7/30/90

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

In the Matter of Proposed Rule Amendments of the Department of Human Services Relating to Nursing Home Preadmission Screening, Minnesota Rules, parts 9505.2440 and 9505.2445 and the Alternative Care Grant Program, Minnesota Rules, parts 9505.2395, 9505.2455, 9505.2465, and 9505.2490.

STATEMENT OF NEED AND REASONABLENESS

Introduction

The proposed rule amendments govern Preadmission Screening (PAS) and Alternative Care Grant (ACG) standards and procedures under the Medical Assistance (MA) program, Minnesota Rules, parts 9505.2455, subparts 5 and 8; 9505.2465, subpart 4; and 9505.2490, subparts 1 and 2. The adoption of these amendments is authorized by Minnesota Statutes, section 256B.091, subdivisions 8 and 9, which require the agency to establish procedures for employing or contracting for services and for determining the use of grants for payment of costs of providing care-related supplies, the limits on rates for payment of approved services, and the limits on the total cost of an alternative care grant to an alternative care grant client.

The proposed amendments to parts 9505.2395, 9505.2440, 9505.2445, 9505.2455, 9505.2456, and 9505.2490 would enable the department to: 1) comply with a waiver from the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services; 2) qualify for federal funding of certain medical services and equipment that would otherwise require state funds; 3) establish more accurate reimbursement rates for Preadmission Screening; 4) more efficiently monitor the expenditure of ACG funds and set rate adjustments; and 5) set uniform program recipient and provider qualifications.

History of Preadmision Screening and Alternative Care Grants

Minnesota has implemented a program to reduce inappropriate nursing home and boarding care home placement, reduce the cost of long term nursing home care, and to provide a system of home and community based services as an alternative to institutionalization of the elderly. Since 1980, Minnesota has had a Preadmission Screening (PAS) program, to identify nursing home applicants and residents who would benefit from participation in an alternative care program.

In 1981, the Minnesota legislature provided funding for the Alternative Care Grant program to pay for community care services in lieu of nursing home admission or continued nursing home residency. Under the program, state money was appropriated to provide home and community based services for persons who have been screened and found able to remain at home with support services. A cap on the amount of money which could be used for the program was to encourage the most efficient and effective allocation of funds.

The 1981 PAS/ACG legislation granted authority to the Commissioner of Public Welfare to apply for a federal waiver for federal financial participation to expand the availability of services provided through the PAS/ACG program. The PAS/ACG program served 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.

In 1983, all counties were required to participate in the PAS/ACG program 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. Amendments to Minnesota Statutes, section 256B.091, enacted in 1985, required county preadmission screening of all applicants to nursing homes regardless of age or financial status. The amendments also required the assignment of a case classification to the applicant to tie reimbursement to the nursing home to the amount of care required by the applicant. Other amendments were made to the PAS/ACG program in 1986, 1987, 1988, and 1989.

At the heart of the preadmission screening program is the assessment of the nursing home applicant's health and health-related 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 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 2,076 Medicaid clients statewide with an average per capita annual expenditure of $3,001. For these persons in federal fiscal year 1989, the federal government pays 52.74 percent of the costs, the state provides 42.53 percent and the county pays 4.73 percent. Clients who would be eligible for MA or MA-waivered funds 180 days after admission to a nursing home are funded 90 percent from state funds and 10 percent from county funds under the Alternative Care Grant program.

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. Minnesota Statutes, section 256B.04, subdivision 4, mandates that the state agency cooperate with the federal government in any reasonable manner as may be necessary to qualify for federal aid in connection with the medical assistance program. Though the state legislature could change those requirements in state law, those changes may not be implemented without risking loss of federal financial participation. Changes in the waiver can be requested, but the federal government has indicated that waiver extension applications that were different from the original waiver would be treated as new applications.

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 Procedure Act (APA). Rules for the PAS/ACG program were first promulgated in 1982. Changes to the PAS/ACG legislation in 1983, 1985, 1986, and 1987, and changes in administrative policy created the need to amend the PAS/ACG rules of 1982. Further changes to the PAS/ACG legislation in 1988 and amendments to the federal waiver created the need to amend the PAS/ACG rules of 1988.

Public Participation

Minnesota Statutes, section 245A.09, subdivision 6, requires, in part, that in developing rules and regulations the commissioner consult with appropriate state agencies, persons or relatives of persons who use the service, advocacy groups, representatives of providers of the service, and experts in relevant professional fields. Throughout the development of these proposed rule amendments, the department provided numerous opportunities for input, both from the public and from the individuals and agencies identified in the PAS/ACG medical assistance programs.

On June 19, 1989, and again on August 14, 1989, the Department published a Notice of Intent to Solicit Outside Opinion in the State Register.

On September 19, 1989, the Department of Human Services convened an advisory committee to provide input into the development of these proposed rule amendments. To meet the requirements under Minnesota Statutes, section 245A.09, subdivision 6, and to gain needed input into the development of these rules, the department invited individuals who are knowledgeable in the field of medical assistance programs and representative of a broad range of interests and viewpoints to participate in the advisory committee. Ten individuals agreed to serve on the committee. (See Exhibit 1.)
The advisory committee was comprised of representatives from the following agencies or organizations: four county social service departments; a senior citizen advocacy group; two care providers; a nursing professional association; and a public health agency.

In addition, all comments and criticisms received from interested parties have been considered by the department staff.

9505.2395 DEFINITIONS.

Subp. 6. **Alternative care grant services.** Subpart 6 of the definitions defines "alternative grant services," a term used in these rules. The definition lists services which are reimbursable under the grant program. In the proposed amendment, item H, "extended medical supplies and equipment," has been added to the list of covered services. It is necessary to amend the list because the waiver has been amended by HCFA to include "extended medical supplies and equipment" as a service available to recipients. It is reasonable to include the term on the list of covered services to inform affected persons of services which are provided and reimbursable by the program and encourage full use of the program.

Subp. 19a. **Extended medical supplies and equipment.** Subpart 19a of the definitions defines the term "extended medical supplies and equipment". The definition is necessary to clarify a term used in these rules and to inform recipients, providers, and county agencies of equipment and services that qualify for reimbursement by MA-waivered federal funds and "180 day eligible" funds authorized by Minnesota Statutes, section 256B.091, subdivision 8(2). The definition is reasonable because it incorporates the definition used in the MA definition in part 9505.0310 except that the limitations on the amount, scope, and duration of the supplies and equipment specified in part 9505.0310 do not apply to ACG clients. The definition is also reasonable because it complies with the requirements of the federal MA-waiver which permits the expenditure of MA-waivered funds for certain medical supplies and equipment. Since the definition is similar to the MA definition, it complies with Minnesota Statutes,section 256B.04, subdivision 2, which directs the state agency to make rules for the uniform administration of medical assistance throughout the state. Because the definition uses terminology of the federal waiver, it also complies with Minnesota Statutes 256B.04, subd. 4, which requires the agency to cooperate with the federal government to qualify for federal aid in connection with the medical assistance program. The use of the term "extended medical supplies and equipment" is reasonable because it distinguishes services provided under the waiver from "supplies and equipment" services provided under the MA program. See the amendment of part 9505.2455, subpart 5 and its SNR about the eligibility of extended medical supplies and equipment for reimbursement as an ACG service.

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. This part, which sets screening rates, is necessary to comply with the statutory mandate.

Currently, the department uses the change in the Consumer Price Index - Urban (CPI-U) to annually adjust the screening reimbursement rate. However, the federal Bureau of Labor Statistics advises against using local broad-based indexes for cost adjustments because such indexes are subject to excessive variations. The department is proposing to use, in place of the CPI-U, the Home Health Agency Market Basket of Operating Costs. The Market Basket, a table of health care costs which is copyrighted and published quarterly, is a reasonable alternative to the CPI-U because it more accurately reflects changes in the cost of services related to home health care, including preadmission screening. Moreover, the Market Basket is in common usage for adjusting similar costs in other state programs, such as the Community Alternatives for Disabled Individuals (CADI) program.

It is necessary to specify which quarterly Market Basket table to use in adjusting rates in order to give adequate notice to concerned parties of the established standard. Preadmission screening rates affect the payment rates calculated by the department for nursing home care under parts 9549.0010 to 9549.0080. The nursing home rates take effect on July 1 annually. These rates are determined by the Audits Division of the department. Therefore, the Audits Division must receive data necessary to rate calculations in a timely manner. Use of fourth quarter data is reasonable because it gives the state the most recent information available in time to complete the required nursing home payment rate calculations by the July 1 effective date. See 9549.0020, subpart 36, which defines "rate year" for nursing homes participating in the medical assistance program.

Part 9505.2445 Reimbursement for Preadmission Screening. This part is being amended to provide a sliding fee scale for the payment of preadmission screening costs for persons who are not applicants to or residents of nursing homes that participate in the MA program. The amendment is necessary to comply with the mandate of Minnesota Statutes, section 256B.091 and to inform interested parties of eligibility standards such that they may fully participate in the program or meet program requirements for reimbursement.

Subp. 2. **Medical assistance reimbursement for preadmission screening of a recipient.** Subpart 2 of the existing rule provides for preadmission screening in the case of MA recipients, while existing subpart 3 covers non-recipients. These subparts are combined in the proposed amendment of subpart 3. Thus subpart 2 no longer is necessary and is being repealed. It is reasonable to put all provisions about reimbursement for preadmission screening in the same subpart in order to inform affected persons and simplify the rule.

Subp. 3. **Reimbursement for preadmission screening.** The existing subpart directs the department to reimburse local agencies for screening costs for MA recipients through the Medical Assistance program. The amendment provides for the nursing home to reimburse the local agency for screening costs. The nursing home, in turn, would receive reimbursement from the Medical Assistance program by including screening costs in operating costs that are billed to the department.

Item A, as amended, directs the nursing home to pay the local agency for preadmission screening for all nursing home applicants and residents, which would include private pay persons and MA recipients. Under item A, as amended, the nursing home would receive reimbursement from the department as part of operating costs that are reimbursable by MA. The basis for payment by the nursing home is an estimated monthly amount determined by the county in accordance with Minnesota Statutes, section 256B.091, subdivision 4. Item A is necessary to comply with the requirements of Minnesota Statutes, section 256B.091, subdivision 4, and is reasonable because it incorporates the standards set forth in the statute. The reporting requirement of this provision is necessary to estimate screening costs for the allocation of funds, and is reasonable because it adopts the standard set forth in Minnesota Statutes, section 256B.431, subdivision 2b, clause (g).

Item B of subpart 2 of the proposed amendment provides that the local agency may bill the entire cost of preadmission screening to a person who requests a screening and is neither an applicant to, nor a resident of, a nursing home and would not be eligible for medical assistance within 180 days of admission to a nursing home. This item is necessary to implement Minnesota Statutes, section 256B.091. subd. 4, which requires that screening costs, based on a

sliding fee scale determined by the commissioner, be assessed against all persons who are not nursing home applicants or residents and who request preadmission screening. The item is reasonable because it assesses full cost of screening against those without immediate or foreseeable financial needs. These persons are neither currently eligible to receive MA nor eligible to receive MA within 180 days of admission to a nursing home.

Item C of subpart 2 of the proposed amendment implements the sliding fee scale for yet another class of persons. The item permits the commissioner to assess 50% of screening costs against persons who request a screening and would be eligible for Medical Assistance within 180 days of admission to a nursing home, and who are not nursing home applicants or residents. This part is reasonable because it assesses half cost of screening against those with foreseeable financial needs. These persons are not currently eligible for MA but would be eligible within 180 days of admission to a nursing home.

Item D of the proposed amendment sets the sliding scale fee for a final class of persons who desire preadmission screening and are eligible for medical assistance but who are neither nursing home applicants nor residents. These persons have an immediate financial need which qualifies them for MA. Thus, these persons are eligible to have MA pay the cost of the screening. This item is necessary to comply with Minnesota Statutes, section 256B.091, subdivision 4 which requires the commissioner to provide screening to any interested person on a sliding fee scale determined by the commissioner. This part is reasonable because it assesses no screening fee against those with financial need.

Subpart 4. **Required local agency estimate of the cost and number of preadmission screenings.** The proposed amendment of this subpart will require preadmission screening cost estimates of all nursing home applicants and residents. The existing rule only requires estimates of applicants and residents who are not medical assistance recipients. This subpart is necessary because it complies with Minnesota Statutes, section 256B.091, subd. 4, which requires monthly cost estimates on which to base reimbursements for all "applicants and residents" who request preadmission screening. The change in this provision is necessary and reasonable because the class of "applicants and residents" includes both those who receive and do not receive medical assistance.

Subparts 5 and 6. Subparts 5 and 6 have been changed only to the extent necessary to clarify current rule language, consistent with the requirements of the statute and the substantive changes proposed in subpart 3.

9505.2455 **ALTERNATIVE CARE GRANTS.**
Subp. 5. **Extended medical supplies and equipment.** In the proposed amendment, this subpart has new language to clarify the rule and to comply with changes in the federal waiver. The current rule provides for the expenditure of state funds, authorized under Minnesota Statutes, section 256B.091, subd. 8, for supplies and equipment necessary to keep a qualified individual in the community at less cost than if the same individual were placed in a nursing or boarding care home. Prior to the waiver for which the amendment is offered, all medical supplies and equipment had to be paid by the state portion of the Alternative Care Grant program. The amendment specifies that regular MA funds will be used by recipients for supplies and equipment normally covered by the medical assistance program. Under the amendments, MA waivered funds will be used for MA eligible persons when

required supplies and equipment are not otherwise covered by the regular medical assistance program. ACG funds will be used for supplies and equipment for persons who would be eligible for MA within 180 days of application.

The term "extended medical supplies and equipment" supplants the term "supplies and equipment" to comply with the terms of the federal waiver and is used to distinguish services covered under the waiver and state alternative grant programs from those covered by the medical assistance program. Items A to F of the amendment reorganize the existing rule for clarity. The amendment also provides for an automatic escalator for the "prior authorization" dollar limit used to determine when ACG expenditures must be justified. No use of waivered funds or an automatic escalator is made in the existing rule.

Item A of the amendment is essentially unchanged in language from the existing rule and specifies that reimbursement for extended supplies and equipment is available only where not otherwise covered by third party payers or Medicare health insurance provided under Title XVIII of the Social Security Act. The limitation provided by this item is required by Minnesota Statutes, section 256B.091, subdivision 8(3) and the federal waiver.

Items B and C of the amendment are essentially unchanged from subpart 5(c) of the existing rule. Item B requires that the extended equipment and supplies are necessary, as determined by the department, to enable the client to remain in the community. Item C requires that the cost of all alternative community services and equipment and supplies needed to keep the client in the community are less the cost of institutionalization, as specified in subpart 8 of the rule. These comply with the requirements of Minnesota Statutes, section 256B.091, subdivision 8(1) and the federal waiver.

Item D requires prior authorization for expenditures for supplies and equipment that amount to $150 per month or more per item. This is essentially the same prior authorization requirement of the existing rule, except that the dollar amount has been raised from $100. The increase in the dollar amount limit is necessary because the inflation rate of medical supplies and equipment has increased dramatically since the original limit was established in 1982. The initial adjustment to the limit to $150 represents an increase of fifty percent, and is reasonable because it compares to a total inflationary increase in medical supplies and equipment of 80 percent for the period since rate program was established in 1982. See, Home Health Agency Market Basket of Operating Costs, Health Care Costs, Index of Supplies and Equipment (Data Resources, Inc.).

The increased limit is also necessary to reduce the considerable time, effort, and expense local agencies and the department consume in repeatedly using the prior authorization process. The increased limit is reasonable because it will reduce requests for prior authorization, and a corresponding percentage of local agency and department resources, by an estimated 41%.

Item E reorganizes and clarifies the existing rule which determined how ACG funds were allocated to various types of clients. Item E also takes into account the changes in the federal waiver that permits a wider application of waivered funds.

Subitem (1) applies to MA recipients who need supplies and equipment which are covered by MA. Under the amendment, reimbursement for the materials is through the MA program. This subitem is essentially the same as the existing rule.

Subitem (2) of the amendment is new and reflects changes in the federal waiver which permit the use of waivered funds for extended medical supplies and equipment for MA recipients where such supplies and equipment are not covered by MA but are nevertheless necessary to keep the client in the community in lieu of more costly institutionalization. This subitem is necessary to comply with Minnesota Statutes, section 256B.04, subdivision 4, which requires that the state agency cooperate with the federal government in any reasonable manner as may be necessary to qualify for federal aid in connection with the medical assistance program. The subitem is reasonable because it enables the state to qualify for federal funding for an additional class of services and equipment that are not covered by regular MA. This additional funding will help to further avoid unnecessary institutionalization and state expense while expanding the availability of services and supplies and equipment, as required by Minnesota Statutes, section 256B.091.

Subitem (3) specifies that clients who are not MA recipients shall have qualified extended medical supplies and equipment reimbursed through state ACG funds subject to the prior authorization requirements of Item D. Subitem (3) is essentially the same as existing subpart 5, item B.

Item F of the amendment establishes a method by which the limit for which prior approval is required is regularly adjusted. This provision is necessary to eliminate otherwise unnecessary and costly periodic amendments to the rules and is consistent with Minnesota Statutes, section 256B.04, subdivision 2. The method is reasonable because it ties the increased limits to a market basket indicator that accurately reflects the changes in the costs of medical supplies and equipment.

Subpart 6. **Supervision costs.** The amendment to this subpart clarifies how the cost of supervision of ACG service providers will be paid. The amendment is necessary to comply with Minnesota Statutes, section 256B.04, subdivision 2, which mandates the department to establish uniform assistance rates. This part of the amendment is reasonable because it establishes a rate for the service that is consistent with the MA rate for equivalent services, as specified by the rule amendment under 9505.2490, subpart 1.

Subpart 8. **Monthly limit on costs of ACG client services.** The amendment to this subpart is necessary to clarify the method used to calculate ACG limits and to inform affected persons of such limits which are specified in the waiver.

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. The standard is consistent with the waiver.

The current provision of this subpart sets a limit on the monthly expenditure 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 covered under MA, and supplies and equipment. To calculate the limit, the current rule uses the total statewide monthly average payment rate for the resident class that would be assigned the ACG recipient under parts 9549.0050 to 9549.0059, calculated from the payments

for the cost of providing nursing home service to persons in the resident class and according to parts 9549.0010 to 9549.0080.

The amendment clarifies the calculation method by including in the calculation a deduction of the statewide average monthly income of nursing home residents age 65 and older who are medical assistance recipients.

A recipient's obligation to "spend down" or reduce assets depends on whether a recipient has excess monthly income and, if so, the amount of the excess. Medical assistance pays that portion of the nursing home payment rate applicable to the medical assistance recipient's care that remains after the deduction of the recipient's required spend-down. Thus, the deduction of the statewide average monthly income of nursing home residents who are medical assistance recipients from the statewide monthly average nursing home rate yields the average medical assistance payment for a nursing home resident who is 65 years of age or older and of the same resident class as a ACG client. This calculation is consistent with the waiver which specifies that costs reimbursed under the waiver cannot exceed what medical assistance would otherwise spend for institutional costs for a person. It is reasonable to use this comparison as it ensures coordination between rules applying to the medical assistance program and, thus, reduces the likelihood of confusion about the basis for comparison.

Specifying the costs to be included in the limit is reasonable because it assures compliance with Minnesota Statutes, section 256B.04, subdivision 2 which requires the medical assistance program to be implemented statewide in a uniform manner. Using the statewide monthly average nursing home rates established on or about May 1 and effective July 1 of the fiscal year in which the cost is incurred is reasonable because the bases for the cost and the rate are similar and permits sufficient time to determine the adjusted limit and to notify counties and other affected parties before the beginning of a new ACG waiver year.

Determining the statewide average monthly income of nursing home residents who are recipients must be done in sufficient time to permit the determination of the adjusted limit and to notify counties and other affected parties before the beginning of a new ACG waiver year. It is necessary to specify the time of year to use in calculating the statewide average monthly income of nursing home residents in order to have a uniform method as required under Minnesota Statutes, section 256B.04, subdivision 2. Many nursing home residents receive monthly Retirement, Survivors, and Disability Insurance benefits. These benefits annually are adjusted in January as necessary to reflect inflation. Using the March income of nursing home residents to calculate the average permits the state to base its calculation on recent data. Therefore, March is a reasonable time because the data used in the calculation are up-to-date.

Part 9505.2465. STANDARDS FOR PERSONAL CARE SERVICES

Subpart 4. **Employment of personal care assistants.** The amendment to this provision makes no substantive changes to the current rule, but is necessary and reasonable to clarify who may employ or terminate the services of a personal care assistant. Under the current rule, a personal care assistant must be employed by or under contract with a personal care provider. However, subparts 5 and 11 of the current rule permit a local agency to contract directly with a personal care assistant in certain circumstances. Thus, the amendment recognizes that a personal care assistant must be employed by or under contract with either a personal care provider or a local agency.

9505.2490 RATES FOR ACG SERVICES

Subpart 1. **Statewide maximum ACG service rate.** Minnesota Statutes, section 256B.091 requires the commissioner to set limits on rates for payment of the cost of ACG services. The amendment to this subpart is necessary to more accurately set maximum ACG service rates and adjust rates, consistent with Minnesota Statutes, section 256B.04, subdivision 2, which requires that the department to make uniform rules for the economical and efficient administration of medical assistance, having regard for varying costs of medical care.

The amendment provides for a one time rate adjustment for adult day, homemaker, respite, and personal care services to establish ACG rates at a level which is comparable to rates for similar services provided under other assistance programs, including Medical Assistance (MA) and Community Alternatives for Disabled Individuals (CADI). As in other programs, the supervision of personal care assistants will be billed separately and apart from the covered service. The rates for personal care service and supervision will be increased by the same percentage as increases for similar services under MA. Other services will be adjusted for inflation according to changes in costs as reflected by the Home Health Agency Market Basket. The rates and inflationary adjustments are reasonable because they are consistent with rates and adjustments in other programs and comply with the statutory requirement of uniform rules for the administration of medical assistance.

However, the amendment will freeze the rates for case management and home health aide services until a state study of service rates is completed. The study of the rates used to reimburse case management and home health aide services is being conducted by the department at the present time. The study includes rates for necessary services provided to several populations under federally approved waiver programs of home and community-based services. In addition to ACG, these programs include Community Alternatives for Chronically Ill persons (CAC), Community Alternatives for Disabled Individuals (CADI), and waivered services for persons with mental retardation or related conditions. The study is designed to identify differences and similarities of case management and home health aide services to the different populations and to recommend a uniform approach to reimbursing the cost of the services. When the study is complete, an amendment of this part will be proposed to provide for adjustment of the rate for case management and home health aide services under ACG.

Currently, the department uses the change in the Consumer Price Index - Urban (CPI-U) to annually adjust the rate. However, the federal Bureau of Labor Statistics advises against using local broad based indexes for cost adjustments because such indexes are subject to excessive variations. The department is proposing to use, in place of the CPI-U, the Home Health Agency Market Basket of Operating Costs. The Market Basket, a table in health care costs which is copyrighted and published quarterly, is a reasonable alternative to the CPI-U because it more accurately reflects changes in the cost of services related to home health care, including preadmission screening. Moreover, the Market Basket is in common usage for adjusting similar costs in other state programs, such as the Community Alternatives for Disabled Individuals (CADI) program.

It is necessary to specify which quarterly Market Basket table to use in adjusting rates in order to give adequate notice to concerned parties of the established standard. Maximum payment rates applicable to ACG services that are set by the commissioner under this part affect the ACG service payment rates which are available to the counties as of July 1 annually. Therefore, the information used in adjusting the rates must be available in time to calculate the maximums set by the commissioner and provide these maximums to the counties. Use of the first quarter is reasonable because it gives the

most up-to-date information available in sufficient time to complete the work of setting the maximums for the counties, and notify the counties for their use as of July 1.

Subpart 2. **Local agency maximum ACG service rate set by commissioner; general.** The amendment to this subpart is technical and produces no substantial changes in the current rule. The amendment is nevertheless necessary and reasonable to make the provision consistent with subpart 1, as amended. The amendment makes clear that the maximum rate set by the commissioner in subpart 1, may not be exceeded by the local agency. A local agency may pay less than the maximum set by the commissioner for the local agency. The amendment also replaces the existing CPI-U inflation factor index with the Home Health Care Market Basket index, consistent with the change in subpart 1. This subpart, as amended, remains consistent with the requirements of Minnesota Statutes, section 256B.091, subdivision 8.

SMALL BUSINESS CONSIDERATIONS

This rule is exempt from small business considerations in rulemaking under Minnesota Statutes, section 14.115, subdivision 7, paragraphs (b) and (c).

EXPERT WITNESSES

If this rule should be heard in public hearing, the Department does not plan to have outside expert witnesses testify in its behalf.

Date: July 11, 1990

ANN WYNIA
COMMISSIONER OF HUMAN SERVICES

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES
Human Services Building
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St. Paul, Minnesota 55155-3816

August 6, 1990

Ms. Maryanne Hruby
Exective Director, LCRAR
55 State Office Building
St. Paul, Minnesota 55155

Dear Ms. Hruby:

As required by Minnesota Statutes, section 14.23, I forward a Statement of Need and Reasonableness relating to proposed amendments to permanent rules relating to Nursing Home Preadmission Screening and Alternative Care Program, Minnesota Rules, parts 9505.2395 to 9505.2500.

If you have any questions on the Statement of Need and Reasonableness, please do not hesitate to contact me at 297 4301.

Sincerely,

Eleanor Weber

Eleanor Weber
Rules and Bulletins Division

Enclosure