#06-25-02

Bulletin

June 20, 2006

Minnesota Department of Human Services □ P.O. Box 64976 □ St. Paul, MN 55164-0976

OF INTEREST TO

- County Directors
- Social Services Supervisors and Staff
- EW Program Administrative Contacts
- County Public Health Nursing Services
- Tribal Health Directors
- Elderly Waiver Care Coordinators
- Managed Care Organizations
- County Fiscal Administrative staff

ACTION/DUE DATE

Please use the new Maintenance Needs Allowance effective July 1, 2006. New Case Mix Caps are effective October 1, 2006

EXPIRATION DATE

The policies in this bulletin are ineffective as of July 1, 2007 (MNA) and Sept 30, 2008 (Case Mix Caps)

Annual Increase for Maintenance Needs Allowance and Elderly Waiver Conversion Rates

TOPIC

New Maintenance Needs Allowance for Elderly Waiver (EW) Clients and Conversion Rates for EW clients leaving Nursing Facilities.

PURPOSE

Notify lead agencies of the new Maintenance Needs Allowance effective July 1, 2006.

CONTACT

EW policy questions: Libby Rossett-Brown at 651-431-2569 or Email at Libby.Rossett-Brown@state.mn.us

SIGNED

LOREN COLMAN
Assistant Commissioner
Continuing Care Administration

I. Exception to the Monthly Service Caps for EW Clients Leaving Nursing Facilities: Conversion Rates

Certain persons receiving EW services may access a higher monthly service cap. If an EW eligible person is a resident of a certified nursing facility and has lived there for 30 consecutive days or more, a request for a higher monthly service cap may be submitted to the Department of Human Services (DHS) for approval. To determine whether the EW services would exceed the average monthly service cap, determine the cost of authorized services under the community support plan and compare to the applicable statewide average monthly service cap in **Attachment A.** If implementation of the community support plan would cost less than the assigned case mix cap in Attachment A, the client does not require a conversion rate. If the community support plan cost exceeds this figure, the person may access a higher monthly service cap equal to no more than the cost to Medical Assistance for services in the Nursing Facility (NF) where the person currently resides.

II. To Determine the Medicaid Cost for the Person in their Current NF

1) Determine the annual rate by multiplying the per diem (daily) rate charged by the NF for that client by 365. The daily rate is found on the NF remittance advice.

Note: The daily rate to use for Ah-Gwah-Ching nursing home is the calculated RUGS equivalent daily rate as stated in a DHS memo issued February 2, 2006.

2) Divide the annual rate by 12 to establish the client's average monthly cost for NF care.
3) Subtract the current Maintenance Need Allowance ($816) from the resulting figure in (2).
4) Compare the result to costs of implementing the person's community support plan.

For persons who meet the criteria for a conversion rate and must access the higher service cap to pay for services necessary for their return to the community, the case manager must:

1) Determine the monthly service cap available to the person seeking the conversion rate using the formula above.
2) Submit the completed EW Conversion Rate Request Form (**Attachment B**) or EW Conversion Rate Request Form – Managed Care (**Attachment C**) and a copy of the NF Remittance Advice showing the client's per diem rate to: Department of Human Services, Aging and Adult Services Division, P.O. Box 64976, St Paul, MN, 55164-0976 or FAX request to (651) 431-7415
3) **Attachment C** must be approved by the Health Plan before it is sent to the department and there is a Service Agreement in MMIS for payment.

4) Place the higher conversion rate in the Case Mix/DRG Amount field on the LTC screening document. This will cause edit 784 (Case Mix/TBIW Screening Document requires Approval) to post and keep the screening document in suspense. If all other suspended edits are corrected, edit 784 will automatically route the screening document to DHS staff for review the following working day. DHS staff will retrieve the screening document and approve the higher amount or request further information from the case manager.

NOTE: Conversion Rates are NOT available to persons receiving Alternative Care.

Special Needs

This information is available in other forms to people with disabilities by contacting us at (651) -431-2590 (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

Elderly Waiver Program Monthly Service Caps Effective 10/01/2005 – 9/30/2006

Elderly Waiver	
Case Mix	**Monthly Cap as of 10/1/2005**
A	**$2,103**
B	**$2,393**
C	**$2,807**
D	**$2,900**
E	**$3,199**
F	**$3,296**
G	**$3,401**
H	**$3,837**
I	**$3,938**
J	**$4,198**
K	**$4,892**

Attachment B

ELDERLY WAIVER CONVERSION RATE REQUEST

COUNTY INFORMATION

Contact:	
Address:	
FAX	Telephone:

CLIENT INFORMATION

Recipient:	Date of Birth:
PMI #	Date of Request:
Case Mix	Cost of Care Plan

Nursing facility where client resides:	
(Initial request - Attach the Medical Assistance remittance advice form showing client's NF per diem rate)	
Per diem rate: $_____ X 365 = _____ ÷ 12 =	$_____
Minus current maintenance needs allowance (as of 7/01/06 is $816)	$
Client's monthly cap limit	$

Initial: Approved _____ Denied _____	COLA Increase Approved:_____
Signed: _____	Date _____
Comments:	

EW FAX: 651-431-7415
US MAIL ADDRESS: Department of Human Services
Aging and Adult Services Division
PO Box 64976
St. Paul, MN 55164-0976

Attachment C

ELDERLY WAIVER CONVERSION RATE REQUEST-Managed Care

COUNTY INFORMATION/HEALTH PLAN INFORMATION

Contact:	
Address:	
FAX	Telephone:

CLIENT INFORMATION

Recipient:	Date of Birth:
PMI #	Date of Request:
Case Mix	**Cost of Care Plan**

Nursing facility where client resides:	
(Initial request - Attach the Medical Assistance remittance advice form showing client's NF per diem rate)	
Per diem rate: $_____ X 365 = _____ ÷ 12 =	$_____
Minus current maintenance needs allowance (as of 7/01/06 is $816)	$
Client's monthly cap limit	$

Health Plan Initial: Approved _____ Denied _____

Name of Managed Care Organization: _____
Signed: _____ Date _____
Comments:

DHS Initial: Approved _____ Denied _____	COLA Increase Approved:_____
Signed: _____	Date _____
Comments:	

EW FAX: **651-431-7415**
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