12 MCAR 2

Department of Public Welfare

Income Maintenance Bureau

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

6-19-82

Rule as Adopted

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

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

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

C. Notification about program.

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

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

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

D. Resource material for screening programs.

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

a. present medical conditions;

b. present unmet needs;

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

d. the recipient's preferences;

e. persons consulted in the screening process;

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

g. assessment of functional capacity; and

h. a preliminary service care plan.

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

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

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

E. Screening ~~procedures~~ requirements.

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

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

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

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

F. Criteria for screening team recommendations.

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

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

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

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

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

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

described in H.

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

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

H. Alternative care grant.

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

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

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

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

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

I. Reimbursement of nursing home costs.

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

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

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

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

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

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

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

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

J. Reimbursement for screening costs.

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

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

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

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

K. Right to appeal.

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

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

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

~~admission to a nursing home.~~

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