#06-21-05

Bulletin

May 26, 2006

Minnesota Department of Human Services □ P.O. Box 64941 St. Paul, MN 55164-0941

OF INTEREST TO

- County Directors
- Financial Services Supervisors
- Social Services Supervisors and Staff
- County Public Health Nursing Services
- Waiver managers and case managers
- County managed care staff
- Health Plans

ACTION/DUE DATE

Implement Immediately.

EXPIRATION DATE

The policies in this bulletin are ineffective as of December 31, 2007.

Minnesota Senior Health Options Expansion Update

TOPIC

Update on the Minnesota Senior Health Options program for expansion.

PURPOSE

Update information and replace bulletin number #03-21-02..

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SIGNED

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Background of MSHO

The Minnesota Senior Health Options (MSHO) is a managed health care program that combines Medicare and Medicaid financing and services for seniors age 65 and over who are eligible for Medical Assistance (MA), with or without Medicare. MSHO offers all medically necessary MA state plan services, all Medicare services including prescription drugs covered by the Medicare Prescription Drug Program (Part D), Elderly Waiver services, and any alternative services the health plan may choose to offer. The health plan also pays for the first 180 days of nursing facility care for enrollees who enter a nursing facility after enrollment. Enrollment into MSHO is voluntary.

MSHO enrollment began in 1997 with three health plans (Medica, Metropolitan Health Plan (MHP) and UCare Minnesota) serving the seven-county Metro area. In 2001, MSHO expanded to Mille Lacs, Sherburne and Wright counties.

In August 2004, the Minnesota Department Human Services (DHS) issued a Request for Proposals to expand MSHO statewide and add additional health plans in anticipation of the Medicare Prescription Drug program. Through this process, MSHO is now available in 83 counties being served by nine MSHO health plans. (See Attachment 1 for map). The MSHO health plans are Blue Plus, First Plan Blue, HealthPartners, Itasca Medical Care(IMCare), Medica, MHP, PrimeWest, South County Health Alliance, and UCare Minnesota.

A key feature of MSHO is the care coordinator (a nurse, nurse practitioner, or social worker), who is the enrollee's contact person for help in navigating the health care system and in getting needed services across all settings of care.

MSHO is a demonstration program operating with special permission from the federal Centers for Medicare and Medicaid Services (CMS), which waived certain Medicare and Medicaid regulations to allow DHS to have special financing arrangements and other policies for the program. MSHO plans are Special Needs Plans (SNPs), which is a special designation from CMS that allows health plans to serve specific populations, in MSHO's case dual eligibles. In addition to a contract with DHS, each MSHO health plan also contracts directly with CMS for all Medicare services including Part D.

Passive Enrollment

In order to facilitate enrollment of Medicaid recipients into Medicare Part D, CMS announced in mid-2005 that Medicare SNPs who were also contractors for Medicaid managed care could submit proposals to CMS to "passively enroll" the dually eligible members of their Medicaid plans into their Medicare SNP plan. This was a one-time option related to the start up for Part D coverage of prescription drugs under Medicare effective January 1, 2006 and only applied to the Medicare SNP plans. All MSHO plans sent CMS proposals and were approved to some extent for passive enrollment. Recipients eligible for passive enrollment were not to be auto-assigned into a national or regional stand-alone prescription drug plan on January 1, 2006. In August

2005, a list of dual eligibles to be passively enrolled was submitted to CMS. In order to be considered for passive enrollment, a recipient had to be on PMAP in August, not be enrolled in a Medicare Advantage or Medicare cost plan and their PMAP plan had to have a corresponding MSHO plan available in their county of residence.

Recipients on the passive enrollment lists were sent letters in early October indicating that they would be automatically enrolled in MSHO but were given the option of opting out. CMS indicated that recipients who chose to opt out of MSHO would be auto-assigned to a stand alone prescription drug plan for January 1, 2006 unless the recipient chose to enroll in a plan on their own.

The purpose of passive enrollment was to ensure as smooth of a transition as possible to drug coverage under Medicare Part D. Passive enrollment allowed enrollees to get Medicare drugs without having to change health plans, pharmacies and formularies. These enrollees were also able to avoid having to deal with CMS's auto-assignment process. Some recipients chose to opt out of passive enrollment for several reasons. Recipients on EW may have wanted to stay with their county case manager or a medical provider may have chosen to not participate with MSHO.

In Minnesota, passive enrollment had a significant impact because most seniors are enrolled in Medicaid managed care and all of the current nine Medicaid managed care plans are also participating in MSHO as Medicare SNPs. Health plans wanted to be able to keep care for their current Medicaid enrollees intact and integrated rather than having them auto-assigned to a separate and perhaps out-of-state entity for Medicare Part D. There are no provisions for Medicaid managed care plans to receive information from or to coordinate with these free standing Part D plans so care management, communications and drug access might be difficult for those who were auto-assigned to separate drug plans.

CMS experienced significant systems problems with the implementation of Part D on January 1, 2006. These systems problems resulted in some recipients experiencing enrollment problems including those who were passively enrolled into MSHO. DHS and MSHO health plans continue to work with CMS to correct enrollment problems related to MSHO enrollment.

Health Plans and Sub-contractors

DHS contracts with the nine MSHO health plans, which subcontract with providers, care systems and counties to provide health care services to MSHO enrollees.

Each MSHO enrollee is matched with a "care coordinator" to assist with care planning and service access. Care coordination and clinical models differ among the health plans and care systems, but must meet basic criteria under DHS's contract with the health plans. Depending on each health plan's care coordination model, some care coordinators work for the clinics, some for the care systems, some for counties and some directly for the health plans.

MSHO Eligibility Criteria

Who is eligible?

Seniors can enroll if they:

- are 65 years of age or older, and
- are MA-eligible, with or without Medicare. If they have Medicare, they must have both Medicare Parts A and B in order to be eligible for MSHO;
- reside in one of the 83 counties where MSHO is available. The only four counties that **do not** have MSHO available are Beltrami, Clearwater, Hubbard, and Lake of the Woods. (See attachment A – MSHO Service Area Map)

Clients who have elected hospice or who have End Stage Renal Disease are eligible to enroll in MSHO.

Clients who are on waiver programs including EW, CADI, TBI and MR/RC are also eligible to enroll. (See section on waiver services for additional information on the provision of services)

Seniors with waiver obligations and institutional spenddowns may also enroll in MSHO.

MSHO does have the authority to enroll persons with Medical spenddowns but DHS currently has a moratorium on the enrollment of persons with Medical spenddowns until further notice. Persons enrolled in MSHO and who had medical spenddowns prior to July 1, 2005 were allowed to stay on MSHO. If an enrollee acquires a medical spenddown after being enrolled in MSHO, the enrollee can choose to stay enrolled in MSHO. **Persons with Medical Spenddown and not currently enrolled in MSHO are not eligible for MSHO enrollment.**

Excluded Populations

The following recipients are currently **excluded** from participation in the MSHO program:

- Individuals who have Medicare but are not eligible for MA
- Individuals who have MA but have either Medicare Part A or Part B but not both
- Recipients eligible for the Refugee Assistance Program
- Residents of State Regional Treatment Centers, unless the health plan approves placement
- Individuals who are Qualified Medicare Beneficiaries (QMB), as defined in 42 CFR Part 400.202 and who are not otherwise eligible for MA
- Individuals who are Specified Low-Income Medicare Beneficiaries (SLMB), as defined in United States Code, Title 42, section 1396 a(a)(10)(E)(iii) and who are not otherwise eligible for MA
- Individuals who have Medicare coverage through United Mine Workers

As noted above, persons with medical spenddowns prior to MSHO enrollment are not currently enrolled into MSHO.

Questions about MSHO Eligibility

If counties have any questions about whether a client is eligible to enroll in MSHO, they should contact their county managed care unit or the DHS enrollment coordinator assigned to their county. See Attachment B for enrollment coordinator assignments.

Enrollment Process

Enrollment into MSHO is voluntary and may occur through the county or through MSHO health plans and care systems. MSHO enrollments through the county are primarily for clients who have just become eligible for Medicaid, while the health plans and care systems normally handle enrollments for clients already enrolled in managed care (PMAP now also called Minnesota Senior Care (MSC)/Minnesota Senior Care + (MSC+)for seniors). The enrollment process varies somewhat depending on which entity is processing the enrollment.

Enrollment via Health Plans or Care Systems

The health plans and care systems process most MSHO enrollments. The state's MSHO contract allows MSHO health plans to market to any managed care enrollee, including managed care enrollees in other health plans. Care systems, however, may market only to those enrollees already enrolled in the PMAP or MSHO product of the care system's health plan partner. Care system involvement in enrollments is usually for clients in nursing facilities. Health plan and care system marketing activities must follow Medicare and Medicaid marketing regulations, and all marketing materials are reviewed and approved in advance by DHS and CMS. Health plans and care systems use health plan-specific enrollment forms based on a model developed by DHS and approved by CMS. The health plan/care system is required to review and verify the information on the enrollment form including verifying Medicare eligibilty before faxing the enrollment form to DHS. The health plan retains the original form for its records.

Starting in June 2006, health plans will be able to enter enrollments into a batch file that will update MMIS. Training will be provided to health plans choosing this option. All other changes to enrollment and disenrollments will continue to be submitted to DHS for keying.

When filling out the MSHO enrollment form, clients (or their authorized representatives) are required to initial statements to demonstrate that they are making an informed choice about their health care coverage. For example, the current MSHO enrollment form states that clients understand that if they are enrolled in another Medicare health plan, they will be disenrolled from that health plan when they enroll in MSHO. Another statement indicates that enrollees may no longer have a county case manager for home- and community-based services when they enroll in MSHO unless the MSHO health plan contracts with the county for care coordination.

Enrollment via Counties

The county human services agency/managed care unit mails information about managed care options to clients who have just been determined as MA-eligible. Recipients may also choose to attend a presentation on managed care options held by county managed care personnel. Recipients receive each health plan's Primary Care Network Listing (PCNL), a document

describing the health plan's network (hospitals, clinics, etc). DHS-4106B is available for counties to include in enrollment packets to explain MSHO to potential enrollees.

In the county enrollment process, the MSHO enrollment form is similar to the PMAP form, which is provided by the State. MA recipients (or their authorized representative) indicate their choice of health plan either in person or by mail by completing and signing a Health Plan Enrollment Form. If the client wants to enroll in that health plan's MSHO plan, they must check the MSHO statement indicating that is their choice. Recipients may complete the forms on site at the county managed care unit or mail the forms to the county within 30 days. For clients selecting MSHO, the county must fax the enrollment form to the State. The county retains the original copy.

Unlike PMAP enrollments and disenrollments which county staff enter in the Medicaid Management Information System (MMIS), MSHO enrollments and disenrollments received from the counties are entered in MMIS by DHS staff only. This arrangement is due to the need for handling by staff familiar with MSHO's unique Medicare marketing and enrollment procedures.

After receiving an MSHO enrollment form from the county, MSHO staff at DHS (1) review forms for completeness and for enrollee or authorized representative signature (2) verify MSHO eligibility criteria using MMIS (for MA eligibility) and CMS systems for Medicare eligibility. Following this verification process, MSHO staff enters MSHO enrollment into MMIS.

Enrollee Notification of Enrollment

For all MA managed care programs including MSHO, after enrollment into a specific health plan/product is entered in MMIS, the system produces a notice to recipients confirming their enrollment in a specific health plan and the enrollment effective date. New MSHO enrollees also receive a membership packet from the MSHO health plan within 15 calendar days after the health plan receives readable enrollment data from the State.

Effective Date of Enrollment - Enrollment Guidelines

Medicaid managed care enrollment, including MSHO, occurs on a monthly basis. The effective coverage date for MSHO enrollees is as follows:

- When enrollment occurs and has been entered on the State MMIS System on or before the cut-off date, coverage will begin at midnight on the first day of the month following the month of enrollment
- When enrollment occurs and has been entered on the State MMIS System after the cut-off date, coverage will begin at midnight on the first day of the second month following the month in which the recipient enrolls in the health plan
- For MSHO enrollees who are hospitalized in an acute care facility on the first effective date of coverage, hospital costs for the stay begun before enrollment shall not be the responsibility of the health plan

Disenrolling from MSHO – Effect on PMAP enrollment

Enrollment in MSHO is voluntary, and MSHO enrollees may disenroll on a monthly basis. MSHO enrollees may also change to another MSHO plan on a monthly basis. Enrollees who choose to disenroll from MSHO altogether are automatically enrolled in the PMAP product offered by the health plan with which they were enrolled in MSHO. Or, if they were enrolled in another health plan's PMAP product immediately before enrolling in MSHO, they may request that they be enrolled in that health plan's PMAP product upon disenrolling from MSHO. Enrollees are not permitted to choose any other health plan for Medicaid services unless they meet PMAP change guidelines (See Prepaid Minnesota Health Plan Programs Manual, Chapter 3). As noted below, if the enrollee is exercising the one-time change option within the first year of Medicaid managed care enrollment or it is open enrollment, the enrollee may move to any health plan's PMAP product. Additionally, enrollees who meet a PMAP exclusions such as medical spenddowns are disenrolled to MA fee-for-service. SIS-EW/SPMI/licensed HMO voluntary exclusions may apply along with medical spenddowns

The enrollee must request the disenrollment in writing. The enrollee does not need to provide a reason for the request or use a special form. The written request must be signed by the enrollee or authorized representative.

Disenrollment from MSHO is processed according to the following guidelines:

- When disenrollment occurs and is entered in MMIS on or before the enrollment cut-off date, coverage ends at midnight on the first day of the month following the month of disenrollment.
- When disenrollment occurs and has been entered in MMIS after the enrollment cut-off date, coverage ends at midnight on the first day of the second month following the month on disenrollment.
- If an enrollee is terminated due to ineligibility for MA, and the enrollee is hospitalized in an acute care facility on the effective date of ineligibility, coverage will end at midnight on the first day following discharge from the hospital.
- MSHO enrollees may not be disenrolled involuntarily unless they become ineligible for Medical Assistance or their county of residence is no longer in the MSHO service area.

Effect of MSHO Enrollee Enrolling in a Different Part D/Medicare Plan

If an MSHO enrollee voluntarily chooses to enroll into a different health plan for Medicare coverage including a different MSHO health plan, they will be automatically disenrolled from their current MSHO health plan on CMS's system. DHS will disenroll recipients on MMIS to match CMS's system when recipients select a different Medicare plan including a different MSHO health plan.

Effect of MSHO Disenrollment on Medicare Part D Coverage

For those MSHO enrollees with Medicare, MSHO is providing their Medicare Part D Prescription Drug coverage. If voluntarily disenrolling from MSHO, the client must choose another Part D plan in order to have coverage for Medicare Part D prescription drugs. If the client does not choose a Medicare Part D plan, CMS may auto-assign them to a Part D plan. CMS's process for auto-assigning may result in delay or gaps in prescription drug coverage. Any clients disenrolling from one Part D plan including MSHO, is encouraged to actively chose another Part D plan in order to prevent a delay or gap in coverage. Clients disenrolling from MSHO can find additional information on Medicare Part D plans at http://www.medicare.gov or call 1-800-Medicare (1-800-633-4227). In Minnesota, the Linkage Line is available to assist persons in enrolling in Part D plans at 1-800-333-2433.

Loss of Medical Assistance Eligibility

For Special Needs Plans, CMS requires that elderly recipients who lose eligibility under the Medicaid (MA) program continue to receive Medicare benefits including Medicare Part D covered drugs for 30 days to 6 months. The time period is chosen by the SNP. All MSHO health plans have chosen to continue Medicare benefits through their Special Needs Plan for up to 3 months after MA eligibility ended. MMIS will show the person disenrolled from MSHO but the enrollee will have Medicare coverage on the CMS system for up to three months or until the enrollee chooses a new Part D plan. If the enrollee's Medicaid eligibility is reinstated, MMIS will reflect MSHO once again. See re-enrollment below. For this reason, providers are encouraged to use CMS's system of coverage verification for Medicare and Part D benefits. EVS and MN-ITS may show MSHO as closed for MA benefits, while CMS's system would show the enrollee active for Medicare benefits.

Notification to Counties of MSHO Enrollment

Several InfoPac reports are available for counties to review.

PWMW185L-R0504 PPHP Current Enrollment Report for Worker
PWMW1850-R0506 PPHP Potential Enrollee Report
PWMW185I-R0507 MSHO and MnDHO New Enrollee Report
PWMW 186D-R0510 Pre-Capitation Error/Recipient Capitation Error
PWMW185J-R0535 PPHP County Elderly Disenrollment Report

Breaks in MSHO Enrollment

Reinstatement

A client whose termination from the MSHO health plan has been entered into MMIS by the monthly cut-off date may be reinstated for the following month with no lapse in coverage if the client re-establishes MA eligibility and the eligibility is entered into MMIS by the last business day of the month.

When reinstating MSHO enrollees, county workers should simply update the RELG screen in MMIS, save (PF9), and exit. This will automatically update the MSHO enrollment span on RPPH. Counties cannot update MSHO enrollment spans directly on RPPH. Counties should contact their DHS enrollment coordinator if there are problems with reinstating MSHO enrollees.

Re-enrollment

Clients who experience a break in their MA eligibility for up to 90 days because of delays in submitting and processing their eligibility re-certification may be re-enrolled in the MSHO health plan they were previously enrolled in without completing a new enrollment form. If the break in eligibility is for longer than 90 days, then the client must fill out a new enrollment form.

DHS staff monitor a report of MSHO enrollees who have lost MA eligibility. If MA is reopended within 90 days, DHS enrollment staff will re-enroll the client back to the date MSHO was closed so no break in MSHO eligibility exists. DHS notifies the MSHO health plan to open the client up on the health plan's system. If fee-for-service claims including Elderly Waiver (EW) services were paid prior to the MSHO adjustment, DHS will recover claims paid to providers. Providers must rebill the MSHO health plan.

Collection of Waiver Obligations, Medical Spenddowns and Institutional Spenddowns

Waiver Obligations

MA-eligible seniors who have services provided through the EW and have waiver obligations can enroll in MSHO. Prior to June 2005, clients enrolled in MSHO were required to pay their full obligation directly to DHS on a monthly basis. This limited MSHO enrollment to only those clients who met their full waiver obligation on a monthly basis.

The process for the collection of waiver obligations is now a similar process used by DHS for fee-for-service claims. MSHO enrollees with waiver obligations are required to pay their waiver obligations to their providers and the waiver obligation cannot exceed the cost of waiver services received that month. Providers will bill the MSHO health plan for EW covered services. MSHO health plans pay the provider after deducting the waiver obligation. Enrollees cannot be involuntarily disenrolled for non-payment of their waiver obligation. Health plans may assist enrollees in designating providers to receive the waiver obligation in the health plans' payment system.

Medical Spenddowns

Clients who were on MSHO prior to July 2005 with automated monthly medical (AMM) spenddowns or who acquire automated monthly medical (AMM) spenddowns after being enrolled into MSHO may continue enrollment in MSHO. MSHO clients with medical spenddowns are required to pay the full amount of their spenddown to DHS each month.

Therefore, MSHO clients with medical spenddowns should stay enrolled in MSHO only if their monthly MA-covered medical expenses are routinely more than the amount of their medical spenddown. While enrolled in MSHO, these clients are required to pay their full spenddown directly to DHS on a monthly basis. DHS's Special Recovery Unit bills these spenddowns to the client on a monthly basis.

Institutional Spenddowns

See "MSHO Nursing Facility Policies" on page 12.

Provision of Waiver Services and Screenings

Elderly Waiver (EW)

Recipients eligible for EW receive waiver services from the MSHO health plan. Providers providing EW services to MSHO enrollees must bill the MSHO health plan for payment. The MSHO health plan is responsible for entry of screenings into MMIS to open and close EW waiver spans as required by EW policy. The manual that contains instructions for completing and entering LTCC screening documents into MMIS is found on the DHS website at http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4669-ENG
The health plan may sub-contract with clinics, care systems or counties for this function. Attachment C – LTC Functions Under County and MSHO Management outlines screening processes.

CADI, MR/RC and TBI

Recipients age 65 and older and meet other MSHO eligibility criteria and are eligible for CADI, MR/RC, and TBI waivers may enroll into MSHO. These recipients will continue to receive their waiver services through fee-for-service and will continue to be managed by the county. Providers will continue to bill DHS for payment of CADI, MR/RC and TBI services. All other services including state plan home care services must continue to be billed through the MSHO health plan. Counties continue to enter required waiver screens for these waiver clients. MSHO health plans do not enter screens into MMIS for MSHO enrollees on the CADI, MR/RC and TBI waivers. The county waiver case manager and the MSHO care coordinator work together to coordinate services for MSHO enrollees on these three waivers.

Telephone Screens

MSHO health plans are responsible for conducting and entering telephone screens for their enrollees according to bulletins issued by DHS. These are listed on Attachment D. Counties do not conduct or enter telephone screens for MSHO enrollees unless the county is acting as a subcontractor of an MSHO health plan. Attachment C outlines LTC screening policy including MSHO.

DHS as Third Party Administrator for EW

Three MSHO health plans, Blue Plus, South Country Health Alliance and UCare Minnesota have contracted with DHS to be their third party administrator (TPA) for payment of EW services in some counties. Health plans may contract with counties for the entry of service

agreements into MMIS for these services. Providers may be instructed by these health plans to continue to bill DHS for EW services provided to MSHO enrollees. See Provider Update MCO-05-01. Questions regarding billing of EW services for MSHO enrollees should be directed to the MSHO health plan.

Tribal EW
DHS has a contract in place with White Earth that allows for tribal management of EW services. MSHO enrollees who live on the White Earth reservation can choose to have their EW managed by the tribe. If the enrollee chooses this option, the MSHO enrollee will have two case managers: one from the tribe for EW services and one through the MSHO health plan to coordinate all other medical services.

Transitions
If an enrollee chooses MSHO and is currently on EW, the county should contact the MSHO health plan to transition the provision of services to the health plan. If an MSHO enrollee is on EW and chooses to disenroll from MSHO, the MSHO care coordinator should contact the county to transition the provision of services to the county. In neither case should the EW span be closed on MMIS. The county or the health plan who is receiving the new enrollee may choose to do a reassessment at the time of transition but a screening document would not be due until the reassessment date in MMIS. The county should enter service agreements into MMIS based on the services identified by the health plan and the needs indicated on the screening document.

MSHO Eligibility for the Elderly Waiver Maintenance Needs Allowance

RPPR and RWVR Screens on MMIS

In the past, MSHO enollees eligible for EW did not have open waivers spans. Since June 2005, MSHO enrollees eligible for Elderly Waiver services also have open waiver spans on the RWVR screen in MMIS. **EW spans on RWVR for clients who transition from receiving EW services through the county to receiving them through the MSHO health plan should remain open.** When clients receiving EW services through MSHO disenroll from MSHO, the EW span will also remain open.

1. In MMIS
- Verify enrollment in MSHO, Product ID "MA02" on RPPH
- Verify enrollee has an open waiver on RWVR.

2. In MAXIS:

On STAT/DISA:
- For "Elderly Waiver Begin Dt", use waiver begin date.
- For "Health Care Disability Status," use "23" {MA Waiver}
- For "Ver" (Verification), use "8" {LTC Consult Services}
- Enter "Home and Community Based Waiver" type K (diversion)

In HC ELIG: Set up the budget (SIS-EW Budget or SBUD) and waiver obligation (Elderly Waiver or "EWWO") on MAXIS per usual procedures

3. In MMIS:

- On RELG, a "Y" should be coded for the spenddown indicator
- On RSPD, enter a waiver obligation using A – W – M (automated, waiver obligation, monthly) and enter the Waiver Obligation in appropriate field

Worker Messages
If an MSHO enrollee has an RCC-B but the SIS-EW has not been applied, the following worker message is generated: "MSHO WITH EW WVR ELIG EXISTS, BUT SPDN METHOD IS NOT W"

MMIS Edits Related to MSHO, RSPD and Eligibility for SIS-EW

When an MSHO enrollee's rate cell category changes, and the client is no longer eligible for EW, the following warning edit appears in MMIS.

EDIT: WARNING: CHANGE IN WAIVER OBLIGATION ELIG, CONTACT COUNTY CASE MGR

In these cases, DHS notifies the financial worker of change in waiver eligibility

If a financial worker tries to set up a waiver obligation for an MSHO enrollee who is not eligible for SIS-EW, they will get the following edit:

EDIT: MSHO RECIPIENT DOES NOT HAVE ELDERLY WAIVER ELIGIBILITY

Designated Providers for MSHO enrollees

Because MSHO health plans pay for EW services, designated providers should not be set up in MMIS during MSHO enrollment periods. The MSHO enrollee should be referred to their MSHO health plan to see if a designated provider can be set up in the health plan's claims payment system.

If an MSHO care coordinator exits an MSHO enrollee from EW, the MSHO care coordinator is instructed to contact the county financial worker to report this change.

MSHO Nursing Facility Policies

1503 Form

Medicaid-certified nursing facilities are required to send DHS Form 1503 to county financial workers whenever any MA-eligible client is admitted to the facility. Form 1503 serves as

notification to the county that the enrollee has been institutionalized for a short or long-term stay. The county financial worker uses this information to adjust the client's eligibility for MA and calculates institutional spenddowns as needed. This information is also used by CMS to set the Medicare Part D co-pay levels for dually eligible institutional enrollees so it is very important that this information is reported and updated as soon as possible.

County financial workers need to update MAXIS/MMIS with nursing facility admissions information regardless of whether a health plan may be responsible for some of the days. MMIS will track responsibility for payment.

Collection of Institutional Spenddowns During Health Plan Liability

For MSHO enrollees with institutional spenddowns, the Nursing Facility (NF) collects the institutional spenddown (also known as "recipient resource") from the enrollee just as it does for other Medicaid recipients. In cases where the MSHO health plan has responsibility for the 180-day nursing facility benefit, nursing facilities bill the full charges for 180 days of Medicare skilled nursing facility and Medicaid room and board days directly to the health plan, and the health plan pays 100 percent of the negotiated rate. During the months when the plan is responsible for NF services, DHS deducts the institutional spenddown amount from the payment it sends the NF.

Example:
For a NF placement for 30 days at a daily charge of $100/day:

Health Plan payment to NF:	$3,000
NF collects recipient resource:	+$ 200
Total NF receipts - preliminary:	$3,200
DHS debits recipient resource on the Remittance Advice (RA):	- $200
Total NF receipts - final:	$3,000

If, for a given month, the total MA-covered room and board charges incurred for an enrollee is less than the amount of the enrollee's institutional spenddown that was deducted for that month by DHS (including cases where no MA-covered room and board charges were incurred), the NF should contact DHS to arrange for an adjustment.

MSHO, MnDHO, PMAP and Hospice

The hospice policy for MSHO is similar to the policy for other Minnesota Health Care Programs (MHCP) managed care products such as PMAP and MnDHO. MSHO enrollees who elect hospice do not need to disenroll from MSHO. Policies regarding EW and hospice services apply for MSHO as they do for FFS. When an MSHO enrollee elects hospice and resides in a nursing facility, DHS pays room and board directly to the hospice provider, which, in turn, pays the NF. This is true even if the health plan has liability for NF services. If the NF has already collected the institutional spenddown, then the hospice reduces its payment to the NF for room and board by that amount.

During hospice election periods, the hospice and the NF negotiate the payment the hospice makes to the NF for the room and board. Regardless of what the hospice agrees to pay the NF, DHS pays the hospice provider 95% of what MA would have paid the NF if the person had not elected hospice.

See Poli/Temp TE02.07.081 for updating MMIS spenddown information for hospice cases.

180-day Nursing Facility Benefit

If an enrollee who resided in the community at the time of enrollment in MSHO enters a NF sometime after enrollment, the health plan is financially responsible for NF services for the first 180 days. The 180-day period begins at the time of the Enrollee's date of admission to a Skilled Nursing Facility (SNF) or Nursing Facility (NF). Both MA- and Medicare-covered days are counted toward the 180-day benefit period. The 180 days are counted cumulatively. After the 180 days, the NF services are paid by MA on a fee-for-service basis. Nursing facility days during hospice do not count toward the health plan's 180-day obligation.

Transition from PMAP to MSHO

Upon the transition from PMAP to MSHO, the PMAP health plan liability for recipients already in a 90-day NF stay is cancelled and payment responsibility reverts to fee-for-service through DHS on the first of the month of MSHO enrollment.

Appeals and Grievances

Enrollees in the MSHO program have the same appeal and complaint rights as enrollees in other Medicaid managed care programs with the exception of Medicare Part D covered prescription drugs for which CMS requires a different process. For all other covered services, enrollee's have the right to file complaints with their health plan, to contact the State Managed Care Ombudsman's Office, and to file an appeal with the state. MSHO enrollees who have Medicare also have an additional right to file an appeal with a federal administrative law judge if the issue involved is solely a Medicare issue and the enrollee has gone through the state's appeal process. For information on the appeals and grievance process for Medicare Part D covered prescription drugs, enrollees should review their Certificate of Coverage provided by their MSHO health plan or contact their MSHO health plan directly.

Website

For more information about MSHO, check out the website:
http://www.dhs.state.mn.us/healthcare/msho

Legal References

Section 402(a)(1) of the Social Security Act, Public Law No. 90-248, also United States Code 1395b-1, as amended by Section 222(b)(1), Public Law 92-603(42 United States Code, 1395b-1).

Medicaid State Plan Option, Section 1915(a), Social Security Act

Minnesota Statutes, section 256B.69, subdivision 23.

Attachments

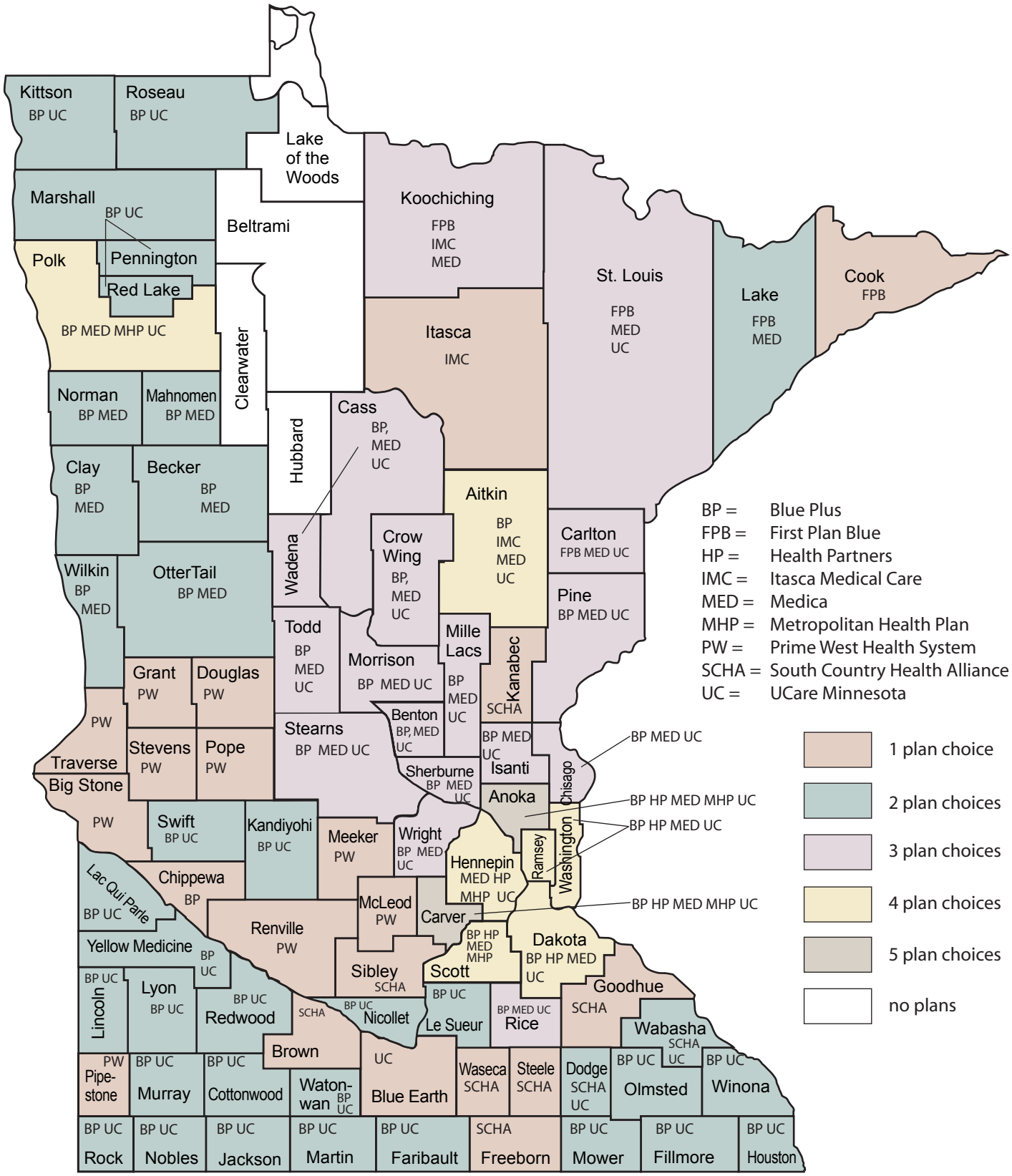
Attachment A – MSHO Service Area Map
Attachment B – DHS enrollment coordinators contact list
Attachment C – LTC Functions Under County and MSHO Management
Attachment D – List of Elderly Waiver Instructional Bulletin and Resources.

Special Needs

This information is available in other forms to people with disabilities by contacting us at 651-431-2478 (voice) or through the Minnesota Relay Service at 1-800-627-3529 (TDD), 7-1-1 or 1-877-627-3848 (speech to speech relay service).

Health Plan Service Areas for Minnesota Senior Health Options (MSHO)

effective January 1, 2006



Minnesota Department of Human Services

www.dhs.state.mn.us/msho/

11/21/2005

SERVICE IMPLEMENTATION SECTION
Jeanine Heller, Supervisor (651) 431-2513
Chris Gibson, Lead (651) 431-2529

PMAP Maintenance Enrollment Coordinators

Jo Ann Jones (651) 431-2524 Maxis email HXC Back-up: Mary	Susan Kennedy (651) 431-2528 Maxis email HJS Back-up: Rotates	Shelly Nelson (651) 431-2542 Maxis email JVG Back-up: Carla	Mary Timm (651) 431-2527 Maxis email WI Back-up:Jo Ann
Anoka (02)	Aitkin (01)	Blue Earth (07)	Becker (03)
Big Stone (06)	Carver (10)	Brown (08)	Cass (11)
Chippewa (12)	Chisago (13)	Cottonwood (17)	Clay (14)
Dakota (19)	Isanti (30)	Dodge (20)	Crow Wing (18)
Douglas (21)	Le Sueur (40)	Faribault (22)	Hennepin (27)
Grant (26)	Mille Lacs (48)	Fillmore (23)	Kittson (35)
Kandiyohi (34)	Nicollet (52)	Freeborn (24)	Mahnomen (44)
LacQuiParle (37)	Pine (58)	Goodhue (25)	Marshall (45)
Lincoln (41)	Rice (66)	Houston (28)	Morrison (49)
Lyon (42)	Scott (70)	Jackson (32)	Norman (54)
McLeod (43)	Sherburne (71)	Kanabec (33)	Otter Tail (56)
Meeker (47)		Martin (46)	Pennington (57)
Murray (51)		Mower (50)	Polk (60)
Nobles (53)		Olmsted (55)	Red Lake (63)
Pipestone (59)		Redwood (64)	Roseau (68)
Pope (61)		Sibley (72)	Todd (77)
Renville (65)		Steele (74)	Wadena (80)
Rock (67)		Wabasha (79)	Wilkin (84)
Stearns (73)		Waseca (81)	
Stevens (75)		Washington (82)	
Swift (76)		Watonwan (83)	
Traverse (78)		Winona (85)	
Yellow Medicine (87)		Wright (86)	

Health Plan Enrollment Coordinators

Jo Ann Jones	Susan Kennedy	Shelly Nelson	Mary Timm
PrimeWest Health System	HealthPartners	South Country Health Alliance	Medica
UCare Minnesota	Metropolitan Health Plan		

Addresses

Physical:
Elmer L. Anderson Human Services Building
540 Cedar Street
St. Paul, MN 55155

Mailing:
Department of Human Se
PO Box 64984
St. Paul, MN 55164-098

11/21/2005

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Other Initiatives

POLICY	
Chris Gibson	MAXIS e-mail - HGX
Appeals - All Programs	
Mary Timm	MAXIS e-mail - WI
PMAP/CBP Expansion and Education Materials	
Jo Ann Jones	MAXIS e-mail - HXC
All MANUALS	
Chris Gibson	MAXIS e-mail - HGX
MinnesotaCare	
Carla Turnbom	MAXIS e-mail - CA
MSHO/MnDHO	
Susan Kennedy	MAXIS e-mail - HJS
Chris Gibson (backup)	MAXIS e-mail - HGX
NF Liability	
Shelly Nelson	MAXIS e-mail - JVG
Open Enrollment	
Mary Timm	MAXIS e-mail - WI

Adjustments: Send requests on MAXIS to 'MADJ'
FAX NUMBERS: Managed Care 651/431-7426 MSHO Only 651/431-7426

Contracting

Health Plan	Contract Manager
Blue Plus	Doris Wong
First Plan	Pam Olson
HealthPartners	Doris Wong
Itasca Medical Care	Mary Freeberg
Medica	Deb Bachrach
Metropolitan Health Plan	Lill Tallaksen
PrimeWest Health System	Lill Tallaksen
South Country Health Alliance	Mary Freeberg
UCare Minnesota	Nancy Paulsen

SERVICE IMPLEMENTATION SECTION
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Chris Gibson, Lead (651) 431-2529

11/21/2005

Carla Turnbom **(651) 431-2525** **Maxis email CA** **Back-up: Shelly**
Benton (05)
Carlton (09)
Cook (16)
Itasca (31)
Koochiching (36)
Lake (38)
Ramsey (62)
St. Louis (69)
Mille Lacs Tribal TANF (88)
MinnesotaCare (MCR)

Carla Turnbom
Blue Plus
First Plan Blue
Itasca Medical Care

ervices

4

SERVICE IMPLEMENTATION SECTION
Jeanine Heller, Supervisor (651) 431-2513
Chris Gibson, Lead (651) 431-2529

11/21/2005

	Phone Number
	(651) 431-2519
(651) 431-2529	(651) 431-2526
(651) 431-2527	(651) 431-2519
(651) 431-2524	(651) 431-2521
(651) 431-2529	(651) 431-2518
(651) 431-2525	(651) 431-2522
(651) 431-2528 (651) 431-2529	(651) 431-2522
(651) 431-2542	(651) 431-2521
(651) 431-2527	(651) 431-2520

- Long Term Care Functions: Preadmission Screening (PAS) Under LTCC and Minnesota Senior Health Options Attachment C

Purpose of PAS Service	People Served	Who Provides the Service	Statutory Timelines & Process Requirements	Forms Used
Preadmission Screening (PAS) ▪ Determine need for NF level of care ▪ Screen for mental illness or mental retardation ▪ Ensure specialized services are provided in the NF for people with MI or MR who are admitted Under state provisions: ▪ Required interventions to avoid . is required for all persons age 20 and under before admission to a nursing facility or certified board and care. See Bulletins 01-25-05 and 01-56-20. ▪ DHS must approve admission and length of stay for people with developmental disabilities of any age. See Bulletin 95-60-1. **PAS**: See **MN Statute Section 256B.0911**, subdivisions 4a – 4d for further information about PAS, exemptions, emergency admissions and screening options.	Required under federal law for *all* persons entering a certified NF or certified boarding care facility, including "swing" beds, regardless of payment source for NF care. **Funding Available** County LTCC allocation Health plan capitations Health plan contract payments to county or other agencies performing PAS duties for the HMO Fee-for-service for face to face assessment for all persons under 65 regardless of public programs eligibility or participation.	***County LTCC staff*:** SW, PHN or both. The county agency may elect to contract "in" staff who function as county employee. Responsible LTCC County: where the hospital is located, or where the person is located for all other admission sources. ***Managed care screeners*:** Under statute and contract, health plans participating in Minnesota Health Care Programs can make the determination of need for NF services and complete Level I screening for their enrolled members participating in Minnesota Health Care Programs. Some plans subcontract with county agencies to do PAS.	***Admission from an acute hospital:*** Before admission for all admissions with a projected length of NF stay of more than 30 days. By the 40th day of admission for a person admitted under a 30 day exemption from an acute hospital who has remained in the facility longer than 30 days. OBRA LEVEL I and LEVEL II are required to be completed within the 40 days as well as the PAS. ***Before any admission from an RTC***. ***Emergency admissions:*** First working day after an emergency admit, or non-exempt hospital transfer on county non-working day. ***Admission from the community:*** Before admission for all admissions from the community. Typically requires a face-to-face visit. A telephone screening is only permitted when a health care professional (physician or clinic nurse, e.g.) is seeking admission and contacts the county LTCC staff or HMO care coordinator directly and can provide the LTCC/screener with enough information to determine the need for NF level of care. ***NF Level of Care Waiver or AC participants*:** PAS is not required to admit a person who has been receiving services in the community that "substitute" for NF level of care. However, OBRA Level I must be completed for all persons. OBRA Level II requirements must be met for all admissions. See Bulletins 97-6-5 and 95-60-1 for Level II information. ***All People Under Age 65:*** Face-to-face visit within 40 working days of admission for persons age 21-64 if phone screening was used to admit. ***All People with Developmental Disabilities:*** See Bulletin 97-6-5 and 95-60-1 for policy and process requirements. DHS *always* must approve admission and length of stay.	***DHS Form 3361***: NF Level of Care Criteria ***DHS Form 3426***: Level I Screening Form County LTCC staff or HMO staff enters a Telephone Screening Document ***DHS Form 3427T*** for all PAS completed by phone. This form documents PAS was completed. This form will be required in MMIS in order for FFS payments to be made for NF services provided to people participating in MA who are not in prepaid health plans This information is also required to be present in MMIS in order for FFS payments to be made to an NF for services provided to a person enrolled in MSHO and who accumulates more than 180 days of NF service (the HMO benefit maximum). The LTC Screening Document ***DHS 3427*** is entered into MMIS for admissions approved during a face-to-face visit. **OBRA LEVEL II NOTE:** OBRA Level 1 is completed for all admissions. OBRA Level II will be coded as "Y" if a referral for completion of Level II activity is made OR if the person is known to have a current completed Level II evaluation.

Long Term Care Functions: Assessment and Support Planning Activity
I. "Early Intervention" Activity
Under LTCC and Minnesota Senior Health Options

Purpose of Early Intervention Service	People Served	Who Provides the Service	Timelines & Process Requirements	Forms Used
MSHO "Risk Assessment" for Community Members Early detection of health needs. Referral for EW or other community services. See Section 6.1.3.A.1 and 6.1.3.A.4 of the managed care contract with DHS.	***All MSHO enrollees living in the community.*** Funded under the HMO capitation. Health plan may subcontract with county or other agencies to perform these duties.	***Managed care screeners*:** Screeners/consultants either employed by or under contract with the HMO. Some plans subcontract with county agencies to perform these initial assessments.	***Within 30 days of enrollment*** for new HMO enrollees. ***Annually*** thereafter. ***Contract requirements*** outline what domains of health and welfare must be addressed in the risk assessment.	Health plans can create their own risk assessment forms. The health plan can opt to perform or contract for these initial and annual member risk assessments by telephone, by mail survey, or in person. Some plans have opted to use DHS 3428 (LTCC Assessment Tool) or 3427 (LTC Screening Document) and have requested that county contracted staff use these tools. A modified LTC Screening Document 3427 is entered into MMIS. See manual "Instructions for Entering the LTC Screening Document in MMIS: MSHO" at http://edocs.dhs.state.mn.us, select DHS 4669-ENG.
MSHO NF Resident Care Plan Assessment Health assessment, evaluation of NF care plan, and relocation intervention. See Section 6.1.3.A.1 and 6.1.3.A.4 of the DHS/managed care contract.	***All MSHO enrollees living in a NF*** Funded under the capitation. Health plan may subcontract with county or other agencies to perform these duties.	***HMO care coordinators*** either employed by or under contract with the HMO. Some plans subcontract with county agencies to perform these activities. Minimum requirement is participation in routine care plan reviews as required in certified NFs.	***Within 30 days of enrollment.*** ***"Routinely"*** according to schedule required in certified NF. ***Contract requirements*** and NF certification requirements outline what domains of health and welfare must be addressed in the NF resident care plan evaluation and assessment.	Health plans can create their own NF resident assessment forms and perform or contract for more frequent or more extensive work with NF residents. No LTC Screening Document is entered into MMIS to record this activity.
LTCC Early Intervention Visit Provides all citizens who have long term care needs access to decision-making support about LTC needs and options. MN Statute 256B.0911	***Any person requesting an LTCC visit at home or in an institution.*** Funded under the county LTCC allocation.	***County LTCC staff where the person is located.***	Within 10 working days of request for visit or referral.	When this activity is carried out under the LTCC program requirements, "Early Intervention" is a type of activity coded in MMIS for any visit that **did not** result in **complete** assessment and support plan development. DHS Form 3427 is used to record this kind of visit, with Screening Document edits reflecting the assumption that assessment was not fully completed.

Types of Assessment and Support Planning Activity
II. Ensuring HCBS Access
Under LTCC and Minnesota Senior Health Options

Purpose of Service	People Served	Who Provides the Service	Timelines & Process Requirements	Forms Used
Community Assessment Level of care determination Identify consumer's needs Identify risks to health and safety Identify consumer goals and preferences Identify plan implications Determine service eligibility for Elderly (and other) Waiver (need for service, LOC)	***Any citizen with long term care needs*** who requests or is referred for assessment, support planning or waiver eligibility determination as provided for under the LTCC program. ***MSHO enrollees*** living in the community who request community-based services. ***MSHO enrollees referred*** for LTCC/EW assessment through the risk assessment process or other referral for community-based service.	***County LTCC***: PHN or SW or both. County may contract "in" additional staff to perform these activities under LTCC. Funded with county LTCC allocation, and, for all persons under age 65, FFS payment for face-to-face assessment and support planning. ***HMO care coordinators*:** Screeners/consultants either employed by or under contract with the HMO. Some plans subcontract with county or other agencies to perform these assessments. Funded under the capitation.	***County LTCC:*** Within 10 working days of referral or request as outlined in MN Statute, section 256B.0911. This process ***HMO:*** Within 30 days of referral resulting from risk assessment, or within 30 days of request by enrollee.	***County LTCC***: **DHS Form 3428 or 3428A**. Can create their own forms but must contain all of the same elements. Must conduct the assessment in person. **DHS Form 3361** is used for level of care determination. Under ***MSHO*** contract with the Department, health plans must also use **DHS Form 3428 or 3428A**. Can create their own forms but must contain all of the same elements. Must conduct the assessment in person. **DHS Form 3361** is used for level of care determination. **LTC Screening Document 3427** is entered into MMIS for all community assessments for both HMO enrollees referred for assessment and persons served under the LTCC program or FFS waiver programs. HMO staff, county or tribal LTCC staff, or HMO contract staff enter this document. See manual "Instructions for Entering the LTC Screening Document in MMIS: MSHO" at http://edocs.dhs.state.mn.us, select DHS 4669-ENG.
Support Plan Development Identify goods and services to meet needs. Consumer choice and decision-making in planning. Choice between institutional and HCBS. Reasonable assurance of health and safety. Personal risk management	***All persons noted above.***	***County LTCC staff: PHN or SW or both.*** Funded with county LTCC allocation, FFS payment for under 65 face-to-face assessment and support planning. ***HMO care coordinators/case managers*** either employed by or under contract with the HMO. Some plans subcontract with county agencies to perform these activities. Funded under capitation. Higher capitation for persons enrolled in EW program.	For support plans developed under the ***LTCC*** requirements, the practice guideline has been within 30 days of referral. ***FFS county or tribal-managed HCBS waiver programs:*** Within 30 days of request or referral for HCBS per the waiver plan for some programs; for EW, within 30 days is the practice guideline. ***HMOs: Same as EW*** practice guidelines. Community support plans developed by county, tribe or HMO must meet all requirements in federal and state law.	Both HMOs and counties/tribes must use **DHS Form 2925 or 4166** (Community Support Plan) or their own version of a support or care plan that contains all required elements. **Section G of the LTC Screening Document (DHS 3427)** must reflect the complete support plan, including informal and quasi-formal services. This information is entered into MMIS by HMO and county or tribal staff.

Supports caregivers.				

Types of Assessment and Support Planning
III. Moving People Out of Institutions
Under LTCC and Minnesota Senior Health Options

Purpose of Service	People Served	Who Provides the Service	Timelines & Process Requirements	Forms Used
Discharge Planning Preparation of discharge summary that includes: ▪ Recapitulation of resident's stay ▪ A final summary of resident's status using the Resident Assessment Instrument (RAI) ▪ Post-discharge plan of care developed with the resident, resident's family which will assist the resident to adjust to his or her new living environment. See CFR section 483.20 for NF staff responsibility, and DHS MSHO contract with HMOs section 6.1.3 for a description of all care coordination and case management requirements.	**All residents of certified NFs** **Funding:** NF rates support NF staff HMO capitation TCM and DD case management payments	***NF Social Worker and RN:*** Discharge planning is a primary responsibility of these NF staff. ***HMO Care Coordinators*** for MSHO enrollees. Participation in discharge planning is a key role of care coordinators. Care coordinators may be employees of the HMO or county or other agency contracted staff.	Follows MDH guidelines, CMS certification and Medicare payment guidelines for review of needs for NF service. For MSHO enrollees, annual review of need for facility residents.	**RAI** **HMOs** may develop their own discharge planning or summary forms for use in transitioning people out of facilities.
Transition Assistance Assessment and development of broad community support plan needed for return to community. Referrals for services	**All residents of certified NFs.** Transition assistance is available to all persons in institutions, regardless of public programs participation. **Funding:** HMO capitation, county LTCC allocation	***County or tribal LTCC staff*** as provided for under Minnesota Statute section 256B.0911. ***HMO Care Coordinators*** for MSHO enrollees.	For LTCC visits: within 10 working days of request or referral For MSHO referral for EW assessment, within 30 days of referral	For people served under the Long Term Care Consultation Program: ▪ LTC Screening Document **DHS Form 3427** ▪ LTC Assessment Tool **DHS Form 3428 or 3428A** or lead agency facsimile version ▪ Community Support Plan **DHS Form 2925 or 4166** or lead agency facsimile version **HMOs** may develop their own discharge planning or summary forms for use in transitioning people out of facilities. HMOs must use the same forms listed above to move a person from an institution into EW services in the community.

Relocation Service Active assistance to relocate people from institutions. Goes beyond transition assistance available under LTCC program as described in MN Statute 256B.0911. Examples of activities completed by an RSC include but are not limited to: ▪ Refine the community support plan, including person-centered planning activity. ▪ Locate housing. ▪ Implement the support plan developed to return to community life. ▪ Broker services See Minnesota Statutes, section 256B.0625, subd. 43-43b and 43d-43h and Bulletin #01-56-23 for more complete information about Relocation Services Coordination.	**MA participants of all ages*:*** For any individual participating in Medical Assistance, regardless of the need for or funding source of community supports that will comprise the relocation plan. **Persons receiving other types of targeted case management** Funding**:** various depending on service and person served.	***Relocation Service Coordinators: See Bulletin 01-56-23and MN Statute section 256B.0621 for description of qualifications.*** ***MSHO case managers***/care coordinators both under case manager responsibility for EW enrollees admitted as well as care coordination responsibility for all members. *Requirement to coordinate with Relocation targeted case managers in contract section 6.1.3.* ***Alternative Care Conversion Case Managers:*** For people aged 65 and over who are eligible for Alternative Care. ***Targeted Mental Health Case Manager*** for people with SPMI and ***DD Case Managers*** for people with developmental disability or related conditions can be Relocation Services Coordinators.	Within 20 working days of a request for Relocation Services Coordination.	**For Relocation Services Coordination provided under FFS*:*** DHS Form 3427, DHS Assessment Form 3428 or 3428A or lead agency facsimile. **DD Screening Document** for people with development disabilities.

Minnesota Department of **Human Services** — **Memo** — Attachemnt D

DATE: May 1, 2006

FROM: Libby Rossett-Brown, Elderly Waiver Program Administrator
651-431-2569
Libby.Rossett-Brown@state.mn.us

SUBJECT: Elderly Waiver Program - RESOURCES

RESOURCES:

- Minnesota Statute: 256B.0915 www.leg.state.mn.us
- Federal Medicaid Waiver approved by Centers for Medicaid and Medicare Services (CMS) –Under 1915(c) of the Social Security Act
- Provider call center – 800 366-5411 or 651 282-5545 – Provides Technical Assistance to all Medical Assistance enrolled providers
- Resource Center County Help Desk 651 296 -4488 or 888 968-8453 – Provides technical assistance to counter waiver staff on MMIS long term care and developmental disability screening documents and service agreements

DHS Manuals: www.dhs.state.mn.us/infocenter/docs

- Disability Services Program Manual
- Health Care Programs Manual
- Health Care Programs Provider Manual
- LTC Screening Document and Service Agreement into MMIS – manual
- MMIS User Manual
- Social Services Manual

Other Resources:

- www.minnesotahelp.info – MinnesotaHelp.info Web site – Online directory of services designed to help people in Minnesota identify resources.
- Minnesota Board on Aging - www.mnaging.org/
- Minnesota Area Agencies on Aging – www.minnesota-aaa.org/
- Aging and Adult Services Web page – www.dhs.state.mn.us/main/groups/aging/documents/pub/DHS_id_030550.hcsp
- List Serv mail group – to get on this information mail group email Lynn Glockner lynn.glockner@state.mn.us
- DHS forms http://edocs.dhs.state.mn.us/index.htm
- Older Minnesotans – Know your Rights about services – DHS 4134 publication available on E-Docs
- Sr Linkage Line -800-333-2433
- Office of Ombudsman for Older Minnesotans 800-657-3591

INSTRUCTIONAL BULLETINS - www.dhs.state.mn.us/fmo/legalmgt/bulletins/default

99-16-2 Special Income Standard Allows Eligibility Expansion of the Elderly Waiver Program
99-25-08 Client Service Cost Limits for AC/EW and Rate Limits for Assisted Living and Residential Care Services for AC/EW for FY 2000
99-25-19 New MDH rule changes home care licensing options for housing with services establishments
00-25-04C Counties may contract directly with Class A Home Care Agency for “Assisted Living Plus” Service delivered in registered Housing with Services Establishments
00-25-04 “Assisted Living Plus” service available for qualified Housing with Services

establishments and “Assisted Living” service Name expands to additional settings
00-56-26 “PCA Choice:” A new Option for FPCA Services
Instructional Bulletins:

00-56-30 DHS clarifies policy on leave days used by persons on HCBS waivers and AC
01-25-08 Approval of Waiver Amendments and Statutory Changes affect services funded by Elderly Waiver Program and the Alternative Care Program
02-25-03 DHS Answers Frequently Asked Questions about Assisted Living Services for Persons 65+ 0n The Alternative Care Program and Elderly Waiver Program
02-25-05 Waiver Amendment changes to services funded by Elderly Waiver and Alternative Care Programs and the FY02 SIS/EW income standards are announced
02-25-11 Clarification of PCA Services for Older Minnesotan
02-25-12 DHS Answers Frequently Asked Questions (FAQ) about Home Care, Elderly Waiver and Alternative Care Program recipients
02-56-13 Hospice Policy Update
02-56-20 PCA Consumer Guide and Changes to the PCA Choice Option
03-21-02 Minnesota Senior Health Options Serves Seniors
03-25-06 Policy Clarification for Caregiver Services and other Respite Options for Families of Older Persons
04-25-04 Elderly Waiver is renewed - Two Additional Services are approved
04-25-05 DHS issues rate limits, monthly service caps and National Procedure Codes for Home and Community Based Services
04-25-06 DHS issues rate limits, monthly service caps and National Procedure Codes for MA and Community Based Services -update

04-25-10 Service Description changes for new National Codes
04-25-11 MMIS changes to Support Consumer Directed Community Supports for AC and Elderly Waiver
04-56-07 Implementation of Consumer Directed Community Supports Across all Waivers, MSHO and MnDHO
04-56-08 Conversion to National HIPPA Procedure Codes for Home Care, Waiver and AC programs.
04-56-09 Implementation of 2003 Legislative Changes to Group Residential Housing Rates and Waiver Services
05-25-03 Changes to LTC Screening Document DHS- 3427 and Telephone screening document form DHS-3427T
05-25-04 Recent MMIS changes to Support Consumer Directed Community Supports for EW and AC Programs
05-24-01 Changes to the County Based Purchasing Model of Managed Care for Minnesota Seniors
05-25-08 Annual Increase for Maintenance Needs Allowance
05-25-09 Legislative Action Increases Alternative Care and Elderly Waiver Program Service Rates and Case Mix Caps
05-56-05 Legislature Provides Increases to Home Care and other Home and Community Based Services
05-56-05C Legislature Provides Increases to Home Care and other Home and Community Based Services

DHS REPORTS AVAILABLE ON INFOPAC

PWMW185L-R0504 PPHP Current Enrollment Report for Worker

This report is generated after capitation and reports data for the next month. It is sorted by financial worker service location and financial worker ID. The data it identifies are: health plan,

product ID, and enrollment period.It can be used to identify people in the servicing county who are enrolled in managed care.

PWMW18500RR0506 - PPHP Potential Enrollee Report

This report is generated after capitation and reports data for the next month. It is sorted by financial worker service location and financial worker ID. It identifies those people in the financial worker's caseload who need to go through the managed care education process who are not currently enrolled in managed care.

PWMW185I-RP507 MSHO AND MnDHO New Enrollee Report

This report is generated after capitation and identifies people who enrolled in managed care that month. It is sorted by county of service and then by health plan. It contatins a lot of information including if the person is on a waiver program , the waiver span and the rate cell.

PWMW185J-R0535 PPHPCounty Elderly Disenrollment Report

This report is generated after capitation and reports data for the next month. It is sorted by financial worker service location and financial worker ID. Some of the data it identifies are: health plan, product ID, and enrollment period. It can be used to identify members who have disenrolled from managed care and the reason.

PWMW9061-R2216 Elderly Waiver Utilization Master List

This report is run nightly and is sorted by county of Financial Responsibility - contains each client on Elderly Waiver, the reassessment date and the processing date for the current waiver year. The Y indicates that the client will be taken off the master list at the beginning of the new waiver year. All other clients have open waiver spans and are open to elderly waiver. If a person is on this report and they are not open to the waiver - a screening document needs to be entered into the system in order to close them properly.