#07-24-01

Bulletin

December 7, 2007

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

OF INTEREST TO

- County Directors
- Financial Assistance Supervisors and Workers
- Social Services Supervisors and Staff
- County Public Health Nursing Services
- Waiver Managers and Case Managers
- County Managed Care Staff
- Health Plans
- Tribal Directors

ACTION/DUE DATE

Implement Immediately.

EXPIRATION DATE

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

Minnesota Senior Care Plus Expansion Update

TOPIC

Update on Minnesota Senior Care Plus program expansion.

PURPOSE

Update information and replace bulletin number 05-24-01.

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SIGNED

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Health Care

Seniors (age 65 and older) receiving Medical Assistance (MA) have been required to enroll in Medicaid managed care since 1983. As of November 2007, 47,000 of the State's approximately 52,000 Medicaid seniors in 83 counties are required to choose from health plan options available in their counties. The other four counties, Lake, Hubbard, Beltrami and Clearwater will begin enrolling recipients into managed care in March 2008. Health plans provide additional member services, transportation, primary care/care system/medical homes, interpreter services, monitoring and facilitation of access to services in addition to what is provided in fee for service. DHS currently contracts with 9 health plans to serve Medical Assistance seniors statewide.

In 2005, DHS requested and received approval from the Centers for Medicare and Medicaid Services (CMS) to move Medicaid eligible seniors (age 65 and older) from Prepaid Medical Assistance Program (PMAP) to a different waiver authority under Federal Regulation 1915(b). The new 1915(b) waiver is called Minnesota Senior Care (MSC). Seniors who were required to enroll in PMAP were automatically switched to MSC in June of 2005. Seniors continue to be required to enroll in MSC unless they fall into certain exempt categories. The exempt categories have not changed under the new waiver authority. MSC continues to include all basic state plan services along with 90 days of Medicaid nursing home coverage for enrollees residing in the community. Seniors enrolled in MSC must obtain their Medicare Part D drugs by enrolling in a separate Medicare prescription drug plan. As of November 2007, 9,850 seniors are enrolled in MSC.

In 1997, DHS began offering Minnesota Senior Health Options (MSHO) which is a voluntary managed care program that combines Medicare and Medicaid financing and services for seniors age 65 and over who are eligible for Medical Assistance, who may or may not have Medicare. MSHO began in the seven county metropolitan area with three health plans and expanded in 2005 to include nine health plans providing coverage in 83 counties. MSHO offers the same Medicaid State Plan Services covered under MSC, and all Medicare services including prescription drugs covered by the Medicare Prescription Drug Program (Part D), and Elderly Waiver services. MSHO covers all Medicaid and Medicare drugs under the same health plan. The health plan also pays for the first 180 days of nursing facility care to enrollees who enter a nursing facility after enrollment. Enrollment into MSHO is voluntary. However, due to access to Part D coverage, most Medicaid seniors (approximately 36,000 as of November 2007) are now enrolled in MSHO.

Background on Minnesota Senior Care Plus

Laws passed in 2003 and amended in 2005 provided for the addition of Elderly Waiver (EW) and nursing home services to the basic MSC benefit package for seniors already required to enroll in managed care. (Minnesota Statutes, section 256B.69, subdivision 6b.(d)). This program is called Minnesota Senior Care Plus (MSC+) and operates under the same 1915(b) waiver as MSC along with the current 1915(c) waiver which provides home and community based (Elderly Waiver) services for Medicaid seniors. The law encouraged collaborative models to be developed between counties and health plans and allowed for MSC+ to be phased in statewide.

Under this phase in, MSC+ has been operating in 25 County-Based Purchasing (CBP) counties since June 2005, serving about 1,100 enrollees as of November 2007.

MSC+ includes all Medical Assistance state plan services covered under MSC and adds Elderly Waiver (EW) services. MSC+ also includes 180 days of nursing facility care for community enrollees who enter a nursing facility after enrollment. MSC+ Medicaid benefits are the same as provided under MSHO but MSC+ does not include Medicare services. Medicaid and long term care rates for health plans are the same for both MSHO and MSC+. Seniors enrolled in MSC+ must obtain their Medicare Part D drugs by enrolling in a separate Medicare prescription drug plan.

In early 2007, DHS issued an RFP to expand MSC+ to all counties except the seven metropolitan area counties (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington). MSC+ is already operating in 25 county based purchasing counties. In 2008, all 9 current managed care plans will offer MSC+ as a replacement for MSC in their current service areas except for the seven county metro area. This expansion will add 55 additional non-metropolitan counties to MSC+. Implementation of 51 new non-metropolitan counties will occur on January 1, 2008. Implementation in the four new counties being added to managed care in 2008 (Beltrami, Clearwater, Hubbard, and Lake of the Woods) will be effective March 1, 2008. Implementation in the seven county metropolitan area is not scheduled until January 2009.

Refer to attachment B for side by side comparisons of MSHO, MSC, and MSC+ covered services.

Health Plan Service Areas

DHS currently contracts with nine MSC+ health plans, which subcontract with providers, care systems and counties to provide health care services to MSC+ enrollees. See map in attachment A for MSC+ service areas for each health plan.

Case Management

Many counties and health plans have developed collaborative case management models for MSC+ including EW services. Counties who are contracting with health plans to provide EW or other case management must work directly with the health plans on details of case management for MSC+ enrollees. Case management under MSC+ may vary somewhat from MSHO requirements since Medicare services are not included in MSC+. Some health plans also contract with care systems or clinics to provide care management for EW services. In the instances where counties have chosen not to contract with health plans to provide case management for MSC+, health plans may contact the counties in preparation for the transition. It is important that counties and health plans work together during this transition.

January 2008 Service Plan Transitions

It is expected that counties and health plans will communicate with each other in order to assure a smooth transition for all enrollees. Counties are requested to share current EW service plans with the health plans to assure continuation of services. Health plans and counties should already be able to identify which MSC enrollees have EW services and will be switching to MSC+. There is no Health Insurance Portability and Accountability Act (HIPPA) barrier for counties or health plans in sharing service plans for EW recipients who will soon receive EW services through their health plan under MSC+. EW recipients included in the MSC+ transition are already enrolled with the health plans that will be implementing MSC+ and managing the EW services, therefore health plans are allowed to access state and county information about these enrollees. Please note that because of open enrollment, there may be a few people who change plans that may be new enrollees to the health plan in January. This will require a quick exchange of information to maintain services.

MSC+ Eligibility Criteria

Seniors are required to enroll in MSC+ if they:

- are 65 years of age or older,
- Medical Assistance eligible,
- reside in a county where MSC+ is available. (See attachment A – MSC+ Service Area Map), and
- do not meet a managed care exclusion

Seniors are also required to enroll if they:

- are enrolled in Home and Community Based Waiver Programs including EW, Community Alternatives for Disabled Individuals (CADI), Traumatic Brain Injury (TBI) and Developmental Disabilities Wavier (DD),
- have waiver obligations and institutional spenddowns, or
- have elected hospice or have End Stage Renal Disease.

Excluded Populations

The following individuals are excluded from enrollment in MSC+:

- Individuals who have medical spenddowns.
- Individuals who are Qualified Medicare Beneficiaries (QMB), as defined in 42 CFR Part 400.202 and who are not otherwise eligible for Medical Assistance.
- 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 Medical Assistance.
- Individuals eligible for the Refugee Assistance Program pursuant to 8 U.S.C. §1522(e).

- Residents of State Regional Treatment Centers, unless the MCO approves placement. Approval by the MCO would include a placement that is court-ordered.
- Individuals, who at the time of notification of mandatory enrollment in MSC/MSC+ have a communicable disease whose prognosis is terminal and whose primary physician is not a Participating Provider in the MCO, and that physician certifies that disruption of the existing physician-patient relationship is likely to result in the patient becoming noncompliant with medication or other health services.
- Individuals who are eligible while receiving care and services from a non-profit center established to serve victims of torture.
- Medical Assistance recipients who are terminally ill as defined in Minnesota Rules, part 9505.0297, subpart 2, item N. and who, at the time enrollment in MSC/MSC+ would occur, have an established relationship with a primary physician who is not part of an MSC/MSC+ MCO.
- Individuals who receive emergency Medical Assistance under Minnesota Statutes, §256B.06, subd. 4.
- Medical Assistance recipients with private health care coverage through a HMO certified under Minnesota Statutes, Chapter 62D. Such Recipients may enroll on a voluntary basis if the private HMO is the same as the MCO the person will select under MSC/MSC+.
- Medical Assistance recipients with cost-effective employer-sponsored private health care coverage or who are enrolled in a non-Medicare individual health plan determined to be cost-effective, pursuant to Minnesota Statutes, section 56B.69, subdivision 4(b)(9).

Enrollment Process

Enrollment into MSC+ continues to be mandatory. DHS estimates that approximately 3,000 seniors statewide will be affected by the transition from MSC to MSC+. Current MSC enrollees affected by the change received a letter from DHS in late October notifying them of the change. MMIS converted all affected enrollees from MSC to MSC+ on the evening of November 19, 2007. All disenrollment and enrollment notices were suppressed by DHS. The enrollment impact to the counties is expected to be very minimal during the conversion. All current managed care enrollment exclusions for seniors over age 65 in MSC continue to apply for people in MSC+ counties. This includes people who have medical spenddowns.

Open Enrollment

Enrollees who change health plans during open enrollment must be transitioned into their new health plan for MSC+ effective January 1, 2008. Please note that because of open enrollment, there may be a few people who change plans in December and may be new enrollees to the health plan in January, requiring a quick exchange of information between the county and health plan to maintain services.

Changes to MSC+ Product Code Conversion

Beginning November 19, 2007, MMIS automatically converted all affected enrollees to a MSC+ product code.

- People without Elderly Waiver will go from MA01/NM01 to MA30/NM30

- People with Elderly Waiver will go from MA01/NM01 to MA35/NM35

Counties can identify enrollees impacted by the transition by looking at INFOPAC report: PWMW185L-R0504 PPHP Current Enrollment Report. On November 18, 2007, seniors with an Elderly Waiver service agreement that is open through January 1, 2008 had their service agreement automatically closed effective December 31, 2007. Health plans will also receive reports for their current MSC members who will be transitioning to MSC+ EW case management and related services. It is expected that counties and health plans will communicate with each other in order to assure a smooth transition.

Effective Date of Enrollment

Medicaid managed care enrollment occurs on a monthly basis. The effective date of coverage for MSC+ enrollment is as follows:

- When enrollment occurs and has been entered on the State MMIS System on or before enrollment cut-off, coverage will begin at midnight on the first day of the following month.
- When enrollment occurs and has been entered on the State MMIS System after enrollment cut-off, 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.

Refer to Attachment C for DHS Enrollment Coordinator contact information.

MOVING TO A NEW COUNTY

Effective January 1, 2008, MSC+ health plans will provide all EW services including EW case management for their enrollees. However, if a recipient moves it could impact health plan enrollment and who is responsible for EW case management. Enrollment into managed care is based on the county of residence (the county in which the enrollee is physically present). Therefore, the county of residence determines the type of managed care (MSC or MSC+) and choice of managed care organizations available.

Moving from MSC to MSC+ County

If a recipient (age 65 or older) moves to a county where a MSC+ product is offered and does not meet any of the criteria for exclusion from mandatory managed care, the recipient must be enrolled into MSC+ when they enter the county. If the recipient meets one or more of the managed care exclusion criteria, then the recipient will continue to receive services through fee-for-service.

Managed care enrollment is based on the county of residence. When a recipient moves to a new county, the choice of managed care organization(s) available is determined by the county in which the recipient is physically present. The recipient should receive a managed care education packet containing applicable information for the new county. The county of financial responsibility may remain their county of origin or it may change to the new county but the county of financial responsibility does not impact enrollment into managed care.

When a MSC enrollee moves from an MSC to an MSC+ county, and the county of residence is updated on MAXIS, MMIS will automatically close the managed care plan at capitation if the current managed care plan is not available in the new county of residence. If the same managed care plan is available in the enrollee's new county of residence, the enrollee will remain in the same plan for MSC+. If the health plan is not available, the new county should send a managed care education packet and begin tracking for new health plan selection in MMIS. EW services are provided by the county fee-for-service until the enrollee is enrolled in the new health plan. Upon enrollment in MSC+, the MSC+ health plan becomes responsible for providing all EW services including case management.

Moving from MSC+ County to MSC County

When a MSC+ enrollee moves from an MSC+ county to a county that only offers MSC, the enrollee will be disenrolled from the MSC+ health plan and enrolled into the same MSC health plan by MMIS. When the new address and county of residence code is updated in MAXIS on STAT/ADDR, the information interfaces to the RCAD screen in MMIS. If the same health plan is available then the enrollee will be enrolled into the same plan for MSC. If the current managed care plan is not available in the new county of residence, the system automatically closes managed care enrollment at the next capitation. The new county should send a managed care education packet and begin tracking for new health plan selection in MMIS.

The MSC+ health plan will discontinue providing EW services, including case management services and the new county must arrange for and approve EW services, including EW case management. Please refer to the January 2008 Service Plan Transitions section on page 4.

Moving from MSC+ County to another MSC+ county

When a MSC+ enrollee moves from an MSC+ county to another MSC+ county the enrollee will be disenrolled from the current MSC+ plan if the same plan is not available in the new county of residence. If the same health plan is available the enrollee will remain in the same health plan. If the same MSC+ health plan is not available in the new county, the system automatically closes managed care enrollment at the next capitation once MMIS is updated with the new county code. The enrollee must be enrolled into a new MSC+ health plan. The new county should send a managed care education packet and begin tracking for new health plan selection in MMIS.

If a plan change is needed, the old MSC+ health plan will discontinue providing EW services, including case management and the new MSC+ health plan must arrange and approve EW services including case management. If no change in health plan is required, the health plan will

continue to provide EW services including case management. The only change that may occur is a new Care Coordinator may be assigned to the enrollee because of the county change.

Moving from MSC+ or MSC county to non-managed care county (Effective until 3/1/08)

All 87 counties will be offering MSC+ or MSC effective March 1, 2008. Until all counties start offering MSC or MSC+, it is possible that an enrollee may move to a county that does not offer managed care for seniors in January or February 2008. The counties in which this may occur are Beltrami, Clearwater, Hubbard, and Lake of the Woods. If a MSC or MSC+ enrollee moves to one of these counties prior to MSC+ availability, the enrollee will be automatically disenrolled in MMIS at capitation once the county of residence code is updated in MMIS. The new county must arrange for and approve EW services, including EW case management. Effective March 1, 2008, all Medical Assistance enrollees age 65 and older in Beltrami, Clearwater, Hubbard, and Lake of the Woods counties who are required to enroll into managed care must select an MSC+ plan.

Notification to Counties of MSC+ Enrollment

Several INFOPAC reports are available for counties to review.

PWMW185L-R0504 PPHP Current Enrollment Report for Worker
PWMW1850-R0506 PPHP Potential Enrollee Report
PWMW186D-R0510 Pre-Capitation Error /Recipient Capitation Error
PWMW185J-R0535 PPHP County Elderly Disenrollment Report

Loss of Eligibility

Some people who lose MA eligibility and subsequently regain eligibility for MA payment of Long Term Care services may have to return to fee-for-service (FFS) temporarily. When this happens health plans will be contacting counties to reopen EW cases in FFS, until the person is re-enrolled in managed care. Health plans have existing forms and processes which outline specific services and providers for EW enrollees that health plans and county case managers are encouraged to use for this process. As long as there is an open EW waiver span and the health plan provides the information necessary, the county should enter the service agreement information in MMIS in these cases.

Waiver Obligations, Medical Spenddowns, Institutional Spenddowns and Designated Providers

Waiver Obligations

The managed care plan is responsible for the EW claims for people enrolled into MSC+. EW members can be enrolled into MSC+ with waiver obligations. The process for the collection of waiver obligations is very similar to the process used by DHS fee-for-service claims. MSC+ enrollees with waiver obligations are required to pay their waiver obligations to their providers. The waiver obligation cannot exceed the cost of waiver services received that month. Providers

will bill the MSC+ health plan for EW covered services. MSC+ health plans pay the provider after deducting the amount of the waiver obligation. DHS provides the amount of the waiver obligation to the health plans monthly. Because the health plans are paying the EW claims, designated providers cannot be used in MMIS because DHS does not pay EW claims under MSC+. However, health plans may assist enrollees in designating providers to receive the waiver obligation in the health plans payment system but a designated provider should not be listed in MMIS. See "Designated Providers" on page 10

Medical Spenddowns

People with Medical Spenddowns are excluded from managed care enrollment. Refer to the MMIS User Manual for more information on coding RPPH with the correct exclusion code.

Institutional Spenddowns

Institutional spenddowns for people enrolled into MSC+ are collected by the provider. DHS automatically deducts the amount of the institutional spenddown from the designated provider when the health plan has the 180 nursing facility (NF) liability. The NF collects the institutional spenddown from the enrollee just as it does for other Medicaid recipients. In cases where the MSC+ health plan has responsibility for the 180 days nursing facility benefit, nursing facilities bill the full charges for 180 days of Medicaid room and board days directly to the health plan, and the health plan pays 100 percent of the negotiated rate. During months when the plan is responsible for NF services, DHS deducts the institutional spenddown amount from the payment sent to 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 institutional spenddown:	+$200
Total NF receipts – preliminary:	$3,200
DHS debits Institutional spenddown on the Remittance Advice (RA):	-$200
Total NF receipts – final:	$3,000

If, for a given month, the total Medical Assistance covered room and board charges incurred for an enrollee is less then the amount of the enrollee's institutional spenddown that was deducted for that month by DHS (including cases where no Medical Assistance covered room and board charges were incurred), the NF should contact the Provider Help Desk at DHS to arrange for an adjustment. The Provider Help Desk can be reached at 1-800-366-5411 or 651-431-2700.

Designated Providers

Designated providers should not be used for MSC+ enrollees with waiver obligations. This policy also applies to enrollees with waiver obligations and medical spenddowns (except

hospice) on MSHO (refer to bulletin #06-21-05 for more information on MSHO). Since the health plans are liable for EW claims, designated providers cannot be used in MMIS because DHS is not paying any of the EW claims for people enrolled in MSC+ and MSHO.

Designated provider numbers should be entered for institutional spenddowns and medical spenddowns for enrollees who elect hospice enrolled in MSC+. DHS has a process for collection of the institutional spenddown that is detailed in the Institutional Spenddown section on page 9.

MSC+ Nursing Facility Policies

1503 Form

Medicaid-certified nursing facilities are required to send DHS Form 1503 to the county financial workers whenever any Medical Assistance 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 worker uses this information to adjust the client's eligibility for Medical Assistance 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. It is extremely important that this information be reported and updated as soon as possible.

It is equally important that financial workers update MAXIS/MMIS with nursing facility admission information regardless of whether a health plan may be responsible for some of the days or not. MMIS will track responsibility for payment. MMIS coding is used by CMS to set the Medicare Part D co-pay level for dually eligible enrollees. Both the nursing home and the county play a large role in CMS reflecting the correct co-pay amount for enrollees.

Hospice

Hospice policy for MSC+ is similar to policy for all the other Minnesota Health Care Programs (MHCP) managed care products such as MSC, MSHO, and MnDHO. MSC+ enrollees who elect hospice should not be disenrolled from MSC+. Policies regarding EW and hospice services apply the same for MSC+ as fee-for-service. When an MSC+ 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 Medical Assistance would have paid the NF if the person had not elected hospice.

180 Day Nursing Facility Benefit

If an enrollee who resides in the community at the time of enrollment in MSC+ enters a nursing facility 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 cumulatively. After the 180 days, the NF services are paid by MA on a fee-for-services basis. Nursing facility days during hospice do not count toward the health plan's 180 day obligation.

NF Liability for Transition from MSC to MSC+

If at the time of transition from MSC to MSC+, a health plan has current liability for 90 days, the NF liability will be cancelled and payment responsibility reverts to fee-for-service through DHS on the first of the month of MSC+ enrollment.

Provision of Waiver Services and Screenings

Elderly Waiver (EW)

Recipients eligible for EW services receive waiver services through the MSC + health plan. Providers providing EW services to MSC+ enrollees must bill the MSC + health plan for payment. The health plan is responsible for entry of the screening document into MMIS to open and/or 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.

CADI, DD, AND TBI

Recipients age 65 and older who meet MSC+ eligibility criteria and are eligible for CADI, MR/RC, and TBI waivers are required to enroll into MSC+ unless they are excluded from managed care enrollment. These recipients continue to receive CADI, MR/RC and TBI 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 MSC+ health plan. Counties continue to enter required waiver screening documents for these waiver clients. MSC+ health plans do not enter screens into MMIS for MSC+ enrollees on the CADI, MR/RC and TBI waivers. The county waiver case manager and the MSC+ care coordinator work together to coordinate services for MSC+ enrollees on these three waivers.

Telephone Screens

MSC+ health plans are responsible for conducting and entering telephone screenings for their enrollees according to bulletins issued by DHS. These are listed on Attachment E. Counties do not conduct or enter telephone screenings for MSC+ enrollees unless the county is acting under an agreement with an MSC+ health plan.

DHS as Third Party Administrator for Elderly Waiver

Three MSC+ health plans, Blue Plus, South Country Health Alliance and UCare Minnesota have contracted with DHS to be the third party administrator (TPA) for payment of EW service claims 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. Questions regarding billing of EW services for MSC+ enrollees should be directed to the MSC+ health plan.

Tribal EW

DHS has a contract with White Earth and Leech Lake that allows for tribal management of EW services. MSC+ enrollees who live on the White Earth or Leech Lake reservations can choose to have EW services managed by the tribe. If an enrollee chooses this option, the MSC+ enrollee will have two case managers: one from the tribe for EW services and one through the MSC+ health plan to coordinate all other medical services. The two case managers should develop a communicate plan, to be included in the care and service plan, which outlines how best to coordinate services for the individual to avoid duplication and to reduce confusion for the enrollee as well as for the tribe and MCO.

Ongoing Transitions

If a recipient is required to enroll into MSC+ and is currently on EW, the county should contact the MSC+ health plan to transition the provision of services to the health plan. If an MSC+ enrollee is on EW and is disenrolled from MSC+, the MSC+ care coordinator should contact the county to transition the provision of services to the county. The EW span should not 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.

Elderly Waiver Service Agreement Changes for the MSC+ Expansion

The MSC+ expansion into an additional 51 counties effective January 1, 2008, will affect those enrollees on the Elderly Waiver (EW) program. On November 18, 2007, EW service agreements were automatically closed effective December 31, 2007. The service agreement was closed if the following criteria were met:

- The county of residence field is not 002, 004, 010, 015, 019, 027, 029, 039, 062, 070, or 082;
- The header status is not D – denied;
- The header period includes 1/1/08;
- The enrollee is currently open to managed care with product MA01/NM01 that includes 1/1/08; and
- The recipient is not excluded from managed care with a date that includes 1/1/08.

On November 18, 2007, enrollees with an EW service agreement that meet the above criteria had the header end date and line item end dates automatically changed to December 31, 2007. Reason code 859 was added to those line items that extended beyond January 1, 2008. It is possible that no line items extend beyond January 1, 2008 in which only the header end date will close to December 31, 2007.

County staff must adjust the units of these line items to fit within the new period. Line items that begin January 1, 2008 or greater were changed from a status of approved (A) to denied (D). Edits that post against those line items do not need to be corrected.

Enrollees with Medica, Metropolitan Health Plan, HealthPartners, Itasca Medical Care, First Plan Blue, or Primewest Health System will have their Elderly Waiver and State Plan services coordinated by the health plan organization as of January 1, 2008.

Enrollees with South Country Health Alliance, UCare Minnesota (UCare is not contracted for MSC+ in all counties), or Blue Plus will need a new service agreement entered for services beginning January 1, 2008 to the end of the current waiver eligibility span. Elderly Waiver services are added to this new agreement. The total cost of any State Plan services are shown on one line item and represented by procedure code x5609. The State Plan services are then identified on the DHS Comment Screen.

On November 19, 2007, enrollees in the above counties who are enrolled in managed care using Minnesota Senior Care (product ID MA01/NM01 on the RPPH screen in MMIS) were automatically enrolled in product ID MA35/NM35 or MA30/NM30. The distinction of whether MA30/NM30 or MA35/NM35 is assigned was determined by an open EW waiver span that includes January 1, 2008.

Identifying Care Coordinators

Care Coordinators can be identified in MMIS once a screening document is entered by the Health Plan Care Coordinator. Once a screening document is entered, the RMGR screen will indicate that a document was entered by the managed care plan care coordinator. To get the contact information, the worker must PF4 to navigate. If more then one screening has been entered, the worker will see multiple lines of information. The worker should place the curser under the provider number they want to view before hitting PF4 to navigate. The most recent case manager/care coordinator will be listed at the top. RMGR will also show county entered screening documents. Managed Care entered screenings can be identified by the type listed on RMGR. Managed Care screenings will be listed under the type, “MC MGD CARE” and county screenings will be listed under the type, “CO County.” Once the worker navigates from RMGR, the PSUM screen appears. The Care Coordinator name is located in the upper left hand corner of the screen. From the PSUM screen, the worker must Transmit once more to get the phone number contact information. When the worker transmits, it will take them to the PADD screen.

MMIS RMGR

Type:	Begin Date:	End Date:	Provider Number:
CO County	mm/dd/yy	mm/dd/yy	County case manager
MC MGD Care	mm/dd/yy	mm/dd/yy	Managed Care

PF4 to Navigate to PSUM

PSUM

The name of the Care Coordinator is listed the upper left hand corner. Transmit to PADD

PADD

The name and phone number are listed on the PADD screen. The name of the Care Coordinator is still listed in the upper left hand corner and the phone number is listed on the right side.

If no screening has been entered by the Managed Care Coordinator, then the county will need to call the health plan contact number to get the contact information. The contact list for identifying the Care Coordinator is in attachment D.

Appeals and Grievances

Enrollees in the MSC+ program have the same appeal and complaint rights as enrollees in other Medicaid managed care programs. Enrollees 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.

Attachments
Attachment A - MSC+ Service Area Map
Attachment B - Managed Care Options for Seniors Comparison Chart
Attachment C - DHS Enrollment Coordinators Contact List
Attachment D - Contacts for Identifying Care Coordinators for MSHO and MSC
Attachment E - EW Program Memo

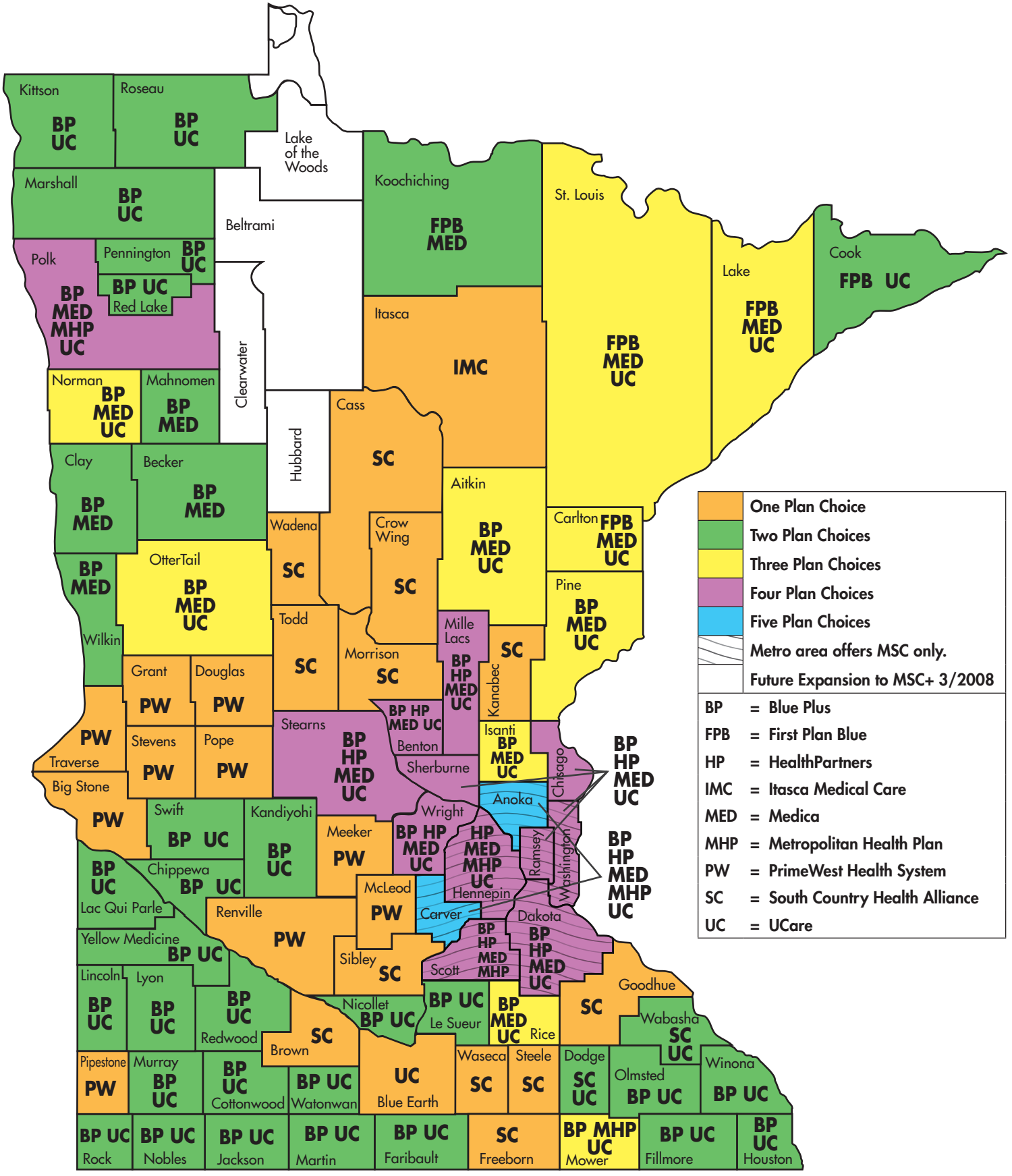
Special Needs
This information is available in other forms to people with disabilities by contacting us at (651) 431-2283 or toll free at (888) 938-3224 or through the Minnesota Relay Service at (800) 627-3529 (TDD), 711 or (877) 627-3848 (speech to speech relay service).

Minnesota Department of **Human Services**

Minnesota Senior Care (MSC) and Minnesota Senior Care Plus (MSC+)

Health Plans by County

Effective Jan. 1, 2008



Managed Care Options for Seniors Comparison Chart

	MSHO	**MSC+**	**MSC**
Enrollment	Voluntary, began 1997 (83 Counties)	Mandatory, began 2005 (76 counties 1/08, 80 counties 3/08, statewide in 2009)	Mandatory, began 1983 (7 county metropolitan area 1/08)
Medicare Part A/B	Medicare Special Needs Plan (SNP)	Medicare fee for service (FFS) or separate Medicare Advantage Plan	Medicare fee for service (FFS) or separate Medicare Advantage Plan
Medicare Part D Drugs	SNP	Separate free standing Medicare PDP or separate Medicare Advantage Plan	Separate free standing Medicare PDP or separate Medicare Advantage Plan
Remaining Medicaid Drugs	SNP	Medicaid MCO	Medicaid MCO
Medicaid Basic Care	SNP	Medicaid MCO	Medicaid MCO
Medicaid NF	SNP (180 days for new community enrollees) remainder FFS	MCO (180 days for new community enrollees) remainder FFS	MCO (90 days for new community enrollees) remainder FFS
Medicaid EW	SNP	Medicaid MCO	Medicaid fee for Service

12/07/2007

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

PMAP Maintenance Enrollment Coordinators

Tammy Ecklund (651) 431-4227 Maxis email HBZ Back-up: Carla/JoAnn	Jo Ann Jones (651) 431-2524 Maxis email HXC Back-up: Carla	Shelly Nelson (651) 431-2542 Maxis email JVG Back-up: Mary	Mary Timm (651) 431-2527 Maxis email WI Back-up:Shelly	Carla Turnbom (651) 431-2525 Maxis email CA Back-up: JoAnn
Carver (10)	Anoka (02)	Aitkin (01)	Becker (03)	Benton (05)
Scott (70)	Big Stone (06)	Blue Earth (07)	Cass (11)	Carlton (09)
	Chippewa (12)	Brown (08)	Clay (14)	Cook (16)
	Dakota (19)	Chisago (13)	Crow Wing (18)	Itasca (31)
	Douglas (21)	Cottonwood (17)	Kittson (35)	Koochiching (36)
	Grant (26)	Dodge (20)	Le Sueur (40)	Lake (38)
	Hennepin (27)	Faribault (22)	Mahnomen (44)	Mille Lacs (48)
	Kandiyohi (34)	Fillmore (23)	Marshall (45)	Ramsey (62)
	LacQuiParle (37)	Freeborn (24)	Morrison (49)	St. Louis (69)
	Lincoln (41)	Goodhue (25)	Nicollet (52)	Mille Lacs Tribal TANF (88)
	Lyon (42)	Houston (28)	Norman (54)	MinnesotaCare (MCR)
	McLeod (43)	Isanti (30)	Otter Tail (56)	
	Meeker (47)	Jackson (32)	Pennington (57)	
	Murray (51)	Kanabec (33)	Pine (58)	
	Nobles (53)	Martin (46)	Polk (60)	
	Pipestone (59)	Mower (50)	Red Lake (63)	
	Pope (61)	Olmsted (55)	Rice (66)	
	Renville (65)	Redwood (64)	Roseau (68)	
	Rock (67)	Sibley (72)	Sherburne (71)	
	Stearns (73)	Steele (74)	Todd (77)	
	Stevens (75)	Wabasha (79)	Wadena (80)	
	Swift (76)	Waseca (81)	Wilkin (84)	
	Traverse (78)	Washington (82)		
	Yellow Medicine (87)	Watonwan (83)		
		Winona (85)		
		Wright (86)		

Health Plan Enrollment Coordinators

Tammy Ecklund	Jo Ann Jones	Shelly Nelson	Mary Timm	Carla Turnbom
Metropolitan Health Plan	PrimeWest Health System	South Country Health Alliance	Medica	Blue Plus
	UCare Minnesota			First Plan Blue
				HealthPartners
				Itasca Medical Care

Addresses

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

Mailing:
Department of Human Services
PO Box 64984
St. Paul, MN 55164-0984

12/07/2007

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

Other Initiatives

POLICY		
Chris Gibson	MAXIS e-mail - HGX	(651)431-2529
Appeals - All Programs		
Mary Timm	MAXIS e-mail - WI	(651)431-2527
PMAP/CBP Expansion and Education Materials		
Jo Ann Jones	MAXIS e-mail - HXC	(651)431-2524
All MANUALS		
Chris Gibson	MAXIS e-mail - HGX	(651)431-2529
PMHCP (PMAP) MANUAL		
Mary Timm	MAXIS e-mail - WI	(651)431-2527
MinnesotaCare		
Carla Turnbom	MAXIS e-mail - CA	(651)431-2525
MSHO/MnDHO		
Chris Gibson (back-up)	MAXIS e-mail - HGX	(651)431-2529
NF Liability		
Shelly Nelson	MAXIS e-mail - JVG	(651)431-2542
Linda Haider	MAXIS e-mail - LHR	(651)431-3455
Open Enrollment		
Carla Turnbom	MAXIS e-mail - CA	(651)431-2525
Medicare Part D		
Chris Gibson	MAXIS e-mail - HGX	(651)431-2529
Marina Duffert	MAXIS e-mail - HYY	(651)431-2482
Linda Haider	MAXIS e-mail - LHR	(651)431-3455
Managed Care Systems Liasons		
Lori Kelley (Lead)	MAXIS e-mail - GAV	(651)431-2523
Tammy Ecklund	MAXIS e-mail - HBZ	(651)431-4227

Adjustments: Send requests on MAXIS to 'MADJ'

FAX NUMBERS: Managed Care 651/431-7426 MSHO Only 651/431-7548

Managed Care Contract Management and Compliance
Chandra Breen, Manager (651) 431-3487

Health Plan	Contract Manager	Phone Number
Blue Plus	Doris Wong	(651) 431-2519
First Plan	Pam Olson	(651) 431-2526
HealthPartners	Heidi Johnson	(651) 431-2435
Itasca Medical Care	Lill Tallaksen	(651) 431-2522
Medica	Michelle Wernimont	(651) 431-2453
Metropolitan Health Plan	Beryl Palmer	(651) 431-2521
PrimeWest Health System	Lill Tallaksen	(651) 431-2522
South Country Health Alliance	Pam Olson	(651) 431-2526
StedFast Health Plan	Pam Olson	(651) 431-2526
UCare Minnesota	Nancy Paulsen	(651) 431-2520

Contacts for Identifying Care Coordinators for
Minnesota Senior Health Options (MSHO) and Minnesota Senior Care (MSC)

Managed Care Organization	Contact
Blue Plus Secure Blue (MSHO)	Senior Public Programs Phone: 651-662-5540, 1-800-711-9868 Lila Cate Phone: 1-888-878-0139, ext. 2-9005
First Plan Blue	Laura McDonald Phone: 218-529-9955 or 800-635-4159 Marilyn Moore Phone: 218-279-8377 or 877-268-2996 X 6741
HealthPartners	Case Management/MSHO Support Line Phone: 952-883-6983
Itasca Medical Care (IMC)	Ron Storlie, Care Coordinator Phone: 218-327-5591 Dave Sainio, Care Coordinator Phone: 218-327-6193
Medica DUAL Solution (MSHO)	Center for Health Aging Customer Service Phone: 1-800-234-8755
Metropolitan Health Plan (MHP)	Julie Furleigh Phone: 952-440-6067 Jean Sogard Phone: 612-337-7186
PrimeWest Health System (PWHS)	Becki Pender, RN, Senior Care Coordinator Nursing Facility enrollees Phone: 320-335-5204 Elaine Carlquist, RN, CCP Senior Care Coordinator Elderly Waiver and Community Non-EW Phone: 320-335-5354
South Country Health Alliance (SCHA)	Amy Smith, Senior Care Program Manager Phone: 507-444-7775
UCare Minnesota	Care Management Intake, Tobi Clark-Hall Phone: 612-676-3482 Shelley Wagner Phone: 612-676-3254

8/1/07

Minnesota Department of **Human Services**

Memo

DATE: November 21, 2007

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 651 431-2700 – Provides Technical Assistance to all Medical Assistance enrolled providers and answers questions concerning MN-ITS, also a referral for claim and billing problems.
- Resource Center County Help Desk 651 431-2450 or 888 968-8453 or email dhs.resourcecenter@state.mn.us – Provides technical assistance to waiver staff on MMIS long term care and developmental disability screening documents and service agreements

DHS Manuals:
http://www.dhs.state.mn.us/main/groups/publications/documents/pub/DHS_id_000103.hcsp

- 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
- Consumer Directed Community Supports Lead Agency Manual – DHS-4270-ENG
- Consumer Directed Community Supports Consumer Handbook – DHS 4317-ENG

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_aging.hcsp
- EW/AC List Serve 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
- Lead Agency Case Manager/Worker Communication Form – DHS 5181 ENG
- Alternative Care and Elderly Waiver Programs brochure DHS-2988-ENG
- Request for Payment of Long Term Care Services DHS -3543 ENG
- Waiver/AC Case Mix Classification Worksheet DHS-3428B ENG
- Information and Signature Sheet – DHS 2727-ENG
- Senior Linkage Line 800-333-2433
- Office of Ombudsman for Long Term Care 800-657-3591
- Office of State Managed Care Ombudsman 651-431-2660

- Helping Family Care for Older Adults on Echo T.V. in multiple languages – provides recommendations for caregivers so they have support and resources http://www.echominnesota.org/index.cfm/p/tv/
- Aging **CDCS** website www.dhs.state.mn.us/cdcs
  Video Clips

The *You decide. Your help.* video clips are at web site:
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_058825

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

06-25-01 Managed Care Transitional Questions and Answers for Waiver Recipients
06-25-02 Annual Increase for Maintenance Needs Allowance and EW Conversion Rates
06-25-04 Legislative Action Increases AC and EW Program Service Rates
06-25-05 DHS Issues Monthly Service Case Mix Caps for the AC and EW Programs
06-21-05 Minnesota Senior Health Options Updates
06-56-05 Legislature Clarifies Use of Provider Rate Increase for Home Care and other Home and Community Based Services
06-56-02 Phase 2 Conversions to National HIPAA Procedure Codes for Home Care, Waiver, AC programs and DT&H
06-21-14 Home Equity Limit for Medical Assistance Payment of Long Term Care Services
06-21-13 Medical Assistance Policy for Uncompensated Transfers
07-21-02 DHS Announces Changes to Medical Assistance (MA) and MinnesotaCare Eligibility for Continuing Care Retirement Community (CCRC) Residents Regarding Entrance Fee as an Asset
07-21-05 DHS Announces Changes to Transfer Penalty Period Begin Date Policy for Medical Assistance (MA) Enrollees Receiving Payment of Long-Term Care (LTC) Services
07-25-01C Corrected #07-25-01 Comprehensive Policy on Elderly Waiver (EW) Customized (Formerly Assisted) Living
07-25-02 Annual Increase for Maintenance Needs Allowance and Elderly Waiver Conversion Rates
07-69-03 2007 Legislature provides rate increases for continuing care and other providers
07-25-04 Submission of the Annual Quality Assurance Plan for Home and Community Based Service Programs for CY08
07-25-05 DHS Issues Monthly Service Case Mix Caps for Alternative Care and Elderly Waiver programs
07-21-09 New Communication Form and MMIS Coding for Medical Assistance (MA) Payment of Long-Term Care (LTC) Services
07-69-02 Federal Government Updates Poverty Guidelines for 2007

DHS REPORTS AVAILABLE ON INFOPAC: www.intertech.state.mn.us/infopac

PWMW185M-R0503 PPHP Current Enrollment Report for Provider
This report is generated after capitation and reports data for the next month. It is sorted by health plan provider number. It can be used to identify people who are enrolled with managed care. This report is available only to health plan staff.

9200-R2460 Cumulative Encumbrance and Payments (Using Date of Service)
This report is provided on a monthly basis. It is by county of financial responsibility and each managed care organization and shows data by date of service. It can be used to check the clients that are assigned to that county of financial responsibility and compare the usage of services among the clients.

9200-R2457 LTC Cumulative Service Encumbrance and Payments (Using Date of Service)
This is a monthly report for the county of financial responsibility and each managed care organization. It lists the cumulative encumbrance of payments of each procedure code as of the service date. One report is for each of the waiver programs and another report is for the Alternative Care program. Each program has a section for the current year and a section for the past year. It may be used to determine the total encumbered and/or paid amounts for each service during the reporting period, and to compare your county average with the state average amounts.

9200-R2455 Suspended LTC Screening Document
This is a weekly report for the county, tribal agency, health plan, or county based purchasing entity associated with the case manager number. If the case manager field is not filled, the screening document goes to the county identified in the LTCC County field. It identifies the screening documents that are in suspense for more than 2 weeks and the number of days since they were data entered. The screening document needs to be either deleted or a new document entered that corrects the problem that is keeping the document in suspense. This is a cumulative report.

9200-R2453 Screening Documents Approved
This monthly report is sectioned by the case manager or health care coordinator name. Screening documents approved with assessment results 01,10,11,13 or 28 within the reporting period are shown for the case manager or care coordinator listed on the screening document. It is not a cumulative report. This report can be used to track when screening documents were data entered and approved, and if a service agreement was entered to cover the period of eligibility.

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.

PWMW1850-R0506 - 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 and do not have an exclusion reason. Also people with an exclusion reason of YY (delayed or pending decision) or WW (delayed enrollment – new conversion counties only) for over 90 days are listed on the report.

PWMW185I-RP507 MSHO AND MnDHO New Enrollee Report
This report is generated after capitation and identifies people who enrolled in managed care (MSHO and MnDHO) that month. It is sorted by county of service and then by health plan. It Can be used to identify new enrollees who are also on a waiver program.

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. It shows elderly enrollees who disenrolled from managed care and the reason of disenrollment.

DHS REPORTS AVAILABLE ON INFOPAC: continued

PWMW9061-R2216 Elderly Waiver Utilization Master List

This report is run nightly and is sorted by county of Financial responsibility. It should be used by the Elderly Waiver case managers to check that each of their clients are listed on this report, and clients who have left the program no longer show on the report. Each person on the report has a waiver "slot". Those with a "Y" in the delete column are people who will keep their slot until the beginning of the new waiver year. Then their slot is removed to be re-used.

PWMW186D-R0510 Pre-Capitation/Capitation Error Report

This report will identify enrollees whose enrollment spans will be or have been closed by MMIS for the upcoming month. Financial workers need to review the cases prior to enrollment cutoff or capitation to make necessary updates for those cases that should continue. It is sorted by the county of service and then by financial worker ID.