PROPOSED RULEMAKING

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CH. 1187]

Nursing Facility Services; Preadmission Requirements and Civil Rights Compliance for Nursing Facilities

The Department of Public Welfare (Department), under the authority of sections 201(2), 206(2) and 403(b) of the Public Welfare Code (62 P. S. §§ 201(2), 206(2) and 403(b)), proposes to amend Chapter 1187 (relating to nursing facility services) to read set forth in Annex A.

Purpose

The proposed rulemaking requires a nursing facility to have applicants evaluated by the Department or its independent assessor for the need for nursing facility services prior to admission to the facility. The clinical evaluation is intended not only to determine an individual's need for nursing facility services, but also to educate the individual regarding other available long-term care service options. The Department expects that when given the information necessary to make an informed choice, more individuals will choose to receive home and community-based services (HCBS) as opposed to institutional services.

The proposed rulemaking also requires a nursing facility to maintain civil rights compliance information on each applicant who has applied for admission. Through review of this information, the Department can ensure that the nursing facility is operating in conformity to applicable laws that prohibit discrimination on the basis of race, color, national origin and disability.

Need for the Proposed Rulemaking

A. *Background*

In 1965, Congress authorized the Medicaid Program by adding Title XIX to the Social Security Act. See 42 U.S.C.A. §§ 1396—1396r. Medicaid is a grant-in-aid program in which the Federal government provides financial assistance to participating states that furnish various health care services to persons who are poor and needy. State participation in the Medicaid Program is voluntary. If a state chooses to participate in the Medicaid Program, it must comply with Title XIX and the implementing Federal regulation. In addition, the state must administer its Medicaid Program in conformity with Title VI of the Civil Rights Act of 1964 (42 U.S.C.A. §§ 2000d—2000d-7) which prohibits discrimination on the basis of race, color or national origin, section 504 of the Rehabilitation Act of 1973 (29 U.S.C.A. § 794) and Title II of the Americans with Disabilities Act (ADA) (42 U.S.C.A. §§ 12131—12165), which prohibits discrimination on the basis of disability.

States that choose to participate in the Medicaid Program must designate a single state agency responsible for the administration of the state's Medicaid Program. The single state agency must prepare a State Plan for Medicaid (State Plan) and submit it to the Centers for Medicare and Medicaid Services (CMS) of the United States Department of Health and Human Services for approval. See section 1902 of the Social Security Act (42 U.S.C.A. § 1396a) regarding state plans for medical assistance). In administering the state Medicaid Program, the state Medicaid agency enrolls qualified individuals, practitioners and medical facilities as providers in the state's Medicaid Program. These Medicaid providers render health care services to eligible Medicaid recipients. If the services are covered by the State Plan and the provider otherwise complies with applicable requirements, the provider may bill and receive payment for the services from the state Medicaid agency. The state Medicaid agency submits claims to the CMS for Federal financial participation in these payments.

In some instances, the conditions for provider participation in a state Medicaid Program are specified in Federal law and regulation. See section 1919 of the Social Security Act (42 U.S.C.A. § 1396r) and 42 CFR Part 483 (relating to requirements for long term care facilities). The state Medicaid agency may also impose its own additional requirements of participation for providers. See 42 CFR 431.51(c) (relating to free choice of providers). Medicaid providers must comply with civil rights requirements, including Title VI of the Civil Rights Act and the ADA (as applicable) as an ongoing condition of participation in the Medicaid Program.

In 1999, the United States Supreme Court issued its decision in *Olmstead v. L.C.*, 527 U. S. 581 (1999) interpreting Title II of the ADA and its implementing Federal regulation. The Supreme Court held in *Olmstead* that the unjustified institutional isolation of persons with disabilities is a form of discrimination prohibited by the ADA. *Id.*, at 597. Following the Supreme Court's decision in *Olmstead*, the CMS sent a series of letters to the State Medicaid Directors discussing the implications of the Court's ruling. In a letter dated January 14, 2000,[1] the CMS suggested, among other things, that states should ensure that "individuals who may be eligible to receive services in more integrated community-based settings . . . are given the opportunity to make informed choices regarding whether—and how—their needs can best be met." The CMS also recommended that states consider "what information, education and referral systems would be useful to ensure that people with disabilities receive the information necessary to make informed choices."

The Commonwealth participates in the Title XIX Medicaid Program. The Department is the designated single State agency responsible for administration of the Commonwealth's Medicaid Program, which is known as the Medical Assistance (MA) Program. The MA Program provides coverage for a wide array of medical services, including nursing facility services, for needy residents of this Commonwealth. Currently, there are 643 licensed nursing facilities in this Commonwealth that are certified MA nursing facility providers.

B. *Preadmission Assessments*

The Department's case-mix regulation in § 1187.22(2) (relating to ongoing responsibilities of nursing facilities) requires MA nursing facility providers to "[a]ssure that every individual who receives MA, who is eligible for MA or who is applying for MA, is reviewed and assessed by the Department or [its] independent assessor and found to need nursing facility services prior to admission to the nursing facility, or in the case of a resident, before authorization for MA payment."

[1] The CMS' letter is available online at www.cms.hhs.gov/states/letters/smd1140a.asp.

The assessments required by this regulation are made by the local area agencies on aging (AAA) through their OPTIONS programs. In making the assessments, an AAA not only determines whether an individual needs nursing facility services, but also whether the individual can be appropriately served in a noninstitutional setting with HCBS.[2] The AAA advises the individual of the available HCBS alternatives that are appropriate to the individual's needs and that will allow the individual to remain in his own home or community.

Consistent with the CMS' recommendation, the Department has examined whether additional information, education and referral systems would be useful to permit consumers to receive the information necessary to make informed choices. The Department has determined that both consumers and the MA Program could benefit by expanding the Department's current requirement for full preadmission OPTIONS assessment to a wider population; namely, individuals who are likely to use MA as a payer source within 12 months of admission. The Department is concerned that, because these individuals might not be aware of the wide variety of service options available to meet their long-term care needs, they might seek placement in an institutional setting without knowing that other alternatives exist. In some instances, these individuals may vacate their apartments, sell their homes or deplete their assets in anticipation of qualifying for MA or to meet their private-pay long-term care expenses in an institutional setting. As a result, after admission to a nursing home, their ability to transition back to the community would be more difficult.

Consumers have advised the Department that they want a broader array of services, the reallocation of public funds away from institutional (nursing facility) services and into HCBS, and that "nursing facilities should not be the primary or only option when long-term care and services are needed." See Pennsylvania Intra-Governmental Council on Long-Term Care, *Long-Term Care and Services, Discussion Session Findings*, Fall 1997, pp. 5.[3] The proposed rulemaking responds to these consumer wishes. By requiring more nursing facility applicants to be evaluated for the need for nursing facility services prior to admission to a facility, more consumers will be advised of other long-term care service options available in their service areas, particularly HCBS, and will have the opportunity to make better informed decisions on the course of action most desirable and appropriate to their particular long-term care needs.

When consumers are given the information necessary to make a truly informed choice, the Department expects that more consumers will choose to receive HCBS, thereby decreasing the MA Program reliance on the more expensive institutional services and effectively making available a greater share of public funds to home and community-based care. Since most people who are admitted to nursing facilities will eventually become eligible for MA nursing facility services, costs to the MA Program are higher than if even a few of those individuals could be diverted to less expensive HCBS.[4]

C. *Civil Rights Data*

MA nursing facility providers must comply with both Federal and State laws that, among other things, prohibit discrimination on the basis of race, color, national origin and disability as a condition of participation in the MA Program. See § 107.3(d) (relating to requirements).

The Department is aware that discrimination can occur through subtle rather than overt means. In whatever form it takes, discrimination on the basis of race, color, national origin or disability is illegal and intolerable.

Current Departmental regulation in § 107.3(d) specifies that MA nursing facility providers "shall admit persons without regard to race, color, national origin or handicap and shall provide care and treatment without discrimination based upon these factors." The regulation, however, does not require nursing facilities to maintain any record of who has applied for admission and how the facilities have acted on those applications. This gap in recordkeeping requirements can result in adverse consequences to the public and to providers. For example, the alleged absence of applications to a nursing facility could be a facile excuse for a facility's homogeneous resident population. Alternatively, the demographics of a facility's resident population might subject a facility to an unfair charge of discrimination simply because the demographics are at variance with those of the community in which the facility is located.

The Department has determined that the maintenance of certain limited data on applicants would help both to deter discrimination as well as to rebut unsubstantiated charges of discrimination.

Requirements

§ 1187.2. Definitions.

The Department is proposing to add the following definitions.

Admission—This definition is intended to identify the circumstances in which a facility's obligations under § 1187.22 and § 1187.31 (relating to admission or MA conversion requirements) arise. The definition follows the Federal Resident Assessment Instrument (RAI) Manual, which specifies when a facility must submit certain Minimum Data Set tracking forms. Under the RAI Manual, a nursing facility must submit certain assessment forms when an individual is admitted to, reenters or is discharged from the facility. Like the RAI Manual, the proposed definition considers an admission to be both the initial entry of an individual and the reentry of an individual who previously had been formally discharged. Like the RAI Manual, the definition also specifies that the reentry of an individual to a facility following a temporary discharge with the intent to return is not considered an admission. A reentry does not trigger requirements such as those in § 1187.31(2). An example of a situation in which a resident would be discharged with an anticipated return is when a resident is on therapeutic leave or in a hospital, but expected to return to the nursing facility. An example of a situation in which a resident would be discharged with no return anticipated is when a resident is discharged to a different nursing facility or to another setting where the individual's needs may be met.

[2] The Department provides HCBS to individuals who would otherwise be clinically eligible for nursing facility services through programs like the PDA Waiver and the Bridge Program, which are jointly administered by the Department of Aging and the Department's Long Term Care Capitated Assistance Program.

[3] See, also Pennsylvania Intra-Governmental Council on Long-Term Care, *Assisted Living Long-Term Care and Services, Discussion Session Findings*, February 1999, pp. 17. Both reports are available at www.longtermcare.state.pa.us/Index.asp?id=119&fs=2>.

[4] Whether an individual will benefit from HCBS depends on the individual's unique facts and circumstances. While not every individual can be served at home or in a community setting, many can be and at significantly lower cost than that of institutional care. For example, the Statewide average cost for a consumer receiving services under the PDA Waiver is $41-42 per day and the maximum per diem cost for services under the PDA Waiver is $105.78. In contrast, the Statewide average MA nursing facility per diem rate is $132.23, or three times greater than the average cost for HCBS.

Clinical evaluation—This definition is intended to identify the evaluation that is required under §§ 1187.22 and 1187.31. Currently, OPTIONS staffs of the local AAAs conduct clinical evaluations.

MA applicant—This definition is intended to identify an individual who is considered by the Department to be an MA applicant and must receive a preadmission clinical evaluation under § 1187.31(2). The definition specifies that an individual who has an application for MA nursing facility services pending before the Department or is likely to become an MA conversion resident within 12 months of the date of admission is an MA applicant. "MA conversion resident" is currently defined in § 1187.2.

MA conversion date—This definition identifies the point in time at which an individual becomes an MA conversion resident.

MA recipient—This definition incorporates the definition of "MA recipient" in § 1101.21 (relating to definitions), except that this definition deletes reference to "family" since it is inapplicable in the context of an MA resident of a nursing facility.

Nursing facility applicant and nursing facility application—These definitions identify the circumstances in which a facility has obligations under § 1187.22(1) and (18). The definitions make clear that both oral and written requests for admission, as defined in this proposed rulemaking, must be considered "applications" for civil rights data reporting requirements. The definitions also specify that a casual inquiry for information about a facility should not be considered an application.

§ 1187.22. Ongoing responsibilities of nursing facilities.

Section 1187.22 delineates conditions of participation for MA nursing facility providers in addition to those specified in Chapter 1101 (relating to general provisions). The proposed rulemaking makes three changes to this section. First, the Department is revising § 1187.22(1) to substitute "nursing facility applicant," which is the new defined term, for "every individual applying for admission to the facility." This amendment reaffirms the existing requirement that all nursing facility applicants must receive a preadmission screening in accordance with the Department's preadmission screening program.

Second, the Department is revising § 1187.22(2). As originally promulgated, this section required that every individual who received MA, was eligible for MA or was applying for MA had to be assessed by the Department or an independent assessor prior to admission to a nursing facility. This section also required that a resident of a nursing facility be assessed before authorizing MA. The Department is revising this provision to use the defined terms "MA applicant," "MA recipient," "MA conversion resident" and "clinical evaluation" and to make clear that compliance with § 1187.31(2) and (4) is a condition of participation in the MA Program.

Third, the Department is adding § 1187.22(18), which imposes certain civil rights data collection and reporting requirements as an additional condition of participation for nursing facility providers. Under this paragraph, a nursing facility shall collect and maintain basic demographic and other data for each nursing facility applicant for a 4-year period. In addition to this data, this paragraph permits a nursing facility to request other information from each applicant as a condition of admission to the facility, unless otherwise precluded by law, so long as the facility uniformly requests the additional information from all applicants and the facility keeps written records of all requests and responses. Finally, the provision requires nursing facilities to keep a copy of the application data for 4 years and to periodically report the data to the Department in a format and at intervals specified by the Department.

§ 1187.31. Admission or MA conversion requirements.

As originally promulgated, § 1187.31(2) sets forth the requirement for preadmission and MA conversion evaluation and determination. The Department is proposing to amend § 1187.31 by placing the preadmission and the MA conversion requirements in separate provisions and by clarifying the circumstances in which a nursing facility is required to ensure that nursing facility applicants and residents receive clinical evaluations.

Preadmission requirements

Section 1187.31(2)(i) requires that every MA applicant and MA recipient receive a clinical evaluation prior to admission, unless one or more of the exceptions in subparagraph (ii) apply. This provision also specifies that a nursing facility may not admit an MA applicant or MA recipient if a preadmission clinical evaluation finds that the applicant or recipient does not need nursing facility services. This provision serves two purposes. It ensures that MA applicants and MA recipients are given information about service alternatives prior to admission so they can make better informed choices about their service delivery and it ensures that the existing supply of MA certified nursing facility beds is efficiently and effectively utilized.

Section 1187.31(2)(ii) identifies the circumstances in which a facility may admit an MA applicant or MA recipient even though the individual has not received a clinical evaluation. These circumstances include instances when an individual's health or safety is at risk because of the abuse, neglect or absence of a responsible caretaker; when the Department or its independent assessor fails to complete an assessment that has been requested in a timely manner; when it is unlikely that an individual will remain a resident of the facility for more than 30 days; when it is unlikely that a resident will use MA as a payment source within 12 months from the individual's admission to a nursing facility; or when an individual is eligible for Medicare skilled nursing facility services when admitted to the nursing facility and the facility contacts the Department or its independent assessor to request an assessment by the close of the next business day.

Section 1187.31(2)(iii) sets forth civil money penalties for nursing facilities that fail to comply with the preadmission assessment requirements. The provision allows for graduated fines and penalties and is intended to motivate facilities to comply with the new preadmission requirements.

Section 1187.31(2)(iv) requires nursing facilities to keep a copy of each preadmission clinical evaluation for 4 years.

MA conversion requirements

Section 1187.31(4)(i) requires a nursing facility to ensure that a resident who submits an MA application after admission receives a clinical evaluation and is determined to be eligible to receive MA nursing facility services before the facility submits a claim for or receives MA payment for services provided to the resident. Section 1187.31(4)(ii) identifies the circumstances in which a new clinical evaluation for an MA conversion resident is not required.

Affected Organizations

This proposed rulemaking would affect nursing facilities enrolled in the MA Program and local AAAs in their role as the Department's independent assessor.

Accomplishments and Benefits

By requiring preadmission assessments for nursing facility applicants who expect to use MA as a payment source within 12 months of admission, the proposed rulemaking will ensure that more consumers are advised of the long-term care service options available in their service areas, particularly HCBS. Knowing the service care options will enable consumers to make better decisions on the course of action most desirable and appropriate to their particular long-term care needs. When given the information necessary to make a truly informed choice, the Department expects that more consumers will choose to receive HCBS, thereby decreasing the MA Program reliance on the more expensive institutional services.

By requiring nursing facilities to maintain and report minimal civil rights information on individuals who have applied for admission, the proposed rulemaking will deter nursing facilities from illegally discriminating in making admissions and will assist facilities that comply with the law to rebut unsubstantiated charges of discrimination.

Fiscal Impact

A. *Public Sector*

Commonwealth

The Department of Aging will incur increased costs to conduct 11,000 preadmission assessments in the first year of implementation of this proposed rulemaking and 6,900 each year thereafter. The approximate cost in the first year is $2.471 million ($1.372 million in Federal funds and $1.099 million in augmentations from the Intergovernmental Transfers). Out year funding is estimated at $1.505 million ($827,750 Federal and $677,250 State Lottery Funds.)

The Department will experience savings in the MA—Long Term Care appropriation to the extent that individuals choose HCBS as opposed to placements in nursing facilities. The savings are estimated at $1.3 million ($718,674 Federal and $594,000 State) in the first year of implementation and roughly $6.3 million ($3.4 Federal and $2.9 million State) each year thereafter.

Political Subdivisions

No fiscal impact is anticipated. Although the proposed rulemaking would cause an initial temporary acceleration in the need for assessments, the vast majority of individuals who are admitted to nursing facilities eventually become eligible for MA nursing facility services, and thus, the total number of assessments that would have normally been conducted in a fiscal year would remain the same.

B. *Private Sector*

Additional costs may be incurred by nursing facilities. The amount of the costs will depend upon each individual facility's current practices and methods relating to the recording of civil rights data and financial assessments.

C. *General Public*

Consumers of long-term care services will experience no adverse fiscal impact. This proposed rulemaking will make it possible for consumers to avail themselves of the wide range of long-term care options to best meet their individual needs.

Paperwork Requirements

Nursing facilities will be required to maintain written records for all nursing facility applicants relating to the individual's clinical evaluation and civil rights data.

Effective Date

This proposed rulemaking shall take effect 60 days after final-form publication in the *Pennsylvania Bulletin*.

Sunset Date

There is no sunset date for these regulations. The Department will review the effectiveness of these regulations on an ongoing basis and evaluate the need for further amendments.

Public Comments

Interested persons are invited to submit written comments, suggestions or objections regarding the proposed rulemaking to the Department of Public Welfare, Office of Medical Assistance Programs, Attention: Regulations Coordinator, Room 515 Health and Welfare Building, Harrisburg, PA 17105 within 30 calendar days after the date of publication of this proposed rulemaking in the *Pennsylvania Bulletin*.

Persons with a disability may use the AT&T Relay Service, (800) 654-5984 (TDD users) or (800) 654-5988 (voice users).

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on July 19, 2005, the Department submitted a copy of this proposed rulemaking and a copy of a Regulatory Analysis Form to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare. A copy of this material is available to the public upon request.

Under section 5(g) of the Regulatory Review Act, IRRC may convey any comments, recommendations or objections to the proposed rulemaking within 30 days of the close of the public comment period. The comments, recommendations or objections must specify the regulatory review criteria which have not been met. The Regulatory Review Act specifies detailed procedures for review, prior to final publication of the rulemaking, by the Department, the General Assembly and the Governor of comments, recommendations or objections raised.

ESTELLE B. RICHMAN,
Secretary

Fiscal Note: 14-493. (1) Lottery Fund; (2) Implementing Year 2005-06 is $1,099,000 (IGT Reserve); (3) 1st Succeeding Year 2006-07 is $677,250; 2nd Succeeding Year 2007-08 is $677,250; 3rd Succeeding Year 2008-09 is $677,250; 4th Succeeding Year 2009-10 is $677,250; 5th Succeeding Year 2010-11 is $677,250; (4) 2003-04 Program—$5,871,000; 2002-03 Program—$5,691,000; 2001-02 Program—$5,482,000; (7) Pre-Admission Assessment; (8) recommends adoption. Funds for 2005-06 are reflected in the proposed budget for the Department. There will be savings in the MA—Long Term Care appropriation of $594,000 in FY 2005-06 and $2,879,000 in FY 2006-07 from these changes.

Annex A

TITLE 55. PUBLIC WELFARE

PART III. MEDICAL ASSISTANCE MANUAL

CHAPTER 1187. NURSING FACILITY SERVICES

Subchapter A. GENERAL PROVISIONS

§ 1187.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

* * * * *

***Admission*—The initial entry of an individual to a nursing facility as a resident of the facility, or the reentry of an individual to a nursing facility as a resident following a discharge when no return was anticipated. The reentry of an individual to a nursing facility as a resident following a discharge with an anticipated return is not an admission.**

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***Clinical evaluation*—A comprehensive assessment by the Department or its independent assessor of an individual's need for nursing facility services and whether the individual's needs may be met in a setting other than a nursing facility.**

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***MA applicant*—An individual who meets one of the following conditions:**

(i) Has submitted an application for MA nursing facility services which is pending before the Department.

(ii) Based upon information provided by the individual or person making a nursing facility application on behalf of the individual, is likely to be an MA conversion resident within 12 months from the date of admission.

***MA conversion date*—The date specified on the Department's notice authorizing MA nursing facility services for an MA conversion resident.**

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***MA recipient*—An individual who is eligible for MA benefits.**

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***Nursing facility applicant*—An individual who makes a nursing facility application or on whose behalf a nursing facility application is made.**

***Nursing facility application*—A request made orally or in writing, by or on behalf of an individual, to a nursing facility asking the facility to consider the individual for admission; or if the individual is hospitalized, asking the nursing facility to consider the individual for admission upon discharge from the hospital. The request must be made to the nursing facility's administrator, admissions officer or other person with real or apparent authority regarding admissions to the nursing facility to be considered an application. A casual inquiry or a request for information regarding a nursing facility, without expressing the intent to be considered for admission, is not an application.**

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Subchapter C. NURSING FACILITY PARTICIPATION

§ 1187.22. Ongoing responsibilities of nursing facilities.

In addition to meeting the ongoing responsibilities established in Chapter 1101 (relating to general provisions), a nursing facility shall, as a condition of participation:

(1) **[Assure] Ensure** that every **[individual applying for admission to the facility] nursing facility applicant** is prescreened by the Department as required by section 1919 of the Social Security Act (42 U.S.C.A. § 1396r(e)(7)) and 42 CFR Part 483, Subpart C (relating to preadmission screening and annual review of mentally ill and mentally retarded individuals).

(2) **[Assure] Ensure** that every **[individual who receives MA, who is eligible for MA or who is applying for MA, is reviewed and assessed by the Department or an independent assessor and found to need nursing facility services prior to admission to the nursing facility, or in the case of a resident, before authorization for MA payment.] MA applicant, MA recipient and MA conversion resident receives a clinical evaluation and that every admission to the facility and MA conversion are made in accordance with § 1187.31(2) and (4) (relating to admission or MA conversion requirements).**

* * * * *

(18) Meet the following civil rights data collection and reporting requirements:

(i) The nursing facility shall collect the following data for each nursing facility applicant:

(A) Name and address including zip code.

(B) The date of application.

(C) Age.

(D) Race or ethnicity.

(E) Gender.

(F) Primary and secondary diagnoses.

(G) Social Security number.

(H) Religion, if volunteered and used as a factor for admission.

(I) Whether the applicant is ventilator dependent.

(J) The date of disposition of the application.

(K) The disposition of the application.

(L) The reason for disposition.

(M) The nursing facility's occupancy rate on the date of disposition of the application.

(ii) The nursing facility shall maintain the data required by subparagraph (i) for 4 years from the date of the applicant's nursing facility application.

(iii) Unless otherwise prohibited by law, nothing in this paragraph precludes the nursing facility from uniformly requesting a nursing facility applicant to provide information in addition to the data required by this paragraph to be considered for admission. If the nursing facility requires a nursing facility applicant to provide any additional information, the facility shall maintain a written record of the additional information requested and received from each nursing facility applicant for 4 years from the date of the applicant's nursing facility application.

(iv) The nursing facility shall submit reports to the Department on the data collected under this paragraph in a format and at intervals specified by the Department.

Subchapter D. DATA REQUIREMENTS FOR NURSING FACILITY APPLICANTS AND RESIDENTS

§ 1187.31. Admission or MA conversion requirements.

To receive payment for nursing facility services, a nursing facility shall meet the following admission or MA conversion requirements:

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(2) *Preadmission* **[** ***or MA conversion evaluation and determination*** **]** ***requirements.***

(i) ***Evaluation and determination***. The nursing facility shall ensure that **[before an MA applicant or recipient is admitted to a nursing facility, or before authorization for MA payment for nursing facility services in the case of a resident, the MA applicant, recipient or resident has been evaluated by the Department or an independent assessor and found to]** the MA applicant and MA recipient who has submitted a nursing facility application to the facility receives a clinical evaluation prior to admission unless one or more of the exceptions in subparagraph (ii) apply. The nursing facility may not admit an MA applicant or MA recipient whose preadmission clinical evaluation found that the individual does not need nursing facility services.

(ii) **[The nursing facility shall maintain a copy of the Department's or the independent assessor's notification of eligibility in the business office.]** ***Exceptions.***

(A) The nursing facility may admit an MA applicant or MA recipient who did not receive a clinical evaluation prior to admission if any of the following apply:

(I) A physician certifies in writing that it is unlikely that the individual will remain a resident of the facility for more than 30 days and payment for the nursing facility services provided to the individual will be made by a payer other than the MA Program.

(II) There is reasonable cause to believe that the individual was abused or neglected as defined in the Older Adult Protective Services Law (35 P. S. §§ 10225.101—10225.5102); the individual's health or safety is at risk because of abuse, neglect or the absence of a responsible caretaker; the nursing facility immediately files a report regarding the individual with the local older adult protective services agency; and the local older adult protective services agency determines that the individual should be admitted to the nursing facility on an emergency basis.

(III) The nursing facility determines that the individual is eligible for Medicare skilled nursing facility services and contacts the Department or its independent assessor to request a clinical evaluation by the close of the next business day following the day on which the individual is admitted to the facility.

(B) The nursing facility may admit an MA applicant who did not receive a clinical evaluation prior to admission if the following conditions are met:

(I) The nursing facility refers the applicant for a clinical evaluation prior to admission.

(II) The applicant provides the Department or its independent assessor with the information necessary to conduct the evaluation.

(III) The Department or its independent assessor notifies the referring nursing facility that it received the information necessary to conduct the evaluation.

(IV) The Department or its independent assessor does not complete the evaluation after receipt of the information within the following time frames:

(-a-) Three working days if the individual is a patient in a hospital at the time the evaluation is requested

(-b-) Five working days if the individual is residing in a community setting, including a personal care home, at the time the evaluation is requested.

(-c-) Ten working days if the individual is a resident of a nursing facility, other than the admitting facility, at the time the evaluation is requested.

(iii) ***Penalties.***

(A) In addition to any other remedies, penalties or sanctions authorized by law and regulation, including, but not limited to, those in Chapter 1101 (relating to general provisions), the Department may impose a civil money penalty if it determines that a nursing facility has admitted an MA applicant or MA recipient who did not receive a clinical evaluation prior to admission, or if it determines that a nursing facility admitted an MA applicant or MA recipient who received a clinical evaluation prior to admission which found that the individual did not need nursing facility services.

(B) A separate civil money penalty may be assessed for each individual admitted in violation of subparagraph (i). The civil money penalty may range from $150—$3,000 per day but the civil money penalty may not be less than the nursing facility's total aggregate charges to the individual for services rendered during the period of noncompliance. In determining the amount of the civil money penalty, the Department will consider the facility's history of compliance with subparagraph (i).

(C) The period of noncompliance begins on the date of the individual's admission to the facility and ends on the date the individual receives a clinical evaluation which finds that the individual needs nursing facility services, or the date the individual is discharged from the facility with no intent to return, whichever date is earlier.

(D) The Department will not assess civil money penalties if the nursing facility establishes that at the time the individual was admitted, one or more of the exceptions of subparagraph (ii) applied.

(iv) ***Maintaining clinical evaluation reports.*** **The nursing facility shall maintain a copy of the report of each MA applicant's or MA recipient's clinical evaluation for 4 years from the date the clinical evaluation is received.**

(3) *MA conversion requirements.*

(i) The nursing facility shall ensure that a resident who submits an application for MA nursing facility services after admission to the facility, has received a clinical evaluation and has been determined by the Department to be clinically and financially eligible for MA nursing facility services before the facility submits a claim for or receives MA payment for nursing facility services provided to the individual.

(ii) A resident of a facility is not required to receive a new clinical evaluation as a result of the resident's application for MA nursing facility services if the following conditions are met:

(A) The resident received a clinical evaluation prior to admission and was determined to need nursing facility services.

(B) The clinical evaluation was conducted within 12 months of the resident's MA conversion date.

(C) The MA conversion date falls within the time period specified on the physician's original written certification determining the resident's need for nursing facility services.

[(3)] (4) * * *

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[(4)] (5) * * *

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