STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

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

STATEMENT OF NEED AND REASONABLENESS

AUTHORITY FOR RULE 65

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

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

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

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

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

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

DESCRIPTION OF RULE 65

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The state agency expects to call the following expert witnesses:

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

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

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

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

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

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

Arthur E. Noot, Commissioner
Department of Public Welfare

November 20, 198
Date