#06-25-01

Bulletin

May 31, 2006

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

OF INTEREST TO

- County Directors
- Social Services Supervisors and Staff
- Public Health Nursing Directors
- Managed Care Organizations

ACTION/DUE DATE

Please review material

EXPIRATION DATE

The policies in this bulletin are ineffective as of May 31, 2008.

Managed Care Transition Questions and Answers for Waiver Recipients

TOPIC

Questions answered by department staff regarding waiver recipients transitioning into managed care programs.

PURPOSE

Provide answers to questions submitted by county staff

CONTACT

Sue Kvendru at 651 431 2517 or sue.kvendru@state.mn.us for Minnesota Senior Health Options (MSHO) and Minnesota Senior Care (MSC) program questions.

Libby Rossett-Brown at 651 431 2569 or libby.rossett-brown@state.mn.us for Elderly Waiver program questions

SIGNED

LOREN COLMAN
Assistant Commissioner
Continuing Care Administration

BRIAN OSBERG
Assistant Commissioner
Health Care Administration

I. BACKGROUND

Minnesota has a long history of purchasing acute and primary care services for people participating in Minnesota Health Care Programs under a managed care model. The Department believes the managed care model as constructed has features and requirements that can improve access to community-based services for seniors.

However, the expansion of the MSHO program in January 2006 driven by the roll-out of the federal Medicare Part D prescription drug coverage, has raised new questions and uncertainties as providers, health plans, consumers, and local lead agencies adapt to this new purchase and delivery model for Elderly Waiver services and the expansion of the MSHO product statewide.

In an effort to answer these questions and address these concerns, the Department has initiated and continues training for health plans to ensure that case managers and care coordinators, under contract with or employed by the plans, implement the Elderly Waiver program according to state and federal requirements. The Department is also meeting with the Association of Minnesota Counties to discuss issues of concern arising from this transition.

The Minnesota Senior Health Options (MSHO) transition group consisting of county and department staff met on April 28, 2006 to discuss questions and issues related to the transitioning of waiver recipients into the managed care programs. A summary of the questions raised and the Department's response is presented below. The number of (*) shown with each question represents the number of times a particular question (or related questions or concerns) was raised in this meeting.

Attachment A is additional information on the preadmission screening activities, assessment types, and support planning activities under Long Term Care Consultation, MSHO, and MSC+ programs.

II. QUESTIONS AND ANSWERS

1. ****** Why are there so many plan-to-plan inconsistencies/differences ?** Each health plan has its own history, administration and philosophy about how best to provide and manage care. As a result, different decisions have been made about how they want to operate. Differences between health plans, including differing arrangements from county to county, are part of the health care environment. Some health plans have chosen to contract with DHS for third party administration (TPA) to link into the State's MMIS system for billing, payments, data, and related functions. Others have continued to conduct these functions internally or under other TPA arrangements. These administrative arrangements may result in operational differences. However, the contract requirements are the same for all MSHO health plans. DHS uses a model contract for all plans and few if any language differences are

permitted. DHS will be developing a template for MSHO health plans to complete that will identify each health plan's process. DHS has also developed fact sheets/tools that outline PAS processes across all programs and waivers in an attempt to show the many similarities and the few differences between MSHO and the processes counties and tribes implement under FFS management of EW.

2. *** How do we as a State continue to ensure/promote and support informal & quasi formal community services within the managed care structures? See # 6.** From a waiver and contract compliance standpoint, the entire EW benefit set must be available within the managed care products. The department is monitoring the use of all EW services both in counties and health plan networks. From a logistical and practical standpoint, the development, contracting and payment for those services will continue at both the county and plan level to support transitions for people between FFS and managed care, to continue to support people who are not in managed care, and to ensure the availability of EW services which are managed by counties and tribes. The providers themselves are learning how to be "umbrellas" to a range of support services that can be made available to all purchasers. This approach to service provision is being promoted through CS/CD grants and the work of Triple As department staff work with them towards that goal and with providers in each region.

   The Aging Division's training series will continue to spotlight best practices in utilization of support services and caregiver supports for frail elders. There is evidence of the usefulness of community based supports, including those provided to informal caregivers, to sustain elders who might otherwise delay use of services until a crisis requires an institutional stay. MSHO products are designed to incent preventive health and support services in order to lower the costs associated with institutional and crisis interventions for which the managed care organization is at financial risk.

3. ***** Why isn't there a statewide system that tracks enrollment so counties can follow where clients are – status etc? See #13 .** This is somewhat of a short term transition issue as people determine what plan they want to be in and are not expected to continue to change plans frequently. Health plans receive monthly enrollment files that they provide to their contractors. EVS is updated nightly and is available to providers, including counties, and MMIS indicates MSHO health plan enrollment on the RPPH screen. In addition, counties and White Earth Tribal Health have access to five monthly managed care Info Pac reports:

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 contains a lot of information including if the person is on a waiver program, the waiver span and the rate cell.

PWMW185J-R0535 PPHP County 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.

In the future Crystal Reports will be available for internet use - but currently the security has not been worked out. At this time if there is another type of report that counties, tribes, or plans feel will be useful - we can design and put into InfoPac but we need input as to the information that is needed in addition to what is listed above.

We recognize that there will always be some timing issues with new enrollments because there is always some delay between the enrollment and the report distribution. However, most new enrollments can be anticipated if the plans and counties or tribes work together to develop quick turn-arounds and communication mechanisms. For example, most new enrollments can be anticipated since they have to be submitted prior to cut off. If the plans could notify the counties and tribes of the new enrollments submitted each month at the same time as they enter them, counties and tribes might be able to prepare for the new members.

4. **What are the parameters of client choice under managed care; especially with regard to care coordination**? If the enrollee is not satisfied with their care coordinator they should contact their health plan. In some cases, MSHO enrollees are assigned a care system or care coordination system based on their choice of primary care setting. Within that care system, enrollees can choose to change assigned care coordinators. If an enrollee wants a care coordinator outside of their assigned care system, they may need to choose a different primary care setting. For example, if an MSHO enrollee chooses a specific doctor that is included in a health plan's care system, the enrollee could choose from the care coordinators in the care system associated with that doctor. The county or tribe may also be a subcontractor in that county for MSHO enrollees whose primary care is not included in the

other care system. If that MSHO enrollee wanted the county or tribe to be their care coordinator, they would have to change doctors to one outside of the care system they were originally assigned.

5. ***** What DHS training is provided to care coordinators in health plans? What standards / policies /bulletins/ protocols/rate policies are they subject to or under contract for and what can vary by plan?** Health plans receive training on several levels. In the past, MSHO specific trainings were conducted for all plans and care coordinators by a combination of MSHO and Aging division staff. Due to the expansion, we are mainstreaming this training and health plans are now included in all DHS video conferences conducted by Aging and Adult Services. In addition, special managed care video conferences have been scheduled throughout 2006 on a variety of topics including EW assessment and service standards. Special training on entering screening documents into MMIS for MSHO has been developed and is offered periodically based on need. A manual was developed for this training and is available on the DHS website (www.dhs.state.mn.us). In addition, MSHO staff provide onsite training for new care coordinators and new plans upon request from each health plan and care system.

   The MSHO contract lays out a large number of additional specifications for MSHO care coordination. Care coordinators must meet the contract requirements for qualified professionals (i.e. social worker, registered nurse, physician assistant, nurse practitioner, public health nurse or physician). All waiver requirements must be met by the plans in terms of consumer choice and participation in care planning, integrating waiver and other services, and support for informal caregivers, for example. The EW provider standards are included in the MSHO contract and are applicable to MSHO health plans. EW bulletins regarding service provisions do apply to MSHO health plans. MSHO health plans are able to negotiate independent rates with EW providers. The MSHO model contract is available on the DHS website at www.dhs.state.mn.us/healthcare/msho

6. *** Will MCOs cap rates or choose/enforce lower rates? Will this put providers out of business? We understand that some plans are paying for Medicare home care services at Medicaid rate levels. Should there be two rate levels? Who decides which rate is necessary for this client?** Because they are fully at risk for all services, MCOs need to be able to develop their own payment rates for services. But they are also required to ensure that enrollees have adequate access to all covered services. If MCOs pay rates that are too low for the current market, they may have problems with access to covered services. Access to covered services is something that the State monitors through its External Quality Reviews and other analyses. Therefore MCOs have both market and regulatory incentives to pay competitive rates.

   However, while the State is delegating provision of services and payment rates to the MCOs, the State maintains a role in assuring that the overall health and long term care system is meeting the needs of consumers and that access to benefits, providers and services is maintained.

In general, MCOs contract for most service providers and rates paid are a product of negotiations between the MCO and those providers. In addition, MCOs may have a "non-participating provider" rate (often what ever Medicare or Medicaid would pay) for services delivered outside of the network. Further, in order to make things easier for small community service providers, some MCOs do not require formal contracts for certain waiver services. Instead, they will make payments to county approved and contracted providers when services have been approved by their care coordinator.

In some cases, MCOs may want to review existing county or tribal rates for certain services. This review can occur through an individual assessment (the rate paid for a person's particular assessed need) or can occur at a broader policy level. The State and MCOs will be working together on a review of payment mechanisms for Assisted Living providers. DHS is beginning a process to provide MCOs with more information about the variety and range of payment approaches for this service which have been used by counties or tribes to ensure that MCOs understand the service and policies already established. In this discussion, we expect to identify additional policy and payment issues that will need to be clarified and discussed further with providers, counties, and tribes.

Since MSHO Special Needs Plans were largely building on Medicaid networks for their Medicare SNP networks, initially some of them did not clearly delineate Medicare versus Medicaid rates for contracted home care services. Since this issue has been brought to their attention, most of the MCOs have been working with their contractors to address this concern. MCOs have the final responsibility to determine whether a service meets Medicare versus Medicaid criteria for home care services. They may use a variety of utilization and assessment mechanisms in making this determination. Medicare certified home care agencies continue to be required to complete an OASIS assessment for Medicare Advantage plan covered home care services.

If providers have any questions or issues regarding health plan reimbursement rates, they should contact the health plan.

7. **There are problems changing risk status / rate cell reimbursement between 10th of month(s). You can't change the rate cell until the 10th of following month. Are these issues of training or policy clarification?** There appears to be confusion regarding rate cell assignment and the provision of services. Health plans may choose various points in time to pay their subcontractors for work performed. However, health plans must provide and pay for services based on identified need regardless of rate cell paid for that month. For example, if waiver services are assessed and needed prior to the time that the rate cell changes can be made, those services must be provided regardless whether the rate cell has yet changed.

   The following is the time frame in which health plans are paid**.** Rate cells determine the payment rate to health plans and are determined on a monthly basis on the day of capitation for the next month. Managed care capitation occurs six working days from the end of the month. For example, for April 1, rate cells were calculated on March 24 based on the information in MMIS on that date. RCC A = community non-EW, RCC B= community EW

and RCC D = institutional. MSHO rate cells have been automated since January 1, 2006. Rate assignment for an individual is determined by waiver span information and living arrangement information in MMIS. If an open EW waiver span is indicated on MMIS, the plan receives RCC B. If there is no EW waiver span and the enrollee's living arrangement in MMIS is community, the plan receives RCC A. If no EW waiver span and the enrollee's living arrangement in MMIS is institutional, the plan receives RCC D. If an open EW waiver span is indicated on MMIS but the living arrangement is recorded in MMIS as institutional, the plan will still receive RCC B since the health plan may have gotten the person out of the nursing home and started services but the county financial worker has not yet changed the living arrangement in MAXIS. Financial workers enter living arrangement information that is reflected in MMIS and that affects capitation rates paid to plans. Nursing homes also need to submit Form 1503 to county financial workers to change living arrangements to institutional. If a nursing home has done this, counties then should to be contacted to see if the form was received and to inquire why the living arrangement was not changed

8. **Why are some CADI / MRRC enrollees being removed from plans after a LTCC? We will need to ensure that DHS also address those DD client that are non-waiver rule 185 receiving DTH. Will the DD case manager remain involved with this client type? Who will be responsible for the NF screens on this client type (DD non-waiver rule 185) - Will the Health plan provide their own QMRP?** No information on MSHO enrollees who are currently on waivers other than EW should be entered into MMIS. Health plans do not disenroll anyone in this instance unless they request to be disenrolled. We have heard of several instances where county staff were recommending that people on the MR/RC waiver disenroll. MSHO does not affect Rule 185 case management. That stays in place and the function, roles and duties of the DD case manager remain the same. QMRP is a DD function so, health plans would not be providing this service.

9. **Why are health plans requiring that any one who needs PCA services go on EW?** This appears to be a plan specific issue. We are in contact with the health plan to determine which staff are saying this and how to correct misinformation. As a general rule, state plan services should always be used first before accessing EW. To go on EW, the person must need a waiver service to meet their needs in the community; this need is part of EW eligibility determination criteria. This does not preclude a person who was receiving only state plan services prior to enrollment into MSHO from being opened on EW if they are screened to be nursing home certifiable and in need of an EW covered service.

10. **PHN must do authorization of PCA. Are these managed care rules or not?** The requirement for a PHN to conduct PCA assessments is in state statute and applies to fee-for-service as well as to managed care. Managed care does not have separate PCA rules in state statute. Therefore, MSHO health plans contract with PHNs to conduct PCA assessments. However, the department is identifying a number of issues related to assessment, authorization, and monitoring of PCA services, that need further clarification. We will follow up with those clarifications at a later date.

11. **MMIS training for counties hasn't been smooth using → the plans to "filter" this info to counties isn't working** . MMIS training focuses on using the system to navigate, view, and enter documents. While we can train on how to use MMIS, how to code the LTCC screening document and service agreement, and the relationship of the screening document to the rate cell changes; we can not include the internal procedures of each health plan. Counties and other providers with questions should contact the health plans and request the written procedure. When the plan has contracted with DHS for TPA services for payment of EW services, there should be directions available from the plans on how to bill MMIS for the delivery of service and on what is required to authorize the services.

12. **All the Medicare Part D training told all consumers to enroll and get cards. After passive enrollment some MSHO consumers were multiply enrolled and have multiple cards.** CMS had numerous problems with their enrollment system, including enrollment of people in more than one Part D plan at the same time. CMS has initiated a special reconciliation process nationwide for people who appear to have been enrolled in more than one plan at the same time. Special letters were developed by CMS for health plans to send to affected enrollees. These letters went out the last week of March and enrollees were instructed to contact the health plan if they wanted to continue the coverage from the health plan. We hope that this reconciliation process will solve much of the problem with people being in more than one plan at a time. CMS continues to identify and correct problems with their enrollment system and DHS staff will continue to work closely with MSHO health plans to make sure MSHO enrollees are enrolled where they want to be and to make sure that MMIS and CMS's systems match.

13. **** Why are there discrepancies between plan lists of enrollees? Who is their care coordinator in transitions? Why don't hospitals know whom to contact.** Health plans receive enrollment lists from DHS on a monthly basis. Many health plans then assign a care system and that care system gets lists from the health plan. In those cases, it is the care system that assigns the specific care coordinator. According to the contract, MSHO enrollees are to be notified who their care coordinator is by the health plan and/or its subcontractor. These lists will be from a single point in time and will be updated when the health plan gets it next monthly enrollment file.

    Providers, including hospitals, should always check with EVS or MN-ITS to determine which health plan a person in enrolled in. Providers can also contact the health plan and the health plan can either provide the name of the care coordinator or the name of the care system to contact. DHS has also produced a list of contacts for identifying care coordinators. The contact list has been widely distributed and is included in the MSHO MMIS Manual on the DHS website.

14. **** Why are there discrepancy / differences between plans in what they want the county to do and collect? See #1.** The department is developing tools and fact sheets to help plans and counties understand practices, policies, and requirements that are the same in both FFS and managed care EW, what is required in contract and what can vary. DHS and health plans

are currently working together to evaluate use of common processes such as care planning audit tools.

15. *** The Blues are requiring a paper/pencil billing system for community well (non EW). Is a better system in the offing? See #3 & TPA contract**. Yes, plans may develop service authorization and billing procedures different than those that have existed under FFS, and particularly for activity that has not been provided under FFS such as risk assessment or care coordination that the county or tribe may be under contract with plans to provide to community well members. Please note: For plans that have entered into TPA agreements with DHS for EW service authorization and payment of **EW services ONLY**, service agreements, service codes, and service agreement edits are the same as FFS use. However, community-well assessment and care coordination will NOT be billed under these arrangements in MMIS at this time, since there is no comparative service available in FFS by which to authorize or claim this activity.

16. *** Where can we institute uniformity with regard to processes/ county communications with many different plans / systems & county systems? See the fact sheets.** The department will continue to clarify the requirements under managed care contracts and those things that can vary by plan.

17. ** Small non-profits are having trouble dealing with bureaucratic realities of contracting & billing with different health plans, (i.e. foster care, snow shoveling). How can this be mitigated?** See # 6 – to make things easier for small providers, not all MSHO health plans require formal individual contracts. Billing systems will vary from health plan to health plan. MSHO health plans have indicated that they are very willing to provide training to EW providers who need assistance on how to bill.

That said, we appreciate that the most recent addition of community-based services to the managed care benefit set has raised new questions and uncertainties as providers, health plans, consumers, and local lead agencies adapt to the new purchase and delivery model.

The Department does not proscribe how health plans conduct rate-setting or other business negotiations with providers in their network. But health plans recognize the need to offer payment rates that will ensure access for their members. Again, we encourage all providers to contact the health plans operating in their area to discuss inclusion in their network, their service authorization practices, and their rate-setting approach.

18. ****Some plans are not using "managed care" to mix and maximize dollar capitations. They're keeping Medicare separate from long term care and support services. What is the right thing to do? How are plans held accountable for and incented to manage both capitations in a way that maximizes consumer service options? If there are specific examples of where the plans may have used policies that are counter productive to good clinical care, it would be helpful to examine them. The merging of Medicare and Medicaid and acute and long term care funds under one health insurance entity can reduce cost shifting between the two payers, align some of the fiscal incentives, and provide a basis for better clinical use of both

funding sources. But barriers to complete integration at the clinical and financial levels remain. Some of these barriers are inherent in the need to continue to assure separate accountability for Medicare versus Medicaid services. For example, CMS continues to require separate coverage criteria, data and cost tracking, and financial bids for Medicare services. CMS does not allow SNPs to list Medicaid services (including the State's coverage of Medicare cost sharing) in public premium and benefits materials listed on websites, making those materials more confusing than they should be. CMS also requires separate tracking for Medicaid services and costs and has reduced flexibility for benefits under managed care arrangements. The State is also required to continue to track long term care (NF and waiver) services separately.

So health plans continue to face some conflicting incentives for how best to manage and track care under these arrangements. Despite these barriers the MSHO plans have chosen to integrate much of their billing function so providers won't have to bill twice, and have integrated most of the care coordination and service delivery for Medicare and Medicaid. As plans gain more experience with both sets of benefits we expect they will become more sophisticated in making clinical decisions that maximize use of both funding sources. But integration is a double edged sword. As plans do this, both CMS and the State have an interest in ensuring that appropriate use of both benefit sets is made and that neither payer is financially disadvantaged by the arrangement.

19. * Is the network and capacity of local support services (HCBS) threatened by new purchasing and reimbursement options through health plans? See # 2.

20. *******Plans show less appreciation for non-acute medical care and support services; do they understand that the services en-total should prevent and delay institutional services as well as maintain elders with quality of life at home? See #2. There are contract requirements for MCOs to provide access to the same range of community supports that have been available in the county- or tribally-managed Elderly Waiver program. This includes the requirement to use the same assessment tools, level of care criteria and support plan tools to identify the need and plan for long term care services in addition to those provided under the acute and primary care benefit. Financial incentives exist in the capitation system which provides the lowest payment for facility residents and the highest payment for community residents who are Nursing Facility Certifiable (i.e. they meet the NF LOC criteria as applied under the FFS system and are eligible for EW services). The Department has developed strategies and tools for monitoring health plan performance in providing access to EW services. The Department has no evidence that managed care organizations have less appreciation of the need for and value of community-based supports, and has also taken steps to ensure that MCOS can develop the same familiarity with the range of services available as have county and tribal lead agencies in order to offer that same range of services, including those available through quasi-formal agencies. See contract section 6.1.3. for further details about coordination at the local level with county social services and Area Agencies on Aging.

21. * Why are some plans coordinators encouraging placement of difficult clients back to county? A coordinator cannot disenroll a member. Enrollment in MSHO is voluntary and people may choose to disenroll in which case they will return to the Minnesota Senior Care

(MSC) or Minnesota Senior Care Plus (MSC+) mandatory managed care system. People in the twenty MSC+ counties do not return to fee-for-service home and community based services. The person does not get to choose to go back to FFS if they are part of the mandatory managed care population. A managed care organization may negotiate with county contracted staff to serve higher need people in deference to county experience with EW case management and coordination with other county-based services like Adult Protection. One of the Department's quality strategies to ensure access to people with higher needs for supports in the community is to measure the average case mix of each plan's enrollees in EW at transition (using Screening Document Information) in 2006 and again in 2007. In order to recover an amount withheld in capitation payments, plans have to demonstrate that they continue to serve people with at least as many needs over time as those they enrolled from the FFS system.

22. * When some clients disenroll from a plan why are they not helped to find a new plan/system? Plans want help here too. We have all learned much since the start of Part D regarding what CMS's auto-enrollment system for dual eligible people does and does not do. Since Part D was implemented, the Senior Linkage Line has started recommending to anyone disenrolling from one Part D plan to actively enroll in another Part D plan to assure no gap in coverage. This is especially true for dual eligibles. CMS has also started recommending to Part D plans to also remind and assist people choosing to disenroll. MSHO health plans and county managed care units are working on how to address this in their processes for enrollment and disenrollment.

23. * Who is responsible for ensuring that HCBS capacity stays robust? While the State is delegating network contracting, provision of services and payment rates to the MCOs, the State maintains a role in assuring that the overall health and long term care system is meeting the needs of consumers and that access to benefits, providers and services is maintained and enhanced. The State is also engaged in discussions with counties about which county roles are appropriate to maintain in this process

24. * How are we measuring quality of life in this system? The Department has recognized the need to assess both quality of care and quality of life under HCBS programs more systematically regardless of purchase and delivery model. There has been no ongoing strategy to measure quality of life in FFS. The Department has been developing an HCBS quality management strategy and tools during the last 3 or 4 years, including the development of an EW consumer survey that was implemented statewide in 2004. The quality goals for HCBS remain the same regardless of the purchase and delivery model, and quality of care and quality of life will be assessed in both models.

25. * What is the county capacity & role in adult protection especially self-neglect? Who's responsible for initiating conservator/guardian referral? The county **is not** automatically responsible for a guardianship/conservatorship petition. Minnesota Statutes, section 626.557, subpart 10 states "….when necessary to protect a vulnerable adult from serious harm the county shall immediately intervene to protect the vulnerable adult and help the family, vulnerable adult or other interested person by seeking any of the following:". Following that statement are several options including orders or protection, appointment or removal of a guardian or

conservator , referral to a prosecuting attorney for criminal charges. The key concept here is "serious harm" which is distinguished from concerns of "self neglect". Counties are required to respond in cases of serious harm, but many requests for substitute decision makers do not describe a situation where risk of "serious harm" exists.

If the initial VA report is of self-neglect the VA worker will assess the situation and refer/arrange for necessary services. Once the client has been assigned to a care coordinator or case manger the issue of self neglect is moot: Minnesota Statutes, section 626.5572 refers to self-neglect as "absence of services" which is not the situation if the client has a case manager. While any interested person may bring a petition to the court, we do not advise that the health plan bring petitions for guardianship or conservatorship in these self neglect cases. The care coordinator or case manager may work with family or community programs if guardianship or conservatorship is still needed.

If the VA report indicates serious harm and guardianship or conservatorship is determined to be necessary, the petition should be brought by the county. The care coordinator or case manager should refer cases in which there may be serious harm to the county for follow up. Since there is no state or federal funding that supports Adult Protective Services role in initiating a petition and it is a county funded function, counties may vary in their response to such referrals.

26. * Who will inform SSIS that record retention is 10 years for MSHO (changed from 7 years recently)? This is a Medicare requirement that MSHO plans must comply with. We have informed DHS staff working with the SSIS system of this requirement.

27. ****For which services and costs are counties still at risk in providing the safety net to vulnerable adults? Which of these costs should be reimbursed by a plan and which are the responsibility of a county or through another funding source? Counties are providing services and then finding out that a plan was being paid. This is a question we are discussing in greater detail as a group in our county MSHO transition work group . We need to clarify the role of counties during transitions and for all vulnerable adults regardless of how health care is being delivered.

28. *** Do counties have to pay 2% MNCare tax?** The MNCare tax applies statewide at the provider level, not the health plan level. It applies to providers of basic services, and NOT to nursing facilities, waiver or home care providers. Waiver services include county case management services. In general, managed care rates to all plans including CBPs reflect the levels of MNCare tax that are applied to their providers. There is also a separate managed care premium tax on State managed care premiums (both public programs and commercial products). That premium tax does NOT apply to County-Based Purchasing plans. The premium tax also does NOT apply to any Medicare premiums paid by the federal government to the plans.

29. * How does the arrangement for tribal management of Elderly Waiver work with a person's choice to enroll in MSHO? That information was clarified for MCO representatives at the meeting on April 5, 2006. Also, Minnesota Statutes, section 256B.0915, subd. 9 states:

> Subd. 9. **Tribal management of elderly waiver.** Notwithstanding contrary provisions of this section, or those in other state laws or rules, the commissioner may develop a model for tribal management of the elderly waiver program and implement this model through a contract between the state and any of the state's federally recognized tribal governments. The model shall include the provision of tribal waiver case management, assessment for personal care assistance, and administrative requirements otherwise carried out by counties but shall not include tribal financial eligibility determination for medical assistance.

Minnesota currently has a contract with the White Earth band for the provision of Elderly Waiver services to any eligible senior who lives on the White Earth Reservation. Under the contract, seniors can choose between county-based or tribally-managed EW. White Earth has successfully been managing EW services for its members for several years. Several other tribes are in the discussion/preparation phase for tribal provision of EW services.

In January, with the auto-enrollment of many of our dual eligibles into MSHO, it became clear that we hadn't dealt with MSHO enrollees who are receiving EW services through the tribe. When tribal staff attempted to enter screening documents and service agreements into the system, they were overwritten. MMIS will be changed to allow these documents to be entered while the member is enrolled with managed care if the member chooses to remain enrolled but receive their EW and extended home care services through the tribal agency.

III. MANAGED CARE ORGANIZATION CONTACTS

MSHO Health Plan Contacts	
Blue Plus	(800) 262-0820
First Plan Blue	(800) 584-9488
HealthPartners	(952) 883-7699 or (888) 663-6464
Itasca Medical Care	(218) 327-5527
Medica	(952) 992-2232 or (800) 458-5512
Metropolitan Health Plan	(612) 347-5025
PrimeWest Health System	(866) 431-0802
South Country Health Alliance	(507) 444-7770
UCare ewquestions@ucare.org	(888) 531-1493

IV. ATTACHMENT A

a. Preadmission Screening (PAS) Under LTCC, Minnesota Senior Care, Minnesota Senior Care Plus, and Minnesota Senior Health Options
b. "Early Intervention" Activity Under LTCC, Minnesota Senior Care, Minnesota Senior Care Plus, and Minnesota Senior Health Options
c. Ensuring HCBS Access Under LTCC, Minnesota Senior Care, Minnesota Senior Care Plus, Minnesota Senior Health Options
d. Moving People Out of Institutions Under LTCC, Minnesota Senior Care, Minnesota Senior Care Plus, and Minnesota Senior Health Options

V. SPECIAL NEEDS

This information is available in other forms to people with disabilities by contacting us at 651 431-2500 (voice) toll free at 1-800-882-6262 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).

Attachment A

Preadmission Screening (PAS) Under LTCC and Minnesota Senior Health Options

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	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.	***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.	***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

Purpose of PAS Service	People Served	Who Provides the Service	Statutory Timelines & Process Requirements	Forms Used
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.	**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		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	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.

Purpose of PAS Service	People Served	Who Provides the Service	Statutory Timelines & Process Requirements	Forms Used
	face to face assessment for all persons under 65 regardless of public programs eligibility or participation.		and 95-60-1 for policy and process requirements. DHS *always* must approve admission and length of stay.	

Types of 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,	***All MSHO enrollees living in a NF*** Funded under the	***HMO care coordinators*** either employed by or under contract with the HMO. Some plans subcontract with county agencies to perform these activities.	***Within 30 days of enrollment.*** ***"Routinely"*** according to schedule required in	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.

Purpose of Early Intervention Service	People Served	Who Provides the Service	Timelines & Process Requirements	Forms Used
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.	capitation. Health plan may subcontract with county or other agencies to perform these duties.	Minimum requirement is participation in routine care plan reviews as required in certified NFs.	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.	
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	***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	***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 ***HMO*** 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

Purpose of Service	People Served	Who Provides the Service	Timelines & Process Requirements	Forms Used
Determine service eligibility for Elderly (and other) Waiver (need for service, LOC)	process or other referral for community-based service.			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	***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:***	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

Purpose of Service	People Served	Who Provides the Service	Timelines & Process Requirements	Forms Used
and HCBS. Reasonable assurance of health and safety. Personal risk management Supports caregivers.			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 guideline. Community support plans developed by county, tribe or HMO must meet all requirements in federal and state law.	or tribal staff.

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 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*** forMSHO 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.

Purpose of Service	People Served	Who Provides the Service	Timelines & Process Requirements	Forms Used
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	**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**	***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	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.

Purpose of Service	People Served	Who Provides the Service	Timelines & Process Requirements	Forms Used
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.	**types of targeted case management** Funding**:** various depending on service and person served.	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.		