#08-21-02

Bulletin

February 8, 2008

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
- Providers

ACTION/DUE DATE

Effective immediately.

EXPERATION DATE

February 8, 2010

Special Needs BasicCare

TOPIC

Special Needs BasicCare (SNBC) program.

PURPOSE

Introducing a new voluntary managed care program for people with disabilities called Special Needs BasicCare that is available January 1, 2008.

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Health Care

History of Managed Care in Minnesota

In 1983, the Department of Human Services (DHS) began offering Medical Assistance state plan services (including acute and primary care and home care services) through managed care organizations (MCOs). The product was called the Prepaid Medical Assistance Program (PMAP). Enrollment in MCOs is mandatory for most families and children and most people 65 and over. In 2005 seniors were transferred to a separate managed care program, Minnesota Senior Care or Minnesota Senior Care Plus. Persons with disabilities under 65 are excluded from mandatory enrollment in MCOs. Currently, managed care is available through nine MCOs in 83 counties.

Minnesota has experience developing managed care products which are uniquely tailored to the population they are designed to serve, specifically, Minnesota Senior Health Options (MSHO) and Minnesota Disability Health Options (MnDHO). MSHO/MnDHO are voluntary managed care programs which integrate Medicare and Medicaid financing and service delivery for primary, acute and long term care services including home and community based waiver services and additional care coordination. Health plans offering MSHO and MnDHO converted to Medicare Advantage Special Needs Plans (SNP) in 2006. SNP is a special designation from the Centers for Medicare and Medicaid Services (CMS) that allows Medicare Advantage health plans to enroll specific populations, in MSHO and MnDHO's case, dual eligibles. Special Needs Plans are required to provide Part D prescription drugs along with other Medicare benefits. Enrollment in an integrated SNP, such as MSHO/MnDHO, provides a simpler option for people as all Medicaid and Medicare drugs will be covered under one plan.

Except for seniors, age sixty five (65) or older, people with disabilities have not been required to enroll in Medicaid managed care in Minnesota. However, people with disabilities often lack access to consistent primary care under fee-for-service programs. During the 2005/2006 session of the Minnesota State Legislature, legislation was passed which allowed DHS to contract with qualified Medicaid approved SNPs to provide basic health care services to people with disabilities on a voluntary basis. The legislation also required DHS to consult with a stakeholder group in developing managed care options for serving people with disabilities.

Background on Special Needs BasicCare (SNBC)

DHS has worked with a large disability stakeholder's group throughout 2006 and 2007 to design the new managed care program for people with disabilities called Special Needs BasicCare (SNBC). The stakeholder group assisted DHS in developing purchasing criteria for the SNBC model contract. The group continues to provide an ongoing avenue of communication between consumer advocacy groups, health plans, counties, providers and DHS for development of managed care programs for people with disabilities.

SNBC is a voluntary managed care program that combines Medicare and Medicaid financing and services for people ages 18 through 64, who have a certified disability or are determined to have a disability by the local agency for individuals with developmental disabilities, and are eligible for Medical Assistance, with or without Medicare. People who choose to enroll in SNBC may disenroll in any month and return to fee-for-service, or change to another SNBC plan

if one is available. SNBC offers all medically necessary Medicaid state plan services with the exception of Home and Community Based Service (HCBS) waivers, Personal Care Assistant (PCA) and Private Duty Nursing (PDN). HCBS waiver services, PCA and PDN will continue to be paid by Medical Assistance fee-for-service. If an enrollee is Medicare eligible, the SNBC plan covers all Medicare services including prescription drugs covered by the Medicare Prescription Drug Program (Part D), and any alternative services the health plan may choose to offer. The SNBC health plan pays for the first 100 days of nursing facility care for community enrollees who enter a nursing facility after enrollment. See Attachment A for a list of covered services. See Attachment B for a list of non-covered services. These lists of covered and non-covered services include broad categories of services and do not specify all individual services at the procedure code level.

Like MSHO and MnDHO, Special Needs BasicCare (SNBC) health plans are MCOs that have entered into a contract with the Centers for Medicare and Medicaid Services (CMS) to provide Medicare Parts A, B, and D services in accordance with the Medicare Modernization Act (MMA) and participate in Medicare Advantage as a Dual Eligible Special Needs Plan (SNP). .

The State has authority to enter into contracts for the provision of prepaid medical and remedial services under Medicaid, pursuant to: 1) Title XIX of the Social Security Act, 42 U.S.C. 1396 et.seq.; 2) 42 CFR Parts 434 and 438; 3) Minnesota Statutes, section 256B.69; and 4) a Medicaid waiver under Section 1915(a) of the Social Security Act.

Health Plan Services Areas

SNBC began on January 1, 2008 with seven (7) Managed Care Organizations (MCO); Blue Plus, First Plan Blue, Medica, Metropolitan Health Plan (MHP), PrimeWest Health Systems, South Country Health Alliance and UCare. SNBC is available in 83 counties in the state. The only four counties that do not have SNBC available are Beltrami, Clearwater, Hubbard, and Lake of the Woods. See Attachment C for Health Plan Service Areas by County. See Attachment D for list of SNBC product names and the counties in which the plan is available.

Case Management

SNBC enrollees have access to various forms of care management, disease management, case management and navigation assistance. The SNBC health plans have broad primary care management responsibilities for all members including a specific contract requirement for facilitation of annual physician visits for primary and preventive care. The SNBC contract requires that health plans provide case management services including risk screening, complex case management for those members who qualify including a partnership with the enrollee, a 24 hour RN line, self management materials and coordination of services across both Medicare and Medicaid. In addition, the SNBC health plan is required to maintain disease management programs for diabetes, asthma and heart disease.

However, most of the SNBC health plans have chosen to provide care management models that go beyond the contract requirements to include an individually assigned navigator or case manager to enrollees. Some SNBC health plans are contracting with counties for this care

management, other health plans are contracting with disability care management organizations to provide case management and some SNBC health plans are providing in-house case management. The case management model through the SNBC health plans varies, however the county case management responsibilities for home and community based waiver case management do not change and remain with the county or county contracted case management system.

SNBC Eligibility Criteria

People can enroll if they:

- Are 18 through 64 years of age.
- Are Medical Assistance-eligible, with or without Medicare. If they have Medicare, they must have both Medicare Parts A and B in order to be eligible for SNBC.
- Are certified disabled by Social Security Administration (SSA) or State Medical Review Team (SMRT) or determined disabled by the county for purposes of the Developmental Disability (DD) waiver services.
- Reside in one of the counties where SNBC is available.

People may be eligible even if they have:

- Medical Assistance-Employed Persons with Disabilities (MA-EPD) coverage.
- Other third-party or insurance coverage or enrollment in a non-Medicare Advantage health plan.
- An institutional or medical spenddown.
- No Medicare coverage.
- Elected hospice coverage.
- Waiver programs, including Community Alternative Care (CAC), Community Alternative for Disabled Individuals (CADI), Traumatic Brain Injury (TBI), and DD. Members who are eligible for waiver services can receive these services on a fee-for-service basis through the county while enrolled in the SNBC plan. The county should contact the SNBC plan for authorization of skilled nursing visits, home health aide, therapies, durable medical equipment and supplies.
- Personal Care Assistant (PCA) or Private Duty Nursing (PDN) under Medical Assistance (MA) state plan.
- PCA or PDN services under the Consumer Support Grant (CSG)

(See section on HCBS waiver services for additional information on the provision of HCBS services.)

Excluded Populations

The following individuals are currently excluded from participation in the SNBC program:

- Individuals who have Medicare but are not eligible for Medical Assistance.
- Individuals who have Medical Assistance and have either Medicare Part A or B but not both.
- Individuals eligible for the Refugee Assistance Program.

- Residents of State Regional Treatment Centers, unless the health plan approves placement.
- Individuals who are Qualified Medicare Beneficiaries (QMB), as defined in 42 CFR Part 100.202 and 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 are not otherwise eligible for Medical Assistance.
- Individuals who have Medicare through United Mine Workers.
- Individuals currently diagnosed with End Stage Renal Disease (ESRD). Individuals who are diagnosed with ESRD after enrollment in a SNBC health plan will be allowed to remain enrolled in the SNBC health plan.

Enrollment Process

Enrollment into SNBC is voluntary and may only occur through a SNBC health plan. Counties are not responsible for enrolling people into SNBC. The state's SNBC contract allows SNBC health plans to market to Medical Assistance recipients who are SNBC-eligible. Health plan marketing activities must follow Medicare and Medicaid marketing regulations, and all marketing and other member materials are reviewed and approved in advance by DHS and CMS. The health plan is required to review and verify the information on the enrollment form including verifying Medicare eligibility before submitting the enrollment form to DHS. The health plan retains the original enrollment form for its records.

Individuals (or their authorized representative) are provided important enrollment information on the SNBC enrollment form that they must sign to demonstrate that they are making an informed choice about their health care coverage. See Attachment G for SNBC model enrollment form.

Starting early 2008, health plans will be able to enter enrollments into MMIS. The SNBC plan may not enter an enrollment if the person is already enrolled in a managed care plan. They may not key the disenrollment of any person. Changes and disenrollments will continue to be submitted to DHS for keying.

Because SNBC's marketing and enrollment will not be done at the county level, if an individual is interested in enrolling, the county worker should direct the individual to the Disability Linkage Line at 1-866-333-2466, the Senior Linkage Line at 1-800-333-2433 or to the SNBC health plan(s), who can educate individuals about SNBC and process enrollments. See Attachment D for SNBC plan's phone number(s).

Questions about SNBC Eligibility

Counties are not responsible for enrolling people in SNBC. If county workers or case managers get questions regarding eligibility to enroll in SNBC health plans they may call the DHS enrollment coordinator assigned to their county. See Attachment E for enrollment coordinator assignments.

The public may be referred to the Disability Linkage Line (DLL) at 1-866-333-2466 or to the SNBC health plan. The DLL has been trained and protocols are in place to help people explore the SNBC options available to them in their county, consider their Medicare Part D needs and to assist in resolution of questions.

For a list of MMIS eligibility types that can be enrolled in SNBC, product MA 17, see attachment F.

If an individual currently pays a premium for Medicare Part A and/or Medicare Part B, they must continue paying the premium in order to keep Medicare Part A and /or Medicare Part B and remain a member of the SNBC health plan.

If the person is on MA-EPD they must continue to pay the MA-EPD premium in order to maintain their Medical Assistance eligibility.

Enrollee Notification of Enrollment

For all Medical Assistance managed care programs including SNBC, after enrollment into a specific health plan/product is entered in MMIS, the system produces a notice to the individual confirming their enrollment in a specific health plan and the enrollment effective date. New SNBC enrollees will receive a membership packet from the SNBC health plan within 15 calendar days after the health plan receives enrollment data from the state.

Effective Date of Enrollment – Enrollment Guidelines

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

- For enrollees who have Medicare, coverage will begin at midnight on the first day of the month following the month in which enrollment was received.
- For enrollees who have Medical Assistance only, enrollment must be entered in the MMIS system on or before the capitation cut-off for the next month. (Occurs 8 working days prior to the end of the month.) Coverage will begin at midnight on the first day of the month following the month in which enrollment was entered.
- For enrollees who have Medicare and are receiving Inpatient Hospitalization services on the first of the month in which SNBC enrollment is effective, the effective date of coverage will not be postponed. Coverage will begin at midnight on the first day of the month following the month in which enrollment for entered on MMIS. Hospital costs for any enrollee who is receiving Inpatient Hospitalization services on the first date of coverage will not be the responsibility of the SNBC health plan.
- For enrollees who have Medical Assistance only and are receiving Inpatient Hospitalization services on the first of the month in which SNBC enrollment is effective, the effective date of coverage will be postponed until the first day of the month following discharge from the hospital.
- For enrollees with Medicare who are in an Inpatient Hospital based Chemical Dependency (CD) or who are in a Residential Treatment Facility, Minnesota Rules, parts

9530.6405 – 9530.6505 (informally known as Rule 31), extended care halfway house or a free standing residential treatment facility at the time of enrollment in the SNBC plan, enrollment will NOT be delayed. Coverage will begin at midnight on the first day of the month following the month in which enrollment was entered.

Chemical Dependency Services

- The SNBC plan will not be financially responsible for inpatient hospital based CD services being received at the time of enrollment unless these services are covered by Medicare. For the other services, financial responsibility of the SNBC plan will be as follows.

    - For January 1, 2008 through June 30, 2008, the SNBC plan will not be responsible for extended care, halfway house or free standing residential CD facility services when the enrollee is receiving those services upon enrollment.
    - For the time period July 1, 2008 through December 31, 2008, the SNBC plan will be financially responsible for CD room and board services that were authorized in combination with CD treatment pursuant to the Minnesota Rules, parts 9530.6600 – 9530.6655 (informally known as Rule 25) assessment criteria.

Disenrolling from SNBC

Enrollment in SNBC is voluntary, and SNBC enrollees may disenroll on a monthly basis. SNBC enrollees may also change to another SNBC plan on a monthly basis. Enrollees who choose to disenroll from SNBC altogether and are under 65 years of age are automatically returned to Medical Assistance on a fee-for-service basis.

If the enrollee is under 65, and meets another Medical Assistance eligibility type other than a disability type, they may enroll in another managed care product. If they are over 65 year old, they may have other options through Minnesota Senior Care (MSC), Minnesota Senior Care + (MSC+) or Minnesota Senior Health Options (MSHO).

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

Disenrollment from SNBC is processed according to the following guidelines:

- When disenrollment occurs and is entered in MMIS on or before the last business day of the month, coverage ends at midnight on the first day of the month following the month in which enrollment was entered on the State MMIS.
- If an enrollee is terminated due to ineligibility for Medical Assistance and the enrollee is hospitalized in an acute care facility on the effective date of ineligibility, coverage will end at midnight on the first day following discharge from the hospital.

SNBC enrollees may not be disenrolled involuntarily unless:

- they become ineligible for Medical Assistance, or
- their county of residence is no longer in the SNBC services area, or
- they become ineligible for one part Medicare (either A or B), or
- their enrollment is rejected by CMS, or
- they are deemed to have engaged in disruptive behavior as determined by CMS, or
- they fail to pay the Medical Spenddown for three consecutive months, or
- they choose another Medicare Part D plan.

Effect of turning 65 years of age

An enrollee may remain in the SNBC plan when they turn 65, unless:

- They lose Medical Assistance eligibility for more than three months or there is a gap in Medical Assistance eligibility and a new enrollment needs to be sent to CMS to restart the Medicare coverage.
- They choose to become a participant in the Elderly Waiver (EW) program and receive Home and Community Based Services through EW.

Things to consider regarding the EW program:

- Special Income Standard – Elderly Waiver (SIS-EW) budget allows the individual to retain more of their income.
- EW may not meet all the needs of an individual who is receiving services through the CAC, CADI, TBI or DD waivers.
- The SNBC service area may not be the same as the Minnesota Senior Care (MSC), Minnesota Senior Care Plus (MSC+) or Minnesota Senior Health Options (MSHO) service area. The same health plans may not be available.

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

If a SNBC enrollee voluntarily chooses to enroll into a different Medicare Part D or Medicare Advantage plan, including another SNBC plan, they will be automatically disenrolled from their current SNBC health plan on CMS's system. Where possible, DHS will disenroll individuals on MMIS to match CMS's system when an enrollee selects a different Medicare Part D or Medicare Advantage plan including a different SNBC health plan. The individual can choose to re-enroll in a plan by submitting another enrollment form.

Effect of SNBC Disenrollment on Medicare Part D Coverage

For those SNBC enrollees with Medicare, SNBC is providing their Medicare Part D Prescription Drug coverage. If voluntarily disenrolling from SNBC, the enrollee must choose another Part D plan in order to have coverage for Medicare Part D prescription drugs. If the enrollee does not choose a Medicare Part D plan, CMS may auto-assign them to a Part D plan. CMS's process for auto-assigning may result in delay or gaps in prescription drug coverage. Any enrollee

disenrolling from one Part D plan, including SNBC, is encouraged to actively choose another Part D plan in order to prevent a delay or gap in coverage. People disenrolling from SNBC can find additional information on Medicare Part D plans at http://www.medicare.gov or call 1-800—Medicare (1-800-633-4227). In Minnesota, the Disability Linkage Line at 1-800-333-2466 and the Senior Linkage Line at 1-800-333-2433 are available to assist people in enrolling in Part D plans.

Loss of Medical Assistance Eligibility

For Special Needs Plans, CMS requires that the individuals who lose Medicaid eligibility, with the auto-close code "EE," continue to receive Medicare benefits including Medicare Part D covered drugs. All SNBC health plans have chosen to continue Medicare benefits through their Special Needs Plan for up to three (3) months after Medical Assistance eligibility ended. MMIS will show the person disenrolled from SNBC but the enrollee will have SNBC Medicare coverage on the CMS system for up to three months or until the enrollee chooses a new Part D plan. For this reason, providers are encouraged to use CMS's system of coverage verification for Medicare and Part D benefits. Eligibility Verification System (EVS) and MN-ITS may show SNBC closed for Medical Assistance benefits, while CMS's system would show the enrollee active for Medicare benefits. If the enrollee's Medical Assistance eligibility is reinstated within three months, MMIS will reflect SNBC coverage once again. See re-enrollment below.

Notification to Counties of SNBC Enrollment

Several Info-Pac reports are available for counties to review. See Attachment H for description.

PWMW185L-R0504 PPHP Current Enrollment Report for Worker
PWMW1850-R0506 PPHP Potential Enrollee Report
PWMW185I-R0507 SNBC, MSHO and MnDHO New Enrollee Report
PWMW186D-R0510 Pre-Capitation Error/Recipient Capitation Error
PWMW185J-R0535 PPHP County Elderly Disenrollment Report

Breaks in SNBC Enrollment

Reinstatement

An enrollee whose termination from the SNBC health plan has been entered into MMIS by the monthly cut-off date may be reinstated for the following month with no lapse in coverage if the person re-established Medical Assistance eligibility, and the eligibility is entered into MMIS by the last working day of the month.

When reinstating SNBC enrollees, county workers should simply update the RELG screen in MMIS, save (PF9) and exit. This will automatically update the SNBC enrollment span on RPPH. Counties should contact the DHS enrollment coordinator if there are problems with reinstating SNBC enrollees.

Re-enrollment

Enrollees who experience a break in the Medical Assistance eligibility for up to three (3) months because of delays in submitting and processing their eligibility re-certification may be re-enrolled in the SNBC health plan they were previously enrolled in without completing a new enrollment form. If the break in eligibility is for longer than three (3) months, the individual

must fill out a new enrollment form. If the individual is not eligible for Medical Assistance (e.g. due to asset reduction) for one month or more, they must fill out a new enrollment form.

DHS staff will continue to monitor a report of SNBC enrollees who have lost Medical Assistance eligibility. If the enrollee has Medical Assistance only and the case is reopened within three (3) months, DHS enrollment staff will re-enroll the individual into the SNBC plan for the next available month unless there is a need for retroactive coverage for continuity of care. If the enrollee has Medicare A and B, the disenrollment reason code on RPPH is EE and the Medical Assistance eligibility is reopened within 3 months, the MMIS system will automatically reopen the SNBC coverage so there is no break in health plan coverage. The SNBC plans will be notified of re-enrollment on their electronic enrollment files. If fee-for-service claims that would be part of the SNBC benefit set were paid prior to the SNBC adjustment, DHS will recover claims paid to providers. Providers must resubmit recovered claims to the SNBC plan.

Medical Spenddowns and Institutional Spenddowns

Individuals may participate in SNBC if they have no spenddown, or if they have an automated monthly medical spenddown or an institutional spenddown. An individual with a manual monthly spenddown or an associated recipient spenddown may not participate in SNBC.

Medical Spenddowns

If a SNBC enrollee has an automated monthly medical spenddown, DHS will determine if the enrollee is also receiving PCA or waiver services. DHS will contact the health plan who will work with the enrollee to help establish designated provider(s) for PCA or waiver services. If the cost of the PCA or waiver exceeds the amount of the monthly medical spenddown, a designated provider should be added to the RSPD screen in MMIS by the county financial worker based on information provided by the enrollee. Up to two designated providers may be used to collect the spenddown amount and should only be entered for future months. If two designated providers are entered, the county should contact the enrollee to determine the amount of the medical spenddown that should be assigned to each provider. It is important to assign the spenddown so that both provider amounts are met by that provider's claims each month. The total collected by both providers must equal the full medical spenddown amount. MMIS sends the designated provider a monthly notice that includes the recipient's name and the spenddown amount to be collected from the recipient. If the medical spenddown is not being met for three months by the designated provider(s) on RSPD, the recipient will be disenrolled from the health plan and returned to Medical Assistance fee-for-service.

Example:
Jim is receiving waiver services and from two different providers. Jim has a medical spenddown of $100. On RSPD, the worker should enter both providers and the dollar amount assigned to each provider.

Designated Provider #1	Amount:	$75
Designated Provider #2	Amount:	$25
Total		$100

Total amount must equal the medical spenddown recipient amount of $100.

If there is no designated provider listed in MMIS, the enrollee will be required to pay the full amount of the medical spenddown to DHS each month. DHS's Special Recovery Unit bills these spenddowns to the individual on a monthly basis. If the enrollee does not pay the spenddown in full for three months, DHS will disenroll the enrollee from the SNBC plan and return the recipient to Medical Assistance fee-for-service.

Institutional Spenddowns

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

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

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

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

SNBC and 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 individual 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 individual'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.

100-day Nursing Facility Benefit
If an enrollee who resides in the community at the time of enrollment in SNBC enters a nursing facility (NF), the health plan is financially responsible for NF services for the first 100 days. The 100-day period begins at the time of the enrollee's date of admission to the skilled nursing facility (SNF) or Nursing Facility (NF). Both Medical Assistance and Medicare covered days are counted toward the 100-day benefit period. The 100 days are counted cumulatively. After the 100 days, the NF services are paid by Medical Assistance on a fee-for-services basis. Nursing facility days during hospice do not count toward the health plan's 100 day obligation.

SNBC and Hospice

The hospice policy for SNBC is similar to the policy for the other Minnesota Health Care Programs (MHCP) managed care products such as MSHO and MnDHO. SNBC enrollees who elect hospice do not need to disenroll from SNBC. Policies regarding hospice services apply for SNBC as they do for Medical Assistance fee-for-service. When a SNBC 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, 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 the amount Medical Assistance would have paid the NF if the person had not elected hospice.

Designated provider numbers should be entered for institutional spenddowns and medical spenddowns for enrollees who elect hospice enrolled in SNBC. DHS has a process for collection of the institutional spenddown that is detailed above in the Institutional Spenddowns section of this bulletin.

SNBC and Medicare Revenue Enhancement Program (MREP)

The purpose of the MREP is to maximize the use of Medicare whether Medicare is fee-for service (FFS) or with a SNBC program. Whenever a denial is issued to a dual eligible recipient the medical records need to be submitted to MREP for review. If you need an updated MREP packet, email Rose Kline, MREP Consultant, rosemary.kline@state.mn.us and request an updated packet.

LTCC Telephone Screens

The SNBC health plans are responsible for determining the community enrollee's need for the nursing facility benefit. The SNBC health plan may choose to either use the local agency for its

Long-Term Care Consultation (LTCC) responsibilities or work in cooperation the local agency to carry out its LTCC responsibilities.

If the SNBC health plan uses LTCCs performed by the Local Agency for the LTCC responsibilities the health plan must abide by all level of care determinations made by the Local Agency. The SNBC health plan shall not be financially responsible for costs of the LTCC. The local agency will continue to follow the current process for billing the LTCC.

If the SNBC health plan chooses to work in cooperation with a local agency, it shall conduct the pre-admission screening process as follows:

- The SNBC health plan must conduct screenings for hospital discharges and emergency placements using the most current Pre-Admission Screening (PAS) process and convey the information obtained during the screenings or a copy of the screening document to the local agency.
- The SNBC health plan must conduct OBRA Level 1 screenings and convey any information obtained during the screenings to the local agency and send a copy to the NF. The telephone screens must be entered in the MMIS system.
- The SNBC health plan must allow the local agency to conduct OBRA Level II evaluations when indicated and provide the NF with documentation of the OBRA Level II evaluations. The telephone screens must be entered into the MMIS system.
- For enrollee living in the community and entering a NF, the SNBC health plan must conduct an in-person, pre-admission screening using the most current PAS tool and level of care criteria tool. The SNBC health plan shall convey information obtained during the screening or a copy of the screening document to the local agency.
- The SNBC health plan must inform all enrollees that they may qualify for services under the HBCS waivers and refer the enrollee to the county of residence for assistance.
- The SNBC health plan must work with and communicate to the local agency using the form #5181 prior to an enrollee entering a NF to allow the local agency to send out to the enrollee form #3543 regarding long term care.
- The SNBC health plan must obtain approval from the state for any enrollee under 21 years of age for admission into a nursing facility.

SNBC and Mental Health Services

The SNBC enrollee receives the following mental health services through the SNBC health plan:

- Adult Mental Health Crisis Services (non-residential and residential)
- Adult Rehabilitative Mental Health Services (ARMHS)
- Assertive Community Treatment (ACT)
- Children's Crisis Response Service
- Children's Therapeutic Services and Supports
- Consultation between the primary care doctor and a psychiatrist
- Crisis assessment and intervention in an emergency room or urgent care setting
- Day Treatment/partial hospitalization
- Diagnostic assessment

- Explanation of findings
- Inpatient psychiatric hospital stay
- Intensive Residential Treatment Services (IRTS)
- Medication management
- Mental health services provided via two-way interactive video
- Neuropsychological services
- Psychological testing
- Psychotherapy
- Sub-acute psychiatric care for person under age 21

Court ordered mental health assessment must be provided through a SNBC plan network provider. The SNBC health plan will not determine medical necessity for court-ordered mental health services.

Additional technical assistance is available to providers at the following websites;

- http://www.dhs.state.mn.us/main/dhs16_137969#May

- http://www.dhs.state.mn.us/id_049094

SNBC and Transportation Services

The SNBC health plan is required to provide transportation to and from health services that the health plan covers. The SNBC health plan covers emergency ambulance, non-emergency ambulance, special transportation for people who, because of physical or mental impairment, cannot safely use a common carrier and do not need an ambulance. The SNBC health plan benefit does not replace the county responsibility for covering access services, such as lodging and meals.

Health Plan Coordination with Local Agency

The SNBC health plan is required to refer to and/or coordinate with the local county agency when the enrollee is in need of the following services:

- Adult Protection
- Case management for people with Developmental Disabilities (Minnesota Rules, parts 9525.0900 – 9525.1020 informally known as Rule 185)
- Child Protection
- Child Welfare Targeted Case Management
- Children's residential mental health treatment facility services (Minnesota Rules, Chapter 2960)
- Group Residential Housing (GRH)
- Home and Community-Based Services
- Long Term Care Consultation (LTCC) services
- OBRA Level II screening
- Pre-petition screening

- Relocation Service Coordination
- Room and board associated with Intensive Residential Treatment Services (IRTS)
- State Medical Review Team or Social Security Disability determination
- Targeted Mental Health Case Management (Minnesota Rules, parts 9520.0900 – 9520.0926, informally known as Rule 79)
- Treatment at Rule 36 (Minnesota Rules, parts 9520.0500 – 9520.0670) facilities which are not licensed as Intensive Residential Treatment Services (IRTS)

County financial worker duties do not change. They continue to:

- Determine and maintain eligibility for Medical Assistance
- Assist with State Medical Review Team or Social Security Administration determination
- Update MMIS with changes regarding living arrangement and address

Home Community Based Service (HCBS) Waivers

SNBC does not cover waiver services, PCA and Private Duty Nursing for individuals on the disability waiver (CAC, CADI, TBI and DD). These services remain fee-for-service and the lead agency continues to authorize these services for the individual. Providers will continue to bill DHS for payment of waiver services.

SNBC does cover Home Health Aide, Skilled Nursing Visits, Home Health Therapies and state plan durable medical equipment and supplies for individuals on the disability waivers. The SNBC health plan will authorize these services. The lead agency must continue to develop an individual service plan with the individual that includes these services, if needed. In order for the lead agency to plan for the costs associated with these services, the lead agency must authorize the services using the X5609 pseudo code. The lead agency is responsible to communicate with the health plan to find out the total number of units the health plan is authorizing for Home Health Aide, Skilled Nursing Visits and Home Health Therapies under Medical Assistance. The lead agency will multiply the number of units by the maximum rate amount for the service and authorize this total amount on the individual's MMIS Service Agreement under the x5609 billing code. This pseudo code can represent more than one service. The lead agency will use the DHS Comment Screen to indicate what the services are, the number of units for each service and the estimated cost for each service. SNBC health plans do not enter screens in MMIS for SNBC enrollees on CAC, CADI, TBI and DD waivers. The lead agency case manager and the SNBC health plan work together to coordinate services for SNBC enrollees on these waivers.

The Waiver Management System has a page designed to assist lead agencies in identifying and tracking the individuals on disability waivers who have chosen SNBC. This page will identify the individuals who have chosen SNBC, whether the MMIS Service Agreement reflects a current X5609 authorization and the amount of that authorization. Lead agencies will be able to sort by various fields to assist in the tracking of the individuals on the disability waivers who have chosen SNBC.

SNBC and Group Residential Housing (GRH)

A person enrolled in SNBC may need to access GRH funding. GRH remains the responsibility of the county and the SNBC health plan is not involved in obtaining this funding from the county.

SNBC and Relocation Service Coordination (RSC)

A person enrolled in SNBC health plan may be eligible for RSC. The RSC targeted case manager provider must coordinate with the SNBC health plan to ensure continuity of care and non-duplication of effort.

Appeals and Grievances

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

Website

For more information about SNBC, see the DHS website:

The SNBC color map:
http://edocs.dhs.state.mn.us/ifserver/Legacy/DHS-5218-ENG

http://www.dhs.state.mn.us/main/id 018058

SNBC: http://www.dhs.state.mn.us/dhs16 139491

The County Contact List: http://www.dhs.state.mn.us/id 018058

Model Contract:

SNBC 2008 Model Contract**:** http://www.dhs.state.mn.us/dhs16_139481.pdf

MCO Model Contracts Web Page: http://www.dhs.state.mn.us/dhs16_139710

Special Needs

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

Special Needs BasicCare (SNBC)
Voluntary Managed Care
Adults with Disabilities Age 18-64
BASIC CARE COVERED CATEGORIES OF SERVICES *

- Adult Mental Health Rehab Services: Crisis Services, Assertive Community Treatment (ACT), Adult Rehabilitative Services (ARMHS), Intensive Residential Treatment Services (IRTS)
- Advanced Practice Nurse Services
- Cancer Clinical Trials
- Care Management Services - (Acute Medical)
  Chemical Dependency Treatment Services
- Child and Teen Checkups
- Children's Residential Mental Health Treatment
- Chiropractic Services
- Clinic Services
- Dental Services
- Disease Management
- Family Planning Services
- Home Care Services - Specified:
  - Home Health Aid (HHA), Skilled Nurse Visit (SNV), Home Care Therapies (PT, OT, RT, ST)
- Hospice Services
- Inpatient Hospital Services
- Interpreter Services
- Laboratory, Diagnostic and Radiological Services
- Medical Emergency, Post-Stabilization Care, and
  Urgent Care Services
- Medical Supplies and Equipment
- Medical Transportation Services
- Mental Health Services including: diagnostic assessment and testing, crisis assessment and intervention, day treatment/partial hospitalization, individual and family group therapy, inpatient and outpatient treatment, neuropsychological assessment and rehab, medication management
- Nursing Home services (100 days for people admitted from the community)
- OBRA Level 1 (NF)
- Obstetrics and Gynecological Services
- Outpatient Hospital Services
- Physician Services
- Podiatric Services
- Prescription and Over-the-Counter Drugs Not
  Otherwise Covered by Part B or D
- Prosthetic and Orthotic Devices
- Public Health Services
- Reconstructive Surgery
- Regional Treatment Centers (under certain circumstances)
- Rehabilitation and Therapeutic Services
  - (PT, OT, RT.ST)
- Transplants
- Tuberculosis-Related Services
- Vaccines and Immunizations
- Vision Care Services

* This is not an all inclusive list of services covered under each category of service.

Special Needs BasicCare (SNBC)

Adults with Disabilities Age 18-64

SERVICES CONTINUED UNDER FEE-FOR-SERVICE

- **BASIC CARE SERVICES**
- Abortion Services, as specified by State and Federal law
- Child Welfare Targeted Case Management
- Circumcision for Newborns, as specified by State law
- Individual Education Plan (IEP) and Individual Family Service Plan (IFSP) Services
- ICF-MR Services
- Mental Health Targeted Case Management
- Long Term Nursing Home services (post 100 days)
- OBRA Level 2 assessments
- Personal Care Assistance Services (PCA)
- Private Duty Nursing (PDN)
- Vulnerable Adult – Developmental Disability (VADD) Targeted Case Management

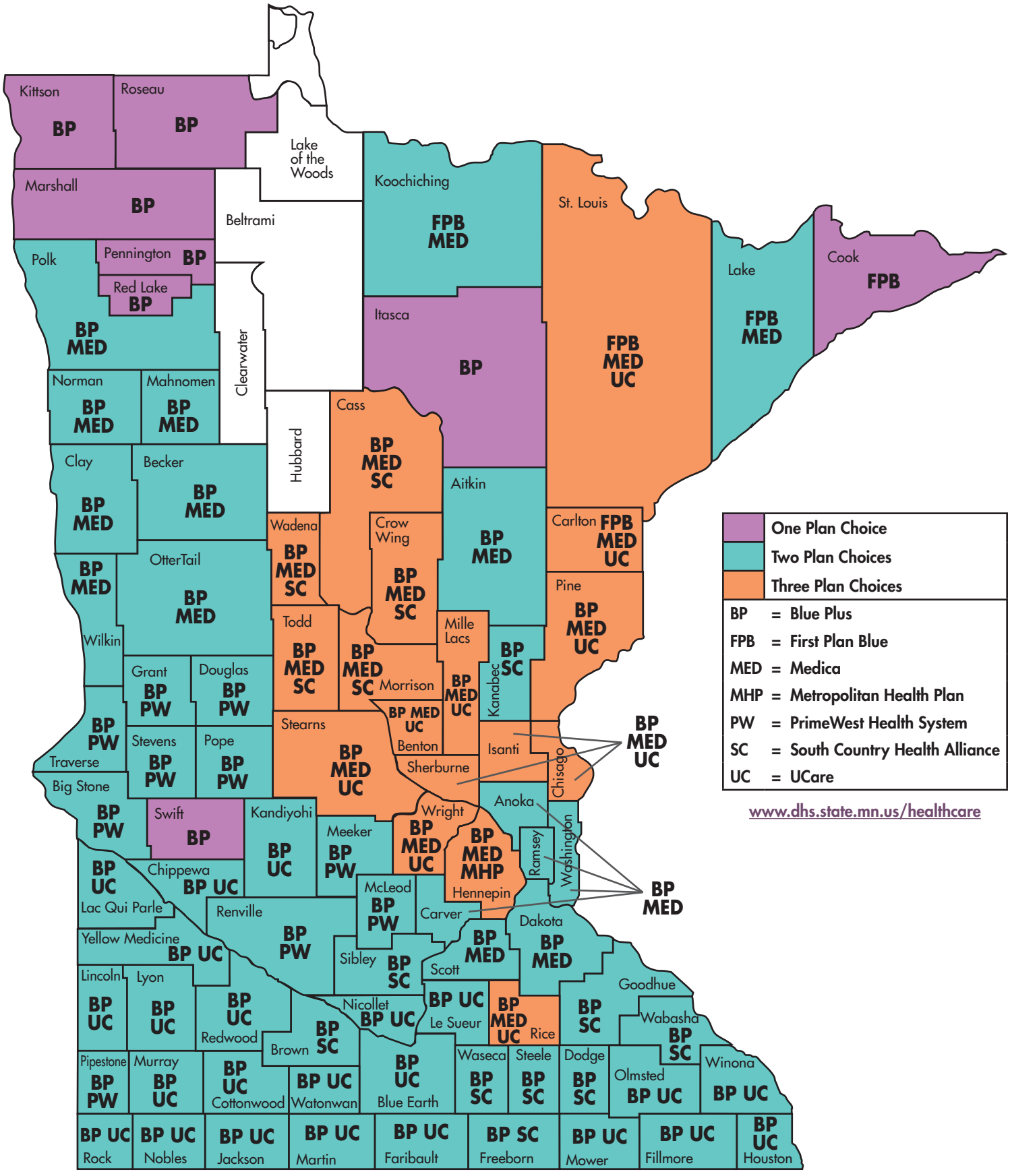
- **HOME AND COMMUNITY BASED SERVICES WAIVER SERVICES**
- Community Alternative for Disabled Individuals (CADI)
- Community Alternative Care (CAC)
- Traumatic Brain Injury (TBI-NF, TBI-NB)
- Developmental Disabilities (DD)
- Waiver Case Management
- Long Term Care Coordination (LTCC)
- OBRA assessments, Level 1 and 2 (waivers)
- Relocation Service Coordination (RSC)

- **SERVICES COVERED ELSEWHERE**
- Group Residential Housing (GRH)
- Medicare
- SSI
- SSDI
- IV-E
- Section 8 Housing
- Food Stamps

Minnesota Department of **Human Services**

Health Plan Service Areas by County for Special Needs BasicCare (SNBC)

Effective Jan. 1, 2008



www.dhs.state.mn.us/healthcare

Special Needs BasicCare

Blue Plus *CareBlue Special Needs Basic Care*

1-866-477-1584 TTY 1-888-878-0137

Counties: Anoka, Aitkin, Becker, Benton, Big Stone, Blue Earth, Brown Carver, Cass, Chippewa, Chisago, Clay, Cottonwood, Crow Wing, Dakota, Dodge, Douglas, Faribault, Fillmore, Freeborn, Goodhue, Grant, Hennepin, Houston, Isanti, Itasca, Jackson, Kanabec, Kandiyohi, Kittson, Lac Qui Parle, Le Sueur, Lincoln, Lyon, Mahnomen, Marshall, Martin, McLeod, Meeker, Mille Lacs, Morrison, Mower, Murray, Nicollet, Nobles, Norman, Olmsted, Otter Tail, Pennington, Pine, Pipestone, Polk, Pope, Ramsey, Red Lake, Redwood, Renville, Rice, Rock, Roseau, Scott, Sherburne, Sibley, Stearns, Steele, Stevens, Swift, Todd, Traverse, Wabasha, Wadena, Waseca, Washington, Watonwan, Wilkin, Winona, Wright, Yellow Medicine.

First Plan Blue *First Plan Blue Basis*

1-877-736-5518 TTY 1-877-475-3879

Counties: Carlton, Cook, Koochiching, Lake, St. Louis

Medica *AccessAbility Solution*

1-800-266-2157 TTY 1-800-234-8819

Counties: Aitkin, Anoka, Becker, Benton, Carlton, Carver, Cass, Chisago, Clay, Crow Wing, Dakota, Hennepin, Isanti, Koochiching, Lake, Mahnomen, Mille Lacs, Morrison, Norman, Otter Tail, Pine, Polk, Ramsey, Rice, St. Louis, Scott, Sherburne, Stearns, Todd, Wadena, Washington, Wilkin, Wright

Metropolitan Health Plan (MHP) *Cornerstone Solution*

1-866-601-8962 TTY 1-800-627-3529

County: Hennepin

Prime West Health System *Prime West Complete*

1-877-600-4913 TTY 1-800-627-3529

Counties: Big Stone, Douglas, Grant, McLeod, Meeker, Pipestone, Pope, Renville, Stevens, Traverse

South Country Health Alliance *AbilityCare*

1-866-722-7770 TTY 1-877-824-5611

Counties: Brown, Cass, Crow Wing, Dodge, Freeborn, Goodhue, Kanabec, Morrison, Sibley, Steele, Todd, Wabasha, Wadena, Waseca

UCare *UCareConnect*

1-866-280-7202 TTY 1-800-688-2534

Counties: Benton, Blue Earth, Carlton, Chippewa, Chisago, Cottonwood, Faribault, Fillmore, Houston, Isanti, Jackson, Kandiyohi, Lac Qui Parle, Le Sueur, Lincoln, Lyon, Martin, Mille Lacs, Mower, Murray, Nicollet, Nobles, Olmsted, Pine, Redwood, Rice, Rock, Sherburne, Stearns, St. Louis, Watonwan, Winona, Wright, Yellow Medicine.

02/11/2008

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

02/11/2008

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

Contracting
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	Doris Wong	(651) 431-2519
Itasca Medical Care	Chandra Breen (Temporary)	(651) 431-3487
Medica	Chandra Breen (Temporary)	(651) 431-3487
Metropolitan Health Plan	Lill Tallaksen	(651) 431-2522
PrimeWest Health System	Lill Tallaksen	(651) 431-2522
South Country Health Alliance	Chandra Breen (Temporary)	(651) 431-3487
UCare Minnesota	Nancy Paulsen	(651) 431-2520

Attachment F

MA Eligibility Types for SNBC

To enroll in SNBC, an individual must be certified as disabled or determined eligible for the Developmental Disability Waiver. People who are certified disabled may meet more than one basis for MA eligibility. Below is a list of Eligibility Types that are eligible to enroll in SNBC.

AA: Parent of a dependent child
BX: BLIND/NO SUB-TYPE
DC: DISABLED/CHILD AGE 18 to 20
DI: WORKING DISABLED WITH NO PREMIUM
DP: WORKING DISABLED WITH PREMIUM
DX: DISABLED/NO SUB-TYPE
*EX: OVER AGE 65/NO SUB-TYPE
PX: PREGNANT WOMAN
15: 1619A
16: 1619B

* Note: Individuals who are age 65 or over are not eligible to enroll in SNBC. However, enrollees who turn age 65 while enrolled in SNBC may choose to remain in SNBC if they maintain eligibility and don't choose to participate in EW services.

Health Plan Logo

Office Use Only:

Date: _____

Name of Authorized Sales Person

_____

SPECIAL NEEDS BASIC CARE ENROLLMENT FORM

Last name:	First name:	MI	Birth Date:	Sex: ❑ M ❑ F

County you live in:	Social Security number (optional):	Home phone number: ( )

Street address (where you live)	City	State	Zip Code:

Mailing address (If different from where you live)	City	State	Zip Code:

Are you a resident in a long term care facility such as a nursing home or ICF-MR? ❑ YES ❑ NO
If Yes, name of facility: Telephone Number:

Please provider your Medical Assistance ID number from your Minnesota Health Care Program Card:

Email address (optional):

Do you have Medicare coverage? ❑ NO ❑ YES, If yes complete the information below

Please provider your Medicare Insurance information (exactly as it appears on your Medicare Card)
Medicare Claim (ID) number (include alpha characters) | | | | | | | | | | | |
Hospital (Part A) Begin Date: ____/____/____
Medical (Part B) Begin Date: ____/____/____

Race (optional): ❑ Asian ❑ American Indian or Alaskan Native ❑ Pacific Islander or Native Hawaiian ❑ White ❑ Black or African American

Do you need an interpreter? ❑ NO ❑ YES, If yes check one of the boxes below

❑ Spanish (01) ❑ Hmong (02) ❑ Vietnamese (03) ❑ Cambodian (04) ❑ Laotian (05)

❑ Russian (06) ❑ Somalian (07) ❑ American Sign Language (08) ❑ Arabic (09)

❑ Bosnian/Serbo Croatian (11) ❑ Oromiffa (12) ❑ (98) Other, explain _____

Please read and answer these important questions:

1. Do you have End Stage Renal Disease: ❑ YES ❑ NO
   If you have answered "YES" to this question and you do not need regular dialysis any more or have had a successful kidney transplant, please attach a note or records from doctor showing you do not need dialysis or have had a successful kidney transplant.
2. Do you or your spouse have other health insurance? ❑ YES ❑ NO

   If **YES**, insurance company name: _____

   Policy holder's name: _____ Policy Number: _____

   Is this insurance through an employer? ❑ YES ❑ NO
3. Do you have a current prescription drug plan? ❑ YES ❑ NO If Yes, name of plan: _____

Primary Care Clinic or Care System you are choosing:	Primary Care Clinic (PCC) number:

Please read and sign the back of this form. When completed, return to:

Under *HEALTH PLAN,* I understand that:

HEALTH PLAN will be providing my care covered by Medicare and Medical Assistance or only Medical Assistance if I am not eligible for Medicare.
I have the right to ask about my health plan's decision about payment or services. I may appeal if I disagree.
If I am already enrolled in another Medicare Advantage plan and I enroll with ***HEALTH PLAN***, I will be canceling my membership in the other Medicare Advantage plan.
I will be notified of the date my coverage will start.
If I do not receive all of my Medicare covered health care from ***HEALTH PLAN's*** network providers, then Medicare or ***HEALTH PLAN*** will not pay for services, except in an emergency, urgently needed services or out-of-area dialysis services.
I will get a Certificate of Coverage from ***HEALTH PLAN*** that will have more information about services, including out-of area and/or authorized covered services and open access services.
My ***HEALTH PLAN*** benefits **cannot** be canceled because I get sick or use health care services.
I can choose to leave ***HEALTH PLAN*** at any time. I understand that I will be enrolled in ***HEALTH PLAN*** through the last day of the month.
I must choose a primary care clinic and my health care services will be coordinated through ***HEALTH PLAN***.
I can only be in (1) Medicare Advantage plan at a time. To be enrolled and stay enrolled in ***HEALTH PLAN***, I must be • certified disabled by the Social Security Administration or State Medical Review Team (SMRT) • at least 18, and under age 65 at the time of enrollment • eligible for Medical Assistance • have Medicare Parts A and B or no Medicare • living in ***HEALTH PLAN'***s service area. If this changes, I will notify ***HEALTH PLAN*** so I can disenroll and find a new Medicare Part D plan.
If I have a medical spenddown and do not pay it to DHS, I will be disenrolled from ***HEALTH PLAN***.

By enrolling in *HEALTH PLAN*, I authorize:

The State to give information about my Medicare and Medical Assistance status and the information on this form to its representatives, the county where I live now and ***HEALTH PLAN***.
The federal Center for Medicare & Medicaid Services (CMS) to give information to ***HEALTH PLAN*** and the State to verify my entitlement to Medicare Parts A and B, if any.
HEALTH PLAN's providers to give CMS (or its medical claims agencies) any information needed to administer my Medicare benefits, if any.
HEALTH PLAN to release my information, including my prescription drug data, to Medicare. Medicare may release my information for research and other purposes which follow all applicable Federal statutes and regulations. This information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from ***HEALTH PLAN***.

I understand that my signature (or the signature of person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of the application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized by State law to complete this enrollment form and 2) documentation of this authority is available upon request by the State, *HEALTH PLAN* or Medicare.

Signature:		Date:
If you are the authorized representative, you must provide the following information:		
Name (Print and Sign):	Relationship to enrollee:	Phone number:
Street Address, City, State, Zip		

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 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.

PWMW185-R0507 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.

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.

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.