover operating expenses for 30 days;

H. disclose fully the names of persons with an ownership or control interest of five percent or more in the contracting agency;

I. demonstrate an accounting or financial system that complies with generally accepted accounting principles;

J. demonstrate a system of personnel management; and

K. if offering personal care services to a ventilator-dependent ACG client, demonstrate the ability to train and to supervise the personal care assistant and the ACG client in ventilator operation and maintenance.

Subp. 6. **Personal care provider responsibilities.** The personal care provider shall:

A. employ or contract with personal care assistants to provide personal care services and to train personal care assistants as necessary;

B. supervise the personal care services as in subpart 9;

C. if the provider is not the local agency, submit a bill to the local agency for personal care services provided by the personal care assistant;

D. establish a grievance mechanism to resolve consumer complaints about personal care services;

E. keep records as required in parts 9505.1750 to 9505.1880;

F. perform functions and provide services specified in the personal care provider's contract under subpart 5;

G. comply with applicable rules and statutes; and

H. perform other functions as necessary to carry out the responsibilities in items A to G.

Subp. 7. **Employment prohibition.** A local agency that provides ACG services to an ACG client whether the services are provided by the local agency as a personal care provider or under contract with a personal care provider must prohibit the employment of a person to provide personal care services for an ACG client if the personal care assistant:

A. refuses to provide full disclosure of criminal history records as specified in subpart 8;

B. has been convicted of a crime that directly relates to the occupation of providing personal care services to a qualified recipient;

C. has jeopardized the health or welfare of a vulnerable adult through physical abuse, sexual abuse, or neglect as defined in *Minnesota Statutes*, section 626.557; or

D. is misusing or is dependent on mood-altering chemicals including alcohol to the extent that the personal care provider knows or has reason to believe that the use of chemicals has a negative effect on the ability of the personal care assistant to provide personal care services or the use of chemicals is apparent during the hours the personal care assistant is providing personal care services.

Subp. 8. **Preemployment check of criminal history.** Before employing a person as a personal care assistant for an ACG client, the personal care provider shall require from the applicant for employment full disclosure of conviction and criminal history records pertaining to any crime related to the provision of health services under the medical assistance program or to the occupation of a personal care assistant.

Subp. 9. **Supervision of personal care assistant.** A personal care assistant must be under the supervision of a registered nurse. The supervising registered nurse shall not be a member of the family of the ACG client who is receiving personal care service from the personal care assistant under the registered nurse's supervision. The supervising registered nurse must:

A. ensure that the personal care assistant is capable of providing the personal care services required in the ACG client's individual treatment plan required by part 9505.2475 through direct observation of the assistant's performance or through consultation with the ACG client and the ACG client's primary caregiver when possible;

B. ensure that the personal care assistant is knowledgeable about the individual treatment plan before the personal care assistant performs the personal care services;

C. ensure that the personal care assistant is knowledgeable about essential observations of the ACG client's health, and about any conditions that should immediately be brought to the attention of either the nurse or the ACG client's physician;

D. evaluate the personal care services of an ACG client through direct observation of the personal care assistant's work or through consultation with the ACG client;

E. review the individual treatment plan with the ACG client and the personal care assistant at least once every 120 days and revise the individual treatment plan as necessary;

F. ensure that the personal care assistant and ACG client are knowledgeable about any change in the individual treatment plan; and

G. review all entries made in the ACG client's health care record showing the services provided and the time spent by the personal care assistant.

Subp. 10. **Evaluation of services.** The supervising registered nurse shall evaluate the personal care assistant's work under the schedule in items A to C.

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The supervising registered nurse must record in writing the results of the evaluation and action taken to correct any deficiencies in the work of the personal care assistant.

A. Within 14 days after the placement of a personal care assistant with the ACG client.

B. At least once every 30 days during the first 90 days after the ACG client first begins to receive personal care services under the individual service plan developed by the screening team.

C. At least once every 120 days following the period of evaluations in item B.

Subp. 11. **Employment and reimbursement of a relative as a personal care assistant.** A relative of an ACG client, with the exception of the ACG client's spouse, shall be reimbursed for providing personal care services to an ACG client only if the relative and the local agency meet the requirements in items A to D.

A. The relative must be employed by or under contract with the local agency or a personal care provider. A local agency employing a relative under this subpart does not have to be licensed as a home health agency under *Minnesota Statutes*, sections 144A.43 to 144A.47.

B. The relative would suffer financial hardship as a result of providing the ACG client's personal care services or a personal care assistant who is not a relative is not available to perform the ACG client's personal care services. For purposes of this subpart, financial hardship refers to a situation in which a relative incurs a substantial reduction in income because he or she resigns from a full-time job, goes from a full-time to a part-time job paying considerably less compensation, takes a leave of absence without pay from a full-time job to care for an ACG client, or incurs substantial expenses in making arrangements necessary to enable the relative to care for an ACG client.

C. The relative and the local agency must meet the requirements of subparts 2, 3, and 7 to 10.

D. The local agency has obtained the department's prior approval.

9505.2470 STANDARDS FOR HOME HEALTH AIDE SERVICES.

Subpart 1. **Employment of home health aide.** A home health aide who provides home health aide services under the ACG program to an ACG client must be an employee of a provider of home health aide services. The home health aide must be under the supervision of a registered nurse. Registered nurses and practical nurses licensed under *Minnesota Statutes*, sections 148.29 to 148.299 shall not be employed as home health aides under the ACG program.

Subp. 2. **Eligible providers.** To be eligible as a provider of home health aide services under the ACG program, a home health agency must be licensed under *Minnesota Statutes*, sections 144A.43 to 144A.46, and certified to participate under titles XVIII and XIX of the Social Security Act.

Subp. 3. **Approval and supervision of home health aide services.** A home health aide providing home health aide services in the ACG program must be approved by the supervising registered nurse to perform the medically oriented tasks written in the ACG client's individual treatment plan. The supervising registered nurse must be an employee of a home health agency that is providing the home health aide services.

Subp. 4. **Record of home health aide services.** A home health agency providing home health aide services to an ACG client must keep a record documenting the provision of home health aide services in the client's individual treatment plan. The documentation shall include the date and nature of the services provided and the names of the home health aide and the supervising registered nurse.

9505.2473 STANDARDS FOR HOMEMAKER SERVICES.

Subpart 1. **Qualified homemakers.** The local agency shall assure that each ACG client receiving homemaker services is served by a homemaker qualified under part 9565.1200, subpart 2. A person who is providing a homemaker service under the ACG program to an ACG client who is the person's relative must meet the standards in part 9565.1200, subpart 2.

Subp. 2. **Contracting for homemaker services and supervision of a homemaker.** The local agency may directly provide or contract for homemaker services that are part of the ACG client's individual service plan. If the local agency provides homemaker services directly, the local agency must also provide supervision of the homemaker's activities. If the local agency contracts with a provider for homemaker services, the provider must meet the requirements of *Minnesota Statutes*, sections 144A.43 to 144A.46.

Subp. 3. **Payment limitations; homemaker.** ACG payments shall be made only for the homemaker tasks specified in part 9505.2395, subpart 23, that are required by and indicated in the ACG client's individual service plan.

9505.2475 ESTABLISHMENT OF INDIVIDUAL TREATMENT PLAN.

Subpart 1. **Requirement.** An individual treatment plan must be developed for an ACG client who receives home health aide services or personal care services. The ACG client's physician and the supervising registered nurse, together with the personal care

assistant or the home health aide, the ACG client and the ACG client's representative, if any, must develop the individual treatment plan. The ACG client's physician and the supervising registered nurse must review the plan every 60 days and revise the plan if a revision is necessary to help the ACG client meet his or her needs. The supervising registered nurse must give a copy of the client's individual treatment plan to the ACG client's case manager and the home health agency that provides the home health or personal care services.

Subp. 2. **Contents of ACG client's individual treatment plan.** The ACG client's individual treatment plan must meet the requirements of Code of Federal Regulations, title 42, section 405.1223.

9505.2480 ALLOCATION OF STATE ACG MONEY.

Subpart 1. **Formula for allocation of state ACG money.** Annually before July 1, the commissioner must allocate state money available for alternative care grants to each local agency. The allocation must include the state share of money for services provided to recipients under the waiver and the state share of money for services to persons who would be eligible to receive medical assistance within 180 days after nursing home admission. The allocation must be made according to *Minnesota Statutes*, section 256B.091, subdivision 8. State funds allocated by the commissioner to a local agency for ACG services provided under the waiver shall not be used for any purpose other than services under the waiver.

Subp. 2. **Review of allocation; reallocation of state ACG money.** The commissioner must review the local agencies' projected and expended state ACG money on a quarterly basis. The commissioner must reduce the allocation of state ACG money to a local agency if the commissioner determines that the local agency will not use the full state allocation during the state fiscal year. The commissioner must reallocate the unused portion of the local agency's allocation to a local agency that has or wants to have more ACG clients than were projected to be served in its biennial plan.

9505.2485 ALLOCATION OF NUMBER OF ACG CLIENTS TO BE SERVED UNDER THE WAIVER.

Subpart 1. **Local agency allocation of ACG clients under the waiver.** At least annually, the commissioner must allocate the number of ACG clients who are recipients and for whom each local agency is financially responsible under the waiver. The commissioner must determine from the medical assistance eligibility data provided as of March 1 by the counties to the department each local agency's allocation according to the county's percentage of the statewide total number of recipients who are age 65 or older.

Subp. 2. **Review of allocation; reallocation of number of ACG clients under the waiver.** The commissioner shall review the projected and actual number of ACG clients served under the waiver by all local agencies on a quarterly basis. The commissioner may reduce the number of ACG clients allocated to a local agency if the commissioner determines that the local agency will serve fewer than its allocated number of ACG clients during the allocation period. The commissioner may reallocate the unused portion of the local agency's initial allocation to another local agency.

Subp. 3. **Notice to local agency.** The commissioner shall notify a local agency annually before May 15 of the number of recipients to be served as ACG clients under the waiver under subpart 1 and shall notify a local agency at least 15 days before the effective date of a change in the number of ACG clients allocated to the local agency under subpart 2.

9505.2486 LOCAL AGENCY ESTIMATION OF NUMBER OF PERSONS OTHER THAN RECIPIENTS TO BE SERVED AS ACG CLIENTS.

A local agency must estimate the number of persons other than recipients to be served as ACG clients. The estimate shall depend on the extent that ACG funds allocated to the local agency as required by part 9505.2480 are available. The local agency must report the estimate in the biennial plan and revisions to the biennial plan required in part 9505.2495, subpart 2.

9505.2490 RATES FOR ACG SERVICES.

Subpart 1. **Statewide maximum ACG service rate.** For years beginning on July 1 following the effective date of parts 9505.2390 to 9505.2500, the commissioner must annually set a statewide maximum rate allowed for payment of providing an ACG service. The statewide maximum rate must not exceed the prior fiscal year's rate by more than the percentage change between the two previous Januarys indicated by the all urban consumer price index (CPI-U) for Minneapolis-St. Paul new series index (1967 = 100), as published by the Bureau of Labor Statistics, United States Department of Labor. The CPI-U is incorporated by reference and is available from the Minitex interlibrary loan system. The CPI-U is subject to frequent change.

Subp. 2. **Local agency maximum ACG service rate set by commissioner; general.** The commissioner shall annually set the

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maximum rate that is available to a local agency for reimbursing an ACG provider for an ACG service. For years beginning on the first of July following the effective date of parts 9505.2390 to 9505.2500, the commissioner shall authorize an increase in the ACG rate available to a local agency for reimbursing an ACG provider equal to the percentage change between the two previous Januarys indicated by the all urban consumer price index (CPI-U) for Minneapolis-St. Paul new series index (1967 = 100), as published by the Bureau of Labor Statistics, United States Department of Labor.

Subp. 3. **Local agency maximum ACG service rate set by commissioner; new ACG service.** A local agency that wants to contract for an ACG service that has not been provided before the effective date of parts 9505.2390 to 9505.2500 shall propose a maximum rate to the commissioner that does not exceed the statewide maximum ACG service rate established by the commissioner under subpart 1.

Subp. 4. **Notice to local agency.** Annually by May 15, the commissioner shall notify each local agency of the statewide maximum rate allowed for payment of providing an ACG service under subpart 1. Additionally, the commissioner shall notify the local agency in writing of the percentage increase allowed under subpart 2.

Subp. 5. **Local agency request to exceed county's maximum rate.** Notwithstanding the limitation on the local agency's maximum rate for an ACG service in subpart 2, a local agency that wants to increase an ACG service rate more than the percentage authorized by the commissioner under subpart 2 may submit a request for the increase to the commissioner. The local agency must justify the need for the greater increase by submitting evidence that documents an increase in costs, such as wages established under a union contract, taxes, utility costs, or transportation charges, that exceeds the percentage change or that shows that the higher rate is necessary to obtain the desired service within the local agency's local trade area. For purposes of this subpart, "local trade area" has the meaning given in part 9505.0175, subpart 22.

Subp. 6. **Local agency ACG service rate subject to audit and approval.** A local agency ACG service rate and a request to exceed the local agency's maximum ACG service rate are subject to audit and approval by the commissioner.

9505.2495 LOCAL AGENCY REPORTS AND RECORDS.

Subpart 1. **Preadmission screening documents.** The local agency must complete and submit to the commissioner a preadmission screening document that summarizes the assessment and recommendations of the preadmission screening team on an applicant, nursing home resident, or ACG client for whom the local agency has completed a preadmission screening or a reassessment. The document must be submitted by the tenth of the month following the month in which a preadmission screening or reassessment was completed.

Subp. 2. **Local agency biennial plans.** The local agency must submit a biennial plan for preadmission screening and ACGs on forms prepared by the commissioner. The local agency must submit the biennial plan to the commissioner by July 1 of odd-numbered years in order for the local agency to receive preadmission screening funds or ACG funds during the next two state fiscal years. The local agency must submit revisions to the biennial plan to the commissioner for approval before implementing the revisions. The biennial plan must include items A to F:

A. name and address of the local agency;

B. names and titles of the preadmission screening team;

C. names of ACG service providers;

D. identification of the types of ACG services the local agency will provide and the rates for the services;

E. an ACG budget and estimates of the number of recipients and other persons to be served as ACG clients for the first year of the biennium and an estimated budget and estimated number of clients to be served for the second year of the biennium. No later than July 1 of the second year of the biennium, each local agency must submit the actual budget and revised estimate of the number of clients to be served proposed for the second year of the biennium; and

F. assurances of compliance with *Minnesota Statutes*, section 256B.091, and parts 9505.2390 to 9505.2500.

Subp. 3. **Commissioner approval of local agency biennial plan.** The commissioner must approve or reject by August 15 a biennial plan submitted by the local agency as required in subpart 2, item E.

Subp. 4. **ACG provider records.** The local agency and each ACG provider under contract with the local agency must maintain complete program and fiscal records and supporting documentation identifying the ACG clients served, the services provided, and the costs incurred. The records must be identified and maintained separate from other provider records. The local agency's and provider's records including the local agency's contract with the ACG provider are subject to the maintenance schedule, audit availability requirements, and other provisions in parts 9505.1750 to 9505.2150.

9505.2496 CRITERION FOR DELAY IN SENDING REQUIRED NOTICES.

If information that the commissioner needs to prepare and send the notices required under parts 9505.2390 to 9505.2500 is not

provided in time for the commissioner to meet the time specified in these parts, the required notices shall be sent as soon as possible after the commissioner receives the needed information.

9505.2500 APPEALS OF SCREENINGS, RESCREENINGS, AND REASSESSMENTS.

Subpart 1. **Information about the right to appeal.** A preadmission screening team must provide a person being screened under part 9505.2400, rescreened under part 9505.2435, or reassessed under part 9505.2455, subpart 11, or the person's representative, information about the person's right to appeal the recommendation of the screening team. The information must be in writing and must be given to the person or the person's representative during the preadmission screening. The information must state the grounds for an appealable action and that ACG services will not be reduced, suspended, or terminated if the appeal is filed before the date specified in the information unless the person requests in writing not to receive continued ACG services while the appeal is pending.

Subp. 2. **Appealable actions.** A person being screened, rescreened, or reassessed may appeal if:

A. the recommendation of the preadmission screening team is to deny ACG services;

B. the preadmission screening team fails to determine with reasonable promptness whether the person is eligible for ACG services; or

C. the recommendation of the case manager based on a reassessment under part 9505.2455, subpart 11, is to reduce, suspend, or terminate ACG services.

Subp. 3. **Denial, reduction, suspension, or termination because of insufficient ACG funds or openings.** A denial, reduction, suspension, or termination of ACG services is not an appealable action if the county of financial responsibility has depleted the amount of money allocated under part 9505.2480 or assigned all the openings to serve ACG clients allocated under parts 9505.2485 and 9505.2486 or if the client's case manager withdraws ACG services as provided under part 9505.2458. Additionally, termination of an ACG service being provided to an ACG client under the waiver is not appealable if the termination results from termination of the waiver.

Subp. 4. **Submission of appeals.** The person being screened or the representative of the person being screened who wants to appeal the screening team's recommendation must submit the appeal in writing to the local agency of the county of service or to the department within 30 days after receiving written notice of the appealable action, or within 90 days of the written notice if a justified reason for delay can be shown.

Subp. 5. **Appeal of action.** An appeal of issues meeting the criteria under subparts 1, 2, and 4 shall be heard and decided in accordance with *Minnesota Statutes*, section 256.045.

REPEALER. *Minnesota Rules*, parts 9505.2250; 9505.2260; 9505.2270; 9505.2280; 9505.2290; 9505.2300; 9505.2310; 9505.2320; 9505.2330; 9505.2340; 9505.2350; 9505.2360; 9505.2370; and 9505.2380, are repealed.

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STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption of State Department of Human Services Rules Governing Preadmission Screening and Alternative Care Grants, Minnesota Rules, Parts 9505.2390 to 9505.2500	FINDINGS OF FACT, CONCLUSIONS, AND ORDER ADOPTING RULE WITHOUT PUBLIC HEARING

Notice of the Commissioner's intent to adopt the above-entitled rule without a public hearing was published in the State Register on March 14, 1988 and was sent by United States mail to all persons on the list maintained by the agency pursuant to Minnesota Statutes, sections 14.14, subdivision 1a and 14.22, on March 9, 1988. The statement of need and reasonableness was prepared before the notice of intent to adopt a rule without a public hearing was mailed to all persons on the rulemaking mailing list and published in the State Register and was available to the public.

All persons were given the opportunity to submit comments on the rule for 30 days after notice of proposed rulemaking. The agency received eight

requests for a public hearing, none of which were subsequently withdrawn. Therefore the agency did not receive requests for a public hearing from 25 or more persons which were not withdrawn. No requests for notice of submission to the attorney general were received by the agency.

Based on the comments and evidence in the record before the agency, I find the following:

Part 9505.2390, Subparts 41 and 42.

Mr. Wayne Carlson, Minnesota Department of Health, requested that the language of these two subparts be checked against the current language of the Local Public Health Act, Minnesota Statutes, chapter 145A.

The department thanks Mr. Carlson for his comment and notes that the citations found in these subparts of the rule as published were repealed upon enactment of Minnesota Statutes (1987), Chapter 145A. The correct citations are found in Minnesota Statutes, chapter 145A. Therefore, it is necessary and reasonable to modify subparts 41 and 42 as follows:

Subpart 41. Public health nurse. "Public health nurse" means a registered nurse certified by the Minnesota Department of Public Health as a public health nurse under Minnesota Statutes, section 145A.02, subd. 18 and employed by a board of health as provided under Minnesota Statutes, ~~sections 145.08 to 145.123~~ section 145A.10, subd.1.

Subp. 42. Public health nursing services. "Public health nursing services" means the nursing ~~services~~ program provided by a board of health under Minnesota Statutes, ~~sections 145.911 to 145.92~~ section 145A.10, subd. 1.

These modifications are not substantial but are only for purposes of clarification.

Part 9505.2400, Subpart 2, item F.

One commenter, Mr. Todd Monson, NHPAS Supervisor, Hennepin County Community Health Department, requested that the item be changed to read, "an applicant who has been screened and who has received services from a certified home health agency since the screening." Mr. Monson suggests that such a change is consistent with Minnesota Statutes, section 256B.091 and avoids the possibility of mandating more screenings than necessary in the case of an applicant who has tried to stay at home with services.

The department has carefully considered Mr. Monson's request. Although the department agrees it is important to avoid mandating more screenings than necessary, the department believes that the timeliness of the screening in relation to the applicant is even more important. The purpose of preadmission screening is to assess an applicant's care and needs. If an applicant is currently receiving services from a certified home health agency, the service provider has knowledge of the applicant's condition and a responsibility to assure that the applicant's needs are being met. See part 9505.2465, subparts 5 and 9 and part 9505.2470. However, the language suggested by Mr. Monson implies that the applicant may not be currently

receiving services from a certified home health agency and raises the question of whether the applicant's health status has changed since the screening. The requirement of another screening is another opportunity for the applicant and the screening team to assess the applicant's health status, to identify the ACG services necessary to remain in the community, and to decide whether to remain outside the nursing home. Such an opportunity is consistent with the ACG program established under Minnesota Statutes, section 256B.091, which is to assist persons to remain in the community. It also is consistent with the waiver. Therefore, the department declines to accept Mr. Monson's request.

Part 9505.2400, Subp. 2, item G.
and Part 9505.2420, Subp. 4.

One commenter, Ms. Patricia J. Reller, Administrator, Crystal Care Center, suggested that "(t)he preadmission screener should only be allowed a 15-day delay period instead of a 30-day delay period to do the PAS." She believes that a shorter delay would aid families in knowing their financial obligations sooner and also would aid the nursing home in obtaining reimbursement at the accurate case level as the required level of care would be identified in the screening process.

The 30-day delay of screening of private pay applicants is consistent with Minnesota Statutes, section 256B.091, subd. 4(3) which provides for an exemption from screening for a private pay individual whose length of stay is expected to be 30 days or less based on a physician's certification. (Also see part 9505.2420, subpart 4.) The department notes that present procedures, which would continue if this rule is adopted, require

completion of the quality assessment and review used to determine an applicant's case mix level within 10 days after the applicant's admission. If the preadmission screening team does not do it, the form must be completed by a registered nurse in the admitting nursing home and submitted to the Minnesota Department of Health no later than 15 days after the applicant's admission. The Minnesota Department of Health then classifies the applicant into one of the resident classes established under part 9549.0058. See parts 4656.0010 to 4656.0090. Thus, it is reasonable to expect that the accurate case level, in most instances, would be available to the nursing home sooner than the 30-day period set for an exception in item G. The department declines to accept the modification suggested by Ms. Reller.

Part 9505.2405.

and Part 9505.2460, Subp. 2

One commenter, Ms. Beverly O'Malley, Director, Dodge County Social Services, questioned why the notices required in these two provisions couldn't "be in the same paper at the same time, or is there a legal reason why the notices must be in different papers."

The two publications may be the same and, if so, the notices could be published at the same time. It is an accepted practice of counties to designate an official paper in which the county places notices about contracts and other matters of official county business. See Minnesota Statutes, section 279.085. Persons seeking county business such as

contracts are familiar with this process. In greater Minnesota, local papers pick up and reprint as a public service the public notices originally published in the county's official newspaper. The notice required under 9505.2405, subpart 4 could be a public service notice. However, part 9505.2405 is written to ensure that the largest number of people will have an opportunity to see the notice and be informed of the availability of preadmission screening whereas part 9505.2460, subpart 2 is directed toward notifying potential providers of services of the opportunity to be selected as an ACG provider. Therefore, the department declines the request to modify the rule.

Part 9505.2420, Subp. 4, item B.

One commenter, Ms. Beverly Webb, Social Service Supervisor, Stearns County Social Service Center, suggested extending the thirty day exemption from screening to 60 days in the case of the terminally ill patient admitted to a nursing home. Minnesota Statutes, section 256B.091, subd. 4, specifies the length of the exemption as 30 days for persons who are not eligible for medical assistance. The provision is consistent with the cited statute and the department declines to modify the rule.

Part 9505.2425, Subp. 10, item A.

One commenter, Mr. Monson, requested "the deletion of the requirement that the county of service must send the county of financial responsibility the entire 10 page screening tool."

The department has considered the requirement and agrees with Mr. Monson that it is not necessary to send the preadmission screening assessment form

to the county of financial responsibility. The department does believe that the county of financial responsibility has a need to review the individual service plan so that it can act in a businesslike manner and know whether the plan is cost effective. Therefore, the department accepts Mr. Monson's request and modifies the item as follows:

A. ~~the original preadmission screening assessment form, including~~ the original individual service plan;

The modification is not substantial but is only for purposes of clarification and minimizing paperwork requirements.

Part 9505.2430, Subp. 4, item B(6).

One commenter, Mr. Monson requested deletion of the requirement "that the treatment plan identifies 'the funding sources for the community services;'". He argued that "it would be an administrative nightmare (for Hennepin County) to try to identify the exact funding source for each of the services that each of the 400 agencies (in Hennepin County) provide."

The department has carfeully considered Mr. Monson's request. However, the department believes that identification of funding sources is very important as the mission of the alternative care grants program and the waiver is to supplement, not supplant, services that are otherwise available under other funding sources or service programs. Thus, ACG funds pay for services that would not be available any other way. For example, possible funding sources available to an ACG client to meet the cost of community services are funds under the Community Social Services program, Community Health Services program, Title III, and the Older Americans Act. Use of these funds to purchase services for eligible clients conserves the

limited amount of ACG dollars for ACG clients who need a mix of services available only under the ACG program and waiver. Furthermore, the requirement is consistent with Minnesota Statutes, section 256B.091, subd. 8 which requires "the county agency (to) provide documentation to the commissioner verifying that the individual's alternative care is not available at that time through any other public assistance or service program...." Therefore, the department declines to accept Mr. Monson's request to delete item B (6).

Part 9505.2445, Subp. 6

One commenter, G. H. Amble, Executive Director, Glenwood Retirement Homes, requested that the rule require the local agency to "submit to each nursing home in that county who is charged a fee for the preadmission screening program an annual report indicating 1) Total number of preadmission screenings done during the past twelve months; 2) Location of the screening process, ie(sic), hospital, residence, nursing home, other; 3) results of screening ie(sic), remain in home, nursing home placement, other type of programs."

In considering G. H. Amble's comment, the department has reviewed the requirement of Minnesota Statutes, section 256B.091, subd. 4 concerning reports of preadmission screening costs. The requirements of subpart 6 are consistent with Minnesota Statutes, section 256B.091, subd. 4. Accepting G. H. Amble's request would add to the county's burden in administering the PAS/ACG program. The estimate required in the cited statute and reflected in subpart 6 is made on a 12-month basis for the rate year applicable to nursing homes. Therefore, the department declines to accept the request to

modify the rule.

G. H. Amble also requested that the rule require the local agency to submit "their billings to the facility by the 10th of the each (sic) month following the month of service."

The department believes that the problem described by G. H. Amble, county delay in submittal of bills to the nursing home, is a local problem that requires discussion and resolution by the county and the nursing home. Therefore, the department declines to accept the request to modify the rule.

Part 9505.2455, Subp. 2

One commenter, Ms. O'Malley, called attention to the omission of item H from the introductory sentence of subpart 2 and requested its inclusion.

The department thanks Ms. O'Malley for her comment. The omission is the result of a typographical error. Therefore, the department modifies the rule as follows:

Subp. 2. Eligibility criteria. A person is eligible for an ACG if the person meets the criteria in items A to ~~G~~ H.

The modification is not substantial but only for purposes of clarification.

Part 9505.2458

One commenter, Mr. Monson, requested that "the word 'provide'...be changed to 'arrange'.....because the county doesn't technically provide living arrangements...."

Mr. Monson is correct that the county does not provide living arrangements. To avoid misunderstandings, the department accepts Mr. Monson's request but believes the phrase "work out" most accurately describes what the county is required to do. Therefore, the department modifies the part as follows:

.....The case manager shall determine whether to withdraw the services, ~~provide~~ work out another living arrangement for the client, or arrange for the services of another ACG provider.....

The modification is not substantial but only for purposes of clarification.

Part 9505.2460

Three comments were made about this part. Ms. Webb protested the public meeting requirements saying that "the procedure is complicated, redundant, and time consuming for all concerned." Mr. Charles Olson, Director, Rock County Family Service Agency, objected to the need for an annual public meeting. Ms. O'Malley commented about the criteria and language set out in subpart 3.

The requirement placed on a county of giving advance written notice of and holding an annual public meeting to explain and review criteria for

selection as ACG providers is set forth in Minnesota Statutes, section 256B.091, subd. 8. Thus, subparts 1 and 2 are consistent with Minnesota Statutes, section 256B.091, subd. 8. Therefore, the department declines the requests to modify the requirement.

In reviewing Minnesota Statutes, section 256B.091, subd.8, the department found that the proposed rule did not duplicate the statute exactly and that one requirement had been inadvertently overlooked. The department believes that item A is consistent with (1) and item C is consistent with (3) of Minnesota Statutes, section 256B.091, subd. 8. The department's comparison of item B with (2) of Minnesota Statutes, section 256B.091, subd. 8 indicates a deviation from the statutory language that might lead to confusion. Therefore, the department accepts Ms. O'Malley's request to clarify the rule and modifies item B as follows:

B. ~~the service needs of the ACG clients of the local agency~~ the population to be served including the number of clients, ~~to be served,~~ the length of time service will be provided, and the ~~health status~~ medical condition of the ACG clients;

The requirement that was overlooked was enacted in 1987 as a result of the department's identification of a nursing home practice of adding administrative costs to the rates charged by contracted providers other than the county. The 1987 amendment came from a compromise agreement between the department and nursing home providers that the Legislature accepted. The requirement is established in Minnesota Statutes, section 256B.091, subd. 8 (5). The department believes it is necessary and

reasonable to modify item E of subpart 3 as follows to ensure consistency with the statute:

E. the rate for each service or unit of service; exclusive of county administrative costs;

The modifications are not substantial but only for purposes of clarification.

Additionally, Ms. O'Malley requested "the addition of a reference to a provider furnishing proof of meeting qualification as outlined in rule."

The department believes that items D, F, and G set out the proof that a provider must provide in establishing the provider's qualifications to provide ACG services. Furthermore, this subpart authorizes the local agency to establish other criteria "consistent with items A to G". Therefore, the department declines to accept Ms. O'Malley's request to add a reference about a provider's furnishing proof of meeting qualifications.

Part 9505.2465, Subparts 1 and 5

One commenter, Mr. David Siegel, Health Resources Division, Minnesota Department of Health suggested that any references to licensure of home care providers under Minnesota Statutes, sections 144A.43 to 144A.47 should also refer to registration under 144A.49.

The department thanks Mr. Siegel for his comment, finds it necessary and reasonable to accept his suggestion, and modifies the rule as follows:

Subpart 1, Item A. " Personal care provider" means a home health agency that meets the requirements of subpart 5 and is under contract to the local agency to provide personal care assistants or a local agency licensed as a home health agency under Minnesota Statutes, sections 144A.43 to 144A.47~~,~~ or registered under Minnesota Statutes, section 144A.49.

Subp. 5. Personal care provider; eligibility. Except as provided in subpart 11, a local agency that is not licensed as a home health agency under Minnesota Statutes, sections 144A.43 to 144A.47 or registered under Minnesota Statutes, section 144A.49 [remainder unchanged].

A. be licensed as a home health agency under Minnesota Statutes, sections 144A.43 to 144A.47~~;~~, or registered under Minnesota Statutes, section 144A.49;

[items B to K unchanged]

A similar modification is necessary and reasonable in part **9505.2470, subpart 2** as follows:

Subp. 2. Eligible providers. To be eligible as a provider of home health aide services under the ACG program, a home health agency must be licensed under Minnesota Statutes, section 144A.43 to 144A.46~~,~~ or registered under Minnesota Statutes, section 144A.49, and certified to participate under titles XVIII and XIX of the Social Security Act.

Finally, a similar modification is necessary and reasonable in **part 9505.2473, subpart 2,** the last sentence, as follows:

.....If the local agency contracts with a provider for homemaker services, the provider must meet the requirements of Minnesota Statutes, sections 144A.43 to 144A.46 or 144A.49.

These modifications are not substantial but are only for purposes of clarification.

Part 9505.2480, Subpart 1

One commenter, Ms. Mary Boom, Program Manager, Mental Health Division, Hennepin County Community Services Department, commented that the average, annual statewide per capita expenditure allowed under the waiver is omitted. Ms. Boom also commented on the expenditure limit of $2,890 under the waiver and the fact that the State no longer requires counties to limit expenditures for persons served under the waiver to $2,890. She asks how the "State will implement the waiver's expenditure cap should the average, annual, statewide per capita expenditure exceed the allowable amount."

Ms. Boom is correct that federal funds are available under the waiver and that the rule limits "..the anticipated cost of providing community services to less than the total annual statewide monthly average payment of the resident class under parts 9549.0050 to 9549.0059 that would be applicable to the person if the person were placed in a nursing home...." See part 9505.2425, subpart 5, item B. There is a statewide monthly average payment that is applied only to persons on the waiver, that is agreed to by the federal government, and that is adjusted annually. However, the statewide monthly average payment is not applied on an individual basis but on a statewide perspective. The state monitors the

statewide average: some clients receive services costing more; some less. The waiver is a statewide perspective and the limit is a condition of the waiver that can be audited mechancially and the expenditures determined. A report of the previous year's expenditures is made annually to the federal government. Since the waiver's implementation, the program has never exceeded this limit nor has the department encountered any problem of remaining within it. It is not the local agency's responsibility to monitor the statewide expenditure allowed under the waiver. The county needs to know its allocation of the state ACG money for services provided to recipients under the waiver in order to carry out the program and the rule gives the county money according to the allocation of the number of ACG clients to be served under the waiver. If state funds under the waiver are exhausted, ACG clients would have to be served under the state allocation to the county to the extent of available state funds.

Ms Boom did not request changes in the rule and none are made in response to her comment.

Finally, Ms. Reller made three general comments as follows:

1. The first comment related to the method of completing the QAR form.

This concern is properly addressed to the Minnesota Department of Health which specifies the requirements for completing the QAR form.

2. PAS appointments should be coordinated with nursing home staff and not always be at the convenience of the screener.

Timeliness of screenings is important. The screening should be concurrent with the QA and R needs. This concern is properly discussed with the local screening team.

3. A copy of the written recommendations should be placed in the chart after screening so that consistent discharge plans can be developed.

Changes may occur in a recipient's condition between the time of a screening and the time of a preparing a discharge plan. The assessment made in the screening only reflects the person's condition on the day of the assessment. It is necessary and reasonable to consider the person's condition at the actual time of discharge because that condition affects the services necessary for the recipient. The department supports the idea of coordinated discharge planning as the method of becoming fully aware of a recipient's ability to return to the community. It is not necessary to modify the rule to permit coordination of discharge planning and screening as the rule does not prohibit such efforts.

CONCLUSIONS

I hereby conclude that:

1. All modifications made to the proposed rule are not substantial changes.

2. The rules, as modified, are necessary and reasonable.

3. Any duplication in these rules of language contained in Minnesota Statutes is crucial to the ability of persons affected by the rules to comprehend their meaning and effect.

4. The Department has complied with all applicable provisions of law and rule in the promulgation of these rules.

5. If any finding or part of a finding, above, is properly characterized as a conclusion, it is adopted as a conclusion.

The above-captioned rule is needed and reasonable.

NOW, THEREFORE, IT IS ORDERED that the rule identified as Governing Preadmission Screening and Alternative Care Grants is adopted this 20th day of June, 1988, pursuant to authority vested in me by Minnesota Statutes, section 256B.091, subd. 9.



SANDRA S. GARDEBRING

Commissioner

FISCAL IMPACT STATEMENT OF PARTS 9505.2390 TO 9505.2500, GOVERNING PREADMISSION SCREENING AND ALTERNATIVE CARE GRANTS PROGRAM

The purpose of this statement is to identify the additional costs that agencies will incur if parts 9505.2390 to 9505.2500 are adopted.

There are four provisions of parts 9505.2390 to 9505.2500 which will have a fiscal impact on county, state, and federal agencies. Three of these provisions will add costs. They are found in part 9505.2400, subpart 1 which requires the preadmission screening of out-of state applicants and persons transferring from an out-of-state certified nursing home or boarding care home to a Minnesota certified nursing home or boarding care home; part 9505.2420, subparts 2 and 4 which require notices to be sent to persons who are eligible for a ten-day delay or a thirty-day exemption from preadmission screening; and part 9505.2460, subpart 2 which requires the local agency to publish a notice of the annual public meeting to inform possible providers of alternative care grant (ACG) services about the criteria for being selected providers and the date for submitting provider applications. Costs will be decreased under part 9505.2400 as persons who are not applicants for admission to a nursing home or current nursing home residents will no longer be eligible to request a preadmission screening.

Table I summarizes the total estimated fiscal impact of these cost changes in Minnesota.

TABLE 1

Source of Change	FISCAL YEAR	
Cost Increase	FY 89	FY 90
1. PAS out-of-state applicants and transfers	$174,000	$174,000
2. Notices for ten-day delay and 30 day exemption	22,998	22,998
3. Annual public notice	21,750	21,750
Cost Savings		
4. Limit on PAS requests	(136,155)	(136,155)
NET COST INCREASE	$ 82,593	$ 82,593

The breakdown of the cost increase is as follows:

County share	$7,741
State share	$69,671
Federal share	$5,181
Total increase	$82,593

Table 2 shows a more complete analysis of the cost changes.

TABLE 2
Cost Changes Resulting from Proposed Rule According to
Source of Change, Source of Funding,
and Percentage of MA Recipients

Source of Change	Total Cost	Source of Funding: County Share	State Share	Federal Share	NH/BCH Share
Cost Increase					
1. PAS/out-of state applicants and transfers					
180 MA recipients	$ 26,100	$ 1,201	$ 10,811	$ 14,088	0
1,020 private pay	$147,900	0	0	0	$147,900
1200 persons	$174,000	$ 1,201	$ 10,811	$ 14,088	$147,900
2. Notices for:					
a. Ten-day delay					
0 MA recipients	0	0	0	0	0
16,782 private	$18,460	$ 1,846	$ 16,614	0	0
16,782 persons	$18,460	$ 1,846	$ 16,614	0	0
b. 30-day exemption					
619 MA recipients	$ 681	$ 341#	0	$ 340#	
3,506 private pay	$ 3,857	$ 386	$ 3,471	0	0
4,125 persons	$ 4,538	$ 727	$ 3,471	$ 340	0
3. Annual Public Notice					
15% MA recipients	$ 3,262	1,631	0	1,631	0
85% private pay	$18,488	$ 1,849	16,639	0	0
87 Counties	$21,750	$ 3,480	$ 16,639	$ 1,631	0
Cost Increase Totals	$218,748	$ 7,254	$ 47,535	$ 16,059	$147,900
Cost Savings					
4. Limit on PAS requests					
141 MA recipients	$ 20,445	$ 941	$ 8,468	$ 11,036	0
798 private pay	$115,710	$ 0	$ 0	0	$115,710*
939 persons	$136,155	$ 941	$ 8,468	$ 11,036	$115,710
Cost Savings Totals	$136,155	$ 941	$ 8,468	$ 11,036	$ 115,710
NET COST INCREASE	$ 82,593	$ 6,313	$ 39,067	$ 5,023	$ 32,190

The amount of $340.50 has been rounded down in one instance and rounded up in the other to add to the total estimated cost of $681.

* These costs are paid to the counties by the nursing homes as an annual assessment for the preadmission screening of applicants who are not eligible for medical assistance and who will be private pay residents if they are admitted to the nursing homes. It should also be noted that other added costs to the counties will be worked into the administrative costs that are included in the fees for service for which the counties receive state reimbursement. Therefore, these other added costs will not result in added costs to the counties.

METHODOLOGY

Minnesota Statutes, section 256B.091 requires all applicants for admission to a nursing home or a boarding care home, regardless of their financial status, to undergo preadmission screening if the nursing home or boarding care home participates in the medical assistance program (MA). Furthermore the cited statute requires the department to seek to maximize the use of federal and state funds in paying for this program.

Preadmission screening and alternative care grant (PAS/ACG) services are provided to persons for the purpose of obtaining health services appropriate to the persons' conditions. Federal financial participation is available toward paying the cost of PAS and ACG services provided to persons who are eligible for medical assistance. The costs of ACG services to persons who would be eligible for medical assistance 180 days after admission to a nursing home are paid in part by the state and in part by the county according to the formula established by the state agency. (The costs of PAS of private paying persons are covered by the nursing homes and boarding care homes). The medical assistance program in Minnesota is jointly funded by federal, state, and county governments, The federal share is determined by a formula in federal statute which produces small annual changes in the rate of federal participation. By state statutes, the state pays 90% and the counties 10% of the non-federal share. For the year beginning October 1, 1987 (FFY 1988), the shares of funding are 53.98% federal, 41.42% state, and 4.60% county. These rates

are used in the division of MA costs shown in Table 2. Rates for subsequent years will not differ greatly from these. The shares of governmental funding determined by these percentages apply to medical assistance vendor payments for medical services. Administrative costs for medical assistance are paid 50% by the federal government and 50% by the state or the county, according to whichever governmental unit incurs the cost.

Not all persons receiving services governed by this rule are eligible for medical assistance. Thus in analyzing the amounts to be paid by the various sources of funding, it was necessary to estimate both the total number of persons the counties anticipate serving in the next two years and the percentage of them eligible for medical assistance at the time of the preadmission screening. Counties were surveyed to determine their best estimate of the number of persons who will require screenings and the percentage of these persons who will be eligible for medical assistance at the time of the screening. The survey found that 18,776 persons required preadmission screenings in FY87 and that fifteen percent of this number are medical assistance eligible at the time of the screening. Thus, an estimate of fifteen percent of those screened being eligible for medical assistance has been used throughout the analysis in Table 2 to assign the shares of the cost to be borne by the county, state, and federal agencies.

The counties were also surveyed to determine the number of out-of state applicants and transfers from out-of state facilities who will enter Minnesota nursing homes and boarding care homes and will be Minnesota residents. These persons are subject to preadmission screening requirements under Minnesota Statutes, section 256B.091. The survey found

that 1,200 persons fall into this group in FY 87. This number has been used to determine the increased costs resulting from their screenings.

The proposed rule requires the counties to send notices when a person is eligible for a ten-day delay or a 30-day exemption from screening before being admitted to a nursing home or a boarding care home. Reports from the county show estimates of 16,782 persons entitled to receive notices of a ten-day delay and 4,125 persons entitled to a 30-day exemption from preadmission screening. These estimates for FY88 are used in the analyses shown in the two tables. (These figures, 4,125 and 16,782, when added together, exceed the total number of screenings anticipated in FY88 because most of those who are exempt will never be screened as they are in a nursing home or boarding care home for respite or other temporary care and will return to their own homes rather than seek continued residence in the nursing home or boarding care home.)

The proposed rule limits preadmission screening to those who must be screened under Minnesota Statutes, section 256B.091. The county survey also reported that about five percent of the number of persons screened in FY87 are being screened voluntarily rather than as a statutory compliance measure. Because under part 9505.2400 a screening team is required to screen only nursing home applicants and residents, it is expected that the number of persons being screened will be reduced by five percent. Thus, the five percent figure has been used in calculating the cost savings shown in Tables 1 and 2.

VOLUNTEERS OF AMERICA
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3245 Vera Cruz Avenue North • Minneapolis, Minnesota 55422 • (612) 535-6260

Print as clean copies



April 5, 1988

Eleanor Weber
Rules Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816

Dear Ms. Weber:

This letter is in response to the proposed adoption of MN rules 9505-2390 and 9505-2500 that will establish the procedures that govern PAS for nursing home applicants. I feel the following changes need to be made to make the rules complete:

The preadmission screener should only be allowed a 15-day delay period instead of a 30-day delay period to do the PAS. This would let the families know the resident's case mix level 15 days earlier and they would, therefore, know the financial obligations sooner. Also, the first 30 days of care are the heaviest in terms of nursing care for the resident. If the nursing home practices good rehabilitative nursing during the first 30 days, the resident will generally improve and the patient will consequently be evaluated by the PAS at a lower case mix level. Financially, this isn't fair to the nursing home, therefore, it the resident was evaluated at 15 days, the nursing home would be reimbursed at an accurate case mix level. If the 30-day delay continues, there will be no incentive for nursing homes to practice good rehabilitative nursing when they aren't getting reimbursed for it.

The PAS should be required to fill out the entire red QAR form. The PAS is filling out most of the information and leaving the rest for the nursing staff to complete. Legally, the person who signed the form should complete the whole form.

PAS appontments should be coordinated with the nursing home staff and not always be at the convenience of the screeners. This often conflicts with our busy schedules and there should be some give and take in this area.

To do adequate, consistent discharge plans, I feel a copy of the written recommendations should be placed in the chart after screening. This will be a great help to our social services department when doing discharge planning, if they know the alternatives available for the residents.

I hope these suggestions will help you with your decisions on the rules concerning PAS. Thank you.

Sincerely,

Patricia J. Reller

Patricia J. Reller
Administrator

PJR/apg

Rock County Family Service Agency

P.O. Box 219
Luverne, Minnesota 56156

(507) 283-9507

April 4, 1988



Eleanor Weber
Rules Division
Department of Human Services
444 Lafayette Road
St. Paul, Minnesota 55155-3816

RE: Proposed Rule - Pre-Admission Screening and Alternative Care Grants 9505.2390 to 9505.2500

Dear Ms. Weber:

I would like to comment about 9505.2460, Local Agency Selection of ACG Providers on pp. 37-38.

The requirement for an annual public meeting for potential providers seems to be a cumbersome way to recruit potential providers. In a rural area, where competitive providers are at a minimum, I would hope that an RFP or some other type of public notice would be sufficient.

I don't oppose public verification, but I object to the need for an annual public meeting.

Sincerely,

ROCK COUNTY FAMILY SERVICE AGENCY

Charles Olson, Director

CO/dt

minnesota department of health
717 s.e. delaware st. p.o. box 9441 minneapolis 55440
(612) 623-5000

March 31, 1988

Eleanor Webber
Rules Division
Department of Human Services
444 Lafayette Road
St. Paul, Minnesota 55155

Dear Ms. Webber:

As you may recall, you called me recently to discuss some definitions in the Preadmission Screening and Alternative Care Grant Rules. We had two hurried conversations in which you suggested some language changes to 9502.2390, Subparts 41 and 42. I asked that you send me a copy of the proposed language so I could check it against current language of the Local Public Health Act (Minn. Stat. 145A).

I am still unsure of exactly what you are trying to do with those two subparts and uncomfortable with not yet having seen the exact written language. Would you please send me a copy of the language you propose? I would like to review it and I'm sure we can agree to language the Hearing Judge will accept as instructions to the Revisor.

Sincerely,

Wayne R. Carlson

Wayne R. Carlson, J.D., Chief
Section of Community Development

WC:kjm

an equal opportunity employer

Dod e County Social Se ces

21 7th Street N. E. Box 278
Mantorville, Minnesota 55955

Income Maintenance
Administration
507-635-2211

Beverly O'Malley
Director
507-635-2211

Social Services
507-635-2361

March 23, 1988

Eleanor Weber
Rules Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816

RE: Proposed MN Rules, Parts 9505.2390 to 9505.2500

Dear Ms. Weber,

I have reviewed the proposed rule and am especially pleased to see services tied to individual service plans and some requirements placed on relative provision of services. I am also pleased to see, in rule, termination of services being unappealable if funding is exhausted or the federal waiver is revoked.

The only comments for improvement in the rule that I have to offer are as follows:

1. Public notice regarding pre-admission screeing is to be annually in the paper with the largest circulation, while the annual notice for selection of providers is to be in the official newspaper of the county.

   Couldn't both notices be in the same paper at the same time, or is there a legal reason why the notices must be in different papers?

2. 9505.2455 Subp 2 refers to eligibility criteria A to G and ignores H which could be critical in an appeal situation even though the subject matter of H is referred to often throughout the rule.

3. 9505.2460 Subp 3 Items A-G, referring to selection criteria for providers. It is unclear what is meant and how these are to be used as selection criteria, especially A, B, and C. The difference between A and B is unclear and B looks more like a requirement for planning than criteria upon which to base the selection of a provider. Items D to G look like valid criteria, but I would like to see addition of a reference to a provider furnishing proof of meeting qualifications as outlined in rule.

Thank you for your consideration of these comments.

Sincerely,

Beverly O'Malley
Director

BOM:dt

HENNEPIN

COMMUNITY SERVICES DEPARTMENT
MENTAL HEALTH DIVISION
A-1605 Government Center
Minneapolis, Minnesota 55487-0165





April 11, 1988

Ms. Eleanor Weber
Rules Division
444 Lafayette Road, Second Floor
St. Paul, Mn 55155

Dear Ms. Weber,

In reading the proposed Preadmission Screening and Alternative Care Grant Rule, I noticed that the average, annual, statewide per capita expenditure allowed under the waiver is omitted. Under the proposed rule the allowable per capita expenditure is equal to or less than the allowable expenditure corresponding to the person's case mix score. Yet, under the waiver, the average, annual, statewide per capita expenditure must not exceed $2,890. As you are aware, expenditures corresponding to even the lowest care needs (i.e., a case mix score of "A") far exceed $2,890.00 annually.

I understand that the State no longer requires counties to limit expenditures for persons served under the waiver to $2,890. Instead, the State is monitoring the statewide average. As there is no provision in the rule which addresses the expenditure limitation under the waiver, I would like to know how the State will implement the waiver's expenditure cap should the average, annual, statewide per capita expenditure exceed the allowable amount.

I appreciate your time and consideration in addressing this issue. Thank you.

Sincerely,

Mary Boom

Mary Boom
Program Manager

MB:el

"or" should be taken out of the statement, as this is a combined training program, t one that provides a c ce or one or the other.

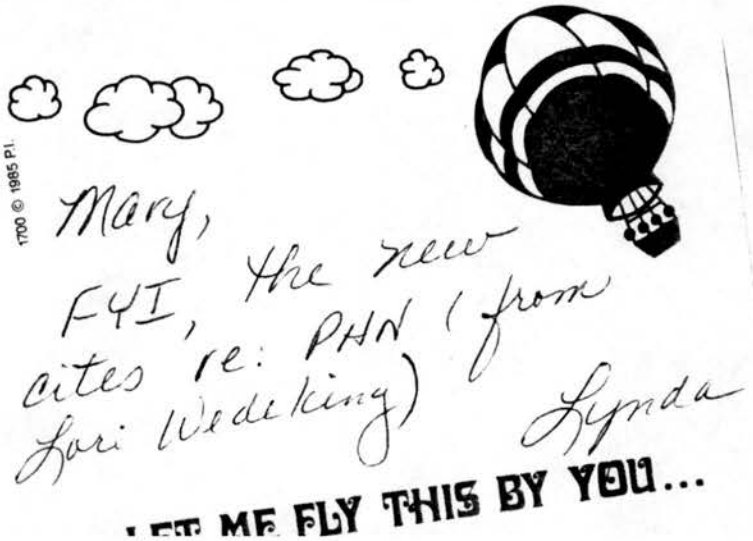
The other editorial changes needed in the CADI rule relate to the recodification of local health law during 1987. This is the change that I did bring up at the last meeting.

On page 6, subp. 43 there are citations noted with the definition of public health nurse. Those citations were repealed in 1987. The correct citation now for the definition of a public health nurse is Minnesota Statute 145A.02, Subd. 18. For clarity, I would suggest the subpart in the rule be rewritten to say:

Public health nurse. "Public health nurse" means a registered nurse certified by the Minnesota Department of Health as a public health nurse under Minnesota Statutes 145A.02, Subd 18., and employed by a ~~local board of health under Minnesota Statutes, section 145.08 to 145.123~~ a public health nursing service as defined in subpart [redacted].

The present subpart 44 also contains repealed language. I would suggest amending subpart 44 as follows: "Public health nursing services" means the nursing program provided by a board of health under Minnesota Statute, ~~145.911 to 145.922~~ 145.10, Subd.1. This change would make a public health nursing service an operation under the Community Health Services system in cooperation with the Minnesota Department of Health. Currently, and we certainly hope far into the future, all counties participate in the CHS system. The new chapter 145A does provide a way for a county to operate a public health services program without participation in CHS. If that option would be the one preferred by you, please contact me and I help you locate a different citation.

lw2/12cadi
03-23-88



MINNESOTA DEPARTMENT OF HEALTH
HEALTH RESOURCES DIVISION

MEMORANDUM

TO: Eleanor Weber
Rules Division
DHS

FROM: Dave Siegel
623-5605

DATE: March 21, 1988

RE: Proposed PAS and ACG rule

This memo follows up our conversation about my suggestion for a technical change to the proposed PAS/ACG rule.

Any references to licensure of home care providers under Minn. Stats. 144A.43 to 144A.47 should also refer to registration under section 144A.49. (In addition, hospices licensed under 144A.48 provide various home care services.)

I suggest the following language:

Part 9505.2465

Subpart 1.

A. "Personal care provider" means ... licensed as a home health agency under Minnesota Statutes, sections 144A.43 to 144A.47, or registered under Minnesota Statutes, section 144A.49.

Subp. 5. **Personal care provider; eligibility.** Except as provided in subpart 11, a local agency that is not licensed or registered as a home health agency under Minnesota Statutes, sections 144A.43 to 144A.47 or 144A.49 ...

The same applies to part 9505.2470, subpart 2, part 9505.2473, subpart 2, and any other references.

Glenwood Retirement Homes

INDEPENDENT LIVING, BOARD & CARE, INTERMEDIATE, SKILLED NURSING

G. H. AMBLE, *Executive Director*

Affiliations

Glenwood Retirement Home, Inc.
Glenwood Retirement Home Foundation, Inc.
Glenwood Nursing Home, Inc.
Glenwood Plaza, Inc.
Glenwood Home Services, Inc.



11 March 1988

Ms Eleanor Weber
Rules Division
Dept. of Public Services
444 Lafayette Rd
St Paul, Mn 55155-3816

RE: Preadmision screening rules

I wish to enter the following comments into the record for the hearing for change in the Minnesota Rules, parts 95055.2390 to 9505.2500.

ADD ITEM 14: The agency (county) shall submit to each nursing home in that county who is charged a fee for the preadmission program an annual report indicating 1) Total number of preadmission screenings done during the past twelve months; 2) Location of the screening process, ie, hospital, residence, nursing home, other; 3) results of screening ie, remain in home, nursing home placement, other type of programs.

Reason for this comment:

Our facility, along with the other homes in the county received a 12% increase in our preadmission screening costs beginning 1 July 1988. I wrote to the local county family service office for the above information and received no information except for the reason the rate was up. I did not ask for names, only numbers and the cost of each screening. I have attached a copy of both my letter and the response.

ADD ITEM 15: The county preadmission screening office shall submit their billings to the facility by the 10th of the each month following month of service.

Reason for this comment:

We have received bills from the county two months old along with the present month for a total of three months payment. In order to keep acturate per day costs, we need the billings on a current basis.

719 S. E. 2nd Street
Glenwood, MN 56334
Phone 612-634-5131

MEMBER: American Association of Homes for the Aged
Minnesota Association of Homes for the Aging

A not-for-profit Organization owned and operated by 8 ALC Congregations
Certified Agency of the American Lutheran Church

I am totally opposed to the county billing the nursing home for preadmission screening with the facility acting as banker for the state, however until that can be changed, I do believe that the nursing home has the right to know what we are paying for. This information will assist the facilities to plan future programs.

Sincerely,

C H Amble
Executive Director

COUNTY O. STEARNS

SOCIAL SERVICE CENTER

– P.S. SERRANO, Director –

700 Mall Germain – Box 1107 – St. Cloud, MN 56302

Social Service .....(612) 255-6000
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Support, Collections, Investigations .....(612) 255-6086
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April 12, 1988



Eleanor Weber
Rules Division
Department of Human Services
444 Lafayette Road
St. Paul, Mn. 55101

Dear Ms. Weber:

We hereby request a public hearing on the proposed Adoption of Rule of the State Department of Human Services Governing Pre-Admission Screening and Alternative Care Grants, MN. Rules, Parts 9505.2390 to 9505.2500.

We wish to protest the public meeting requirements in this rule 9505.2460 Local Agency Selection of ACG Providers. The procedure is complicated, redundant and time consuming for all concerned.

9505.2415 Hospital Notice Requirements

Subp 4. Thirty Day exemption from preadmission screening.
B. The attending physician must certify in the applicant's medical record in the nursing home, that the applicant's expected length of stay in the nursing home will be 30 consecutive days or less.

We would suggest extending that to 60 days for the terminally ill patient.

Sincerely,

Beverly Webb
Social Service Supervisor
255-6007
STEARNS COUNTY SOCIAL SERVICE CENTER

BW/lk

COMMUNITY HEALTH DEPARTMENT
Pre-Admission Screening Program
7th Floor, Harrington Hall
619 South 5th Street
Minneapolis, Minnesota 55415



Eleanor Weber
Rules Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816

April 11, 1988

Dear Ms. Weber,

I am writing regarding the Pre-admission Screening and Alternative Care Grants, Minnesota Rules, Parts 9505.2390 to 9505.2505. Listed below are the three areas of concern that I have with the proposed rule:

1. Pre-Admission Screening Requirement (9505.2400, subpart 1-F p.10 line 14): I am requesting that the statement be changed to read "an applicant who has been screened and who has received services from a certified home health agency since the screening"; my proposed change is consistent with the intent of the Pre-Admission Screening (PAS) law, because the applicant has obviously chosen to use community services rather than enter a nursing home after a screening; the fact that the client is not currently receiving services is not as important as the fact that the client tried to stay at home with services; I don't believe that mandating more screenings of an applicant who has used community care is necessary.

2. Submittal of ACG client information to the county of financial responsibility (9505.2425, subpart 10-A p.22 line 16); I am requesting the deletion of the requirement that the county of service must send the county of financial responsibility the entire 10 page screening tool; there is no point in sending the entire form when in the very next subpart of the Rule (subpart 11-A p.22) the county of financial responsibility must approve the proposed individual service plan when the cost of the plan meets the Program's financial limitations regardless of the data in the 10 page tool since the county of financial responsibility has virtually no discretion, why burden that county with meaningless paper?

HENNEPIN COUNTY
an equal opportunity employer

3. Establishment of Individual Service Plan (9505.2430 subpart 4, B-6, p.27 line 18): I am requesting the deletion of the requirement that the treatment plan identifies "the funding sources for the community services"; in Hennepin County there are 400 different agencies providing community based care, and it would be an administrative nightmare to try to identify the exact funding source for each of the services that each of the 400 agencies provide.

4. Case Manager actions to assure safety and health of ACG client who is vulnerable (9505.2458 line 17) I am requesting that the word "provide"... be changed to "arrange" in the statement about another living arrangement, because the county can find and recommend another living arrangement i.e. nursing home, foster care but the county doesn't technically provide living arrangements - at least in Hennepin County under the ACG program.

5. Authorization to Release Information (9505.2425 subpart 14): I am requesting that County Government be allowed to release information about clients between Departments or Bureaus in the County for the purposes of screening an applicant; currently in Hennepin County the Bureau of Social Services cannot release computerized information about its clients to the Pre-Admission Screening Program in the Bureau of Health because of restrictions in the data privacy rules; I have talked to DHS staff who specialize in data privacy as well as to Barb Colliander and Mary Bruns who have told me that this problem can be addressed in the revision of Rule 65.

If you have questions, or comments, or need more information from me, I can be reached at the address above or at 348-4464.

Sincerely,

Todd Monson

Todd Monson
Program Supervisor
NHPAS Program

In the Matter of the Adoption
of State Department of Human Services
Rules Governing Preadmission Screening
and Alternative Care Grants,.
Minnesota Rules, Parts 9505.2390 to
9505.2500

DECLARATION OF
COUNSEL

I, Deborah Huskins, Special Assistant Attorney General, do hereby declare that I have examined the above-captioned rule, and the supporting rulemaking record, and that, based on my examination, the Administrative Procedure Act and Minnesota Rules, chapter 2010 have been followed. Any exceptions are listed below. For Attorney General billing purposes, the four-digit docket client code is T484.0865

Deborah G. Huskins
Special Assistant
Attorney General

Dated: June 30, 1988

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF THE RULE OF THE STATE DEPARTMENT OF HUMAN SERVICES GOVERNING PREADMISSION SCREENING AND ALTERNATIVE CARE GRANTS, MINNESOTA RULES, PARTS 9505.2390 TO 9505.2500

CERTIFICATE

I hereby certify that the list of persons, associations and other interested groups who have requested, pursuant to Minnesota Statutes, section 14.14, subdivision 1a, and 14.22 or 14.30, that their names be placed on the State Department of Human Services rulemaking mailing list is accurate, complete, and current as of this 9 th day of March, 1988.

Nancy Bishop

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

Human Services Building
444 Lafayette Road
St. Paul, Minnesota 55155-38___

TO: Rita Desmond
515 Transportation Building
St. Paul, MN 55155

6-30-88

FROM: Eleanor Weber EW Supervisor.
74301

SUBJECT: Review of a Rule Adopted Without a Public Hearing; Rules of the State Department of Human Services Governing Preadmission Screening and Alternative Care Grants, Minnesota Rules, Parts 9505.2390 to 9505.2500

Enclosed are the documents required to be submitted under Minnesota Rules, part 2010.0300 for your review of a rule adopted without a public hearing for the above entitled matter.

Official documents in this submitted material include:

1. A copy or photocopy of the notice of solicitation of outside information or opinions as published in the State Register.

2. A copy of the proposed rule with a certificate of approval as to form by the revisor of statutes attached.

3. The notice of intent to adopt a rule without a public hearing as mailed.

4. The statement of need and reasonableness in support of the proposed rule complying with part 2010.0700.

5. The affidavit of mailing the notice of intent to adopt a rule without a public hearing. The affidavits state that the mailing list maintained by the agency pursuant to Minnesota Statutes, sections 14.22 and 14.14, subdivision 1a is accurate, complete, and current and that the notice of intent to adopt the rule without a public hearing was mailed to all persons and groups whose names appear on the list.

6. A copy or photocopy of the notice of intent to adopt the rule without a public hearing as published in the State Register.

Mary Brkas 297-2243 Barb.

7. Four copies of the rule as adopted. Any modification made to the proposed rule is reflected on the rule as adopted and is approved as to form by the revisor of statutes.

8. The findings of fact, conclusions, and order adopting the rule.

9. All written requests, submissions, or comments on the rule received by the agency except requests solely for copies of the rule or of the statement of need and reasonableness.

10. The declaration of the attorney in the attorney general's office who represents the agency.

11. No requests to be notified of submittal of the rule to the Attorney General.

If you have any questions on this submitted material, please call me at 297 4301.

Office of the Revisor of Statutes

Administrative Rules

TITLE: Proposed Permanent Rules Relating to Preadmission Screening and Alternative Care Grants

AGENCY: Department of Human Services

MINNESOTA RULES: Chapter 9505

INCORPORATIONS BY REFERENCE:

Rule Numbers and Material Incorporated:

9505.2440; and 9505.2490, subpart 1: The Urban Consumer Price Index (CPI-U) for Minneapolis-St. Paul new series index (1967 = 100) as published by the Bureau of Labor Statistics, United States Department of Labor.

The attached rules are approved for publication in the State Register

John C. Fuller
Assistant Deputy Revisor

Office of the Revisor of Statutes

Administrative Rules

TITLE: Proposed Permanent Rules Relating to Preadmission Screening and Alternative Care Grants

AGENCY: Department of Human Services

MINNESOTA RULES: Chapter 9505

INCORPORATIONS BY REFERENCE:

Rule Numbers and Material Incorporated:

9505.2440; and 9505.2490, subpart 1: The Urban Consumer Price Index (CPI-U) for Minneapolis-St. Paul new series index (1967 = 100) as published by the Bureau of Labor Statistics, United States Department of Labor.

The attached rules are approved for publication in the State Register

JCF / [signature]

John C. Fuller
Assistant Deputy Revisor

Department of Human Services

Outside Opinion Sought Concerning Rules Regarding Preadmission Screening and Alternative Care Grants

Notice is hereby given that the Minnesota Department of Human Services is considering draft amendments to DHS rule parts 9505.2250 through 9505.2380, Preadmission Screening and Alternative Care Grants.

Parts 9505.2250 through 9505.2380 govern county responsibilities in the completion of preadmission screening for all applicants to licensed nursing homes or boarding care homes. The rule parts also govern the distribution of alternative care grant (ACG) funds to applicants who choose to remain in the community and use community services.

The proposed amendments will clarify existing rule provisions and administrative practices and specify new requirements under 1985 changes to Minnesota Statutes, section 256B.091. The 1985 changes mandate preadmission screening of *all* applicants to licensed nursing homes and boarding care homes. Prior to 1985, preadmission screening was mandated only for applicants who are eligible for medical assistance or who would become eligible for medical assistance within 180 days of being admitted to a licensed nursing home or boarding care home.

The proposed amendments will also specify the new requirements of Minnesota Statutes 1985, section 256B.091, subdivision 8, that limit ACG funds to individuals for whom a preadmission screening team would recommend licensed nursing home or boarding care home admission if the alternative care were not available; who are receiving medical assistance or who would be eligible for medical assistance within 180 days of admission to a licensed nursing home or boarding care home; who need services at that time that are not available at that time in the county through other public assistance; and who are age 65 or older.

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

Mary Bruns
DHS Preadmission Screening and Alternative Care Grants Program
6th Floor, Space Center Building
444 LaFayette Road
St. Paul, MN 55101

Oral statements of information and comment will be received during regular business hours over the telephone at (612) 297-2243.

Metropolitan Council

Public Hearing: Recreation Open Space Development Guide/Policy Plan

The Metropolitan Systems Committee of the Metropolitan Council will hold a public hearing on Monday, September 30, 1985, at 7:00 p.m. in the Council Chambers, 300 Metro Square Building, 7th and Robert Streets, St. Paul, Minnesota, to receive public comment on the updated *Recreation Open Space Development Guide/Policy Plan*.

The Minnesota Legislature has charged the Metropolitan Council with two distinct responsibilities for parks and recreation in the Twin Cities Metropolitan Area. The first charge is to "prepare and adopt . . . a comprehensive development guide for the Metropolitan Area" that "shall recognize and encompass physical, social or economic needs . . . including . . . land use, parks and open space land needs" (Minn. Stat., Ch. 473.145, 1978). The second charge, in the Metropolitan Parks Act (Minn. Stat., Ch. 473.147, 1978), contains a specific mandate to plan and administer a program of grants to implementing agencies for the acquisition and development of a system of regional recreation open space.

The *Recreation Open Space Development Guide/Policy Plan* responds to both legislative directives. It updates and replaces the Recreation Open Space chapter of the *Metropolitan Development Guide* adopted by the Council in November 1980. The Council and the Metropolitan Parks and Open Space Commission will use this policy plan as a basis for awarding acquisition and development grants for regional park funds; as a set of policies, standards and criteria to review state and federal park grants and other matters referred to the Council for review; and as a set of procedures for the activities and responsibilities of the Council, commission and implementing agencies that carry out the acquisition, development, operation and maintenance of the regional system.

All interested persons are encouraged to attend the hearing and offer comments. People may register to speak in advance by contacting Lucy Thompson at 291-6521. Questions about the policy plan should be directed to Jack Mauritz of the Council's Parks