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.)

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 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