

Bulletin

June 4, 2008

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

OF INTEREST TO

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

ACTION/DUE DATE

Please use the new Maintenance Needs Allowance effective July 1, 2008.

EXPIRATION DATE

The policies in this bulletin are ineffective as of July 1, 2009 (MNA) and September 30, 2008 (Case Mix Caps)

Annual Increase for Maintenance Needs Allowance and Elderly Waiver Conversion Rates

TOPIC

New Maintenance Needs Allowance for Elderly Waiver (EW) clients and conversion rates for EW clients leaving nursing facilities.

PURPOSE

Notify lead agencies of the new Maintenance Needs Allowance effective July 1, 2008 and the procedure for requesting conversion rates for EW persons moving from a nursing facility using conventional EW or Consumer Directed Community Supports Services (CDCS).

CONTACT

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

SIGNED

LOREN COLMAN
Assistant Commissioner
Continuing Care Administration

I. For clients who are eligible for the Special Income Standard – Elderly Waiver (SIS-EW) the Maintenance Needs Allowance (MNA) increases on 7/1/2008 to \$860.

II. Exception to the Monthly Service Caps for EW clients leaving Nursing Facilities (NF): Conversion Rates

Certain persons receiving EW services may access a higher monthly service cap. If an EW eligible person is a resident of a certified nursing facility and has lived there for 30 consecutive days or more, a request for a higher monthly service cap may be submitted to the Department of Human Services (DHS) for approval. To determine whether the EW services would exceed the average monthly service cap, determine the cost of authorized services under the community support plan and compare to the applicable statewide average monthly service cap in

Attachment A. If implementation of the community support plan would cost less than the assigned case mix cap in Attachment A, the client does not require a conversion rate.

If the community support plan cost exceeds this figure, the person may access a higher monthly service cap equal to no more than the cost to Medical Assistance for services in the (NF) where the person currently resides.

III. To determine the Medicaid cost for the person in their current NF

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

Note: The daily rate to use for Ah-Gwah-Ching nursing home is the calculated RUGS equivalent daily rate as stated in a DHS memo issued December 20, 2006.

- 2) Divide the annual rate by 12 to establish the clients average monthly cost for NF care.
- 3) Subtract the current Maintenance Needs Allowance (\$860) from the resulting figure in (2).
- 4) Compare the result to costs of implementing the person's community support plan. – the conversion rate that is approved cannot be greater than what is determined using the above formula.

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

- 1) Determine the monthly service cap available to the person seeking the conversion rate using the formula above.
- 2) Submit the completed EW Conversion Rate Request form (Attachment B) and a copy of the NF remittance advice showing the client's per diem rate to: Department of Human Services, Aging and Adult Services Division, P.O. Box 64976, St Paul, MN, 55164-0976 or FAX request to (651) 431-7415

- 3) Attachment B must be approved by the health plan, if the client is enrolled in a managed care product for EW before it is sent to the Department of Human Services (DHS) and there is a service agreement in MMIS for payment.
- 4) Place the higher conversion rate in the Case Mix/DRG Amount field on the LTC screening document. This will cause edit 784 (Case Mix/TBIW Screening Document requires Approval) to post and keep the screening document in suspense. If all other suspended Edits are corrected, edit 784 will automatically route the screening document to DHS staff for review the following work day. DHS staff will retrieve the screening document and approve the higher amount or request further information from the case manager/care coordinator.

**IV. Exception to the Monthly Service Caps for EW clients leaving NF's:
Conversion Rates for people accessing services using Consumer Directed Community
Supports Services.**

Minnesota Statutes, section 256B.0915 subdivision 3b, was amended and sets the conversion rate for persons moving from the nursing facility with Elderly Waiver CDCS services. The conversion rate limit is equal to the NF rate reduced by the percent difference between the CDCS budget limit according to the federally approved waiver plan and the corresponding case mix cap. The MNA is not subtracted from this amount. The MNA was already removed from the budgets for CDCS.

- 1) Determine the annual rate by multiplying the per diem (daily) rate charged by the NF for the client by 365. The daily rate is found on the NF remittance advice.
- 2) Divide the annual rate by 12 to establish the clients average monthly cost for NF care.
- 3) Use this monthly rate and multiply by the percentage corresponding to the Case Mix classification which was assessed for the person. The percentages that are to be used which correspond to the persons case mix cap are found in Attachment A. The amounts will be annually updated when the case mix caps are updated.
- 4) The remaining amount is the maximum monthly amount that can be utilized to implement a person's community support plan using the CDCS service. This limit is the maximum that can be approved.

Example 1:

Burke is in a nursing facility and the daily rate for the past 30 days is \$190/day. He wishes to leave the nursing facility using EW with CDCS services. He has been assessed as a case mix A. The maximum rate to use is calculated as follows:

$$\$190/\text{daily rate at NF} \times 365 \text{ days} = 69,350 / 12 = \$5,779/\text{month in the NF}$$

Look at Attachment A and find the corresponding percentage for case mix A – which is 50% - Multiply the monthly rate in the NF by the % difference as listed in Attachment A- $\$5,779 \times .50 = \$2,889/\text{month CDCS conversion rate limit}$. This amount should be compared to the cost of the care plan for Burke.

- 5) Compare the result to costs of implementing the person's community support plan.
- 6) Submit the completed EW Conversion Rate Request form (Attachment C) and a copy of the NF remittance advice showing the clients per diem rate to: Department of Human Services, Aging and Adult Services Division, P.O. Box 64976, St. Paul, MN, 55164-0976 or FAX request to (651) 431-7415.
- 7) Attachment C must be approved by the health plan, if the client is enrolled in a managed care product for EW before it is sent to DHS and there is a service agreement in MMIS for payment.
- 8) Place the higher conversion rate in the Case Mix/DRG amount field on the LTC screening document. This will cause edit 784 (Case Mix/TBI Screening Document requires approval) to post and keep the screening document in suspense. If all other suspended edits are corrected, edit 784 will automatically route the screening document to DHS staff for review the following work day. DHS staff will retrieve the screening document and approve the higher amount or request further information from the case manager.

Note: Conversion rates are NOT available to persons receiving Alternative Care.

Conversion rate requests need to be submitted for approval annually if the client still has the need for the increased case mix cap. The same form is used.

AUTHORITY

Laws of Minnesota 2007, Minnesota Statutes, Section 256B.0915, subdivision 3b

Special Needs:

This information is available in other forms to people with disabilities by contacting us at (651) - 431-2590 (voice), toll free at 1-800-882-6262 or through the Minnesota Relay Service at 1-800-627-3529 (TDD), 7-1-1 or 1-877-627-3848 (speech to speech relay service).

ATTACHMENTS

Attachment A: Elderly Waiver Program Monthly Case Mix Caps and

Attachment B: Elderly Waiver Percentages by Case Mix used to Determine Monthly CDCS
Conversion Rates

Attachment C: Elderly Waiver Conversion Rate Request Form

Attachment D: Elderly Waiver CDCS Conversion Rate Request Form

Attachment A

**Elderly Waiver Program Monthly Service Caps Effective
10/1/2007 – 9/30/2008**

Elderly Waiver	
Case Mix	Monthly Cap as of 10/1/2007
A	\$2,231
B	\$2,539
C	\$2,978
D	\$3,077
E	\$3,393
F	\$3,496
G	\$3,608
H	\$4,071
I	\$4,178
J	\$4,453
K	\$5,190

**Elderly Waiver Percentages by Case Mix used to Determine CDCS Monthly
Conversion Rates Effective
10/1/2007 – current**

Elderly Waiver	
Case Mix	%
A	50.00
B	51.89
C	51.32
D	53.48
E	61.03
F	60.65
G	59.19
H	67.24
I	76.02
J	72.94
K	64.38

ELDERLY WAIVER CONVERSION RATE REQUEST**COUNTY INFORMATION/HEALTH PLAN INFORMATION**

Contact:	
Address:	
FAX	Telephone:

CLIENT INFORMATION

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

Nursing facility where client resides:	
(Initial request - Attach the Medical Assistance remittance advice form showing client's NF per diem rate)	
Per diem rate: \$ _____ X 365 = _____ ÷ 12 =	\$ _____
Minus current maintenance needs allowance (as of 7/01/08 is \$860)	\$ _____
Client's monthly cap limit	\$ _____

Health Plan Initial: Approved _____ Denied _____
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Name of Managed Care Organization: _____
Signed: _____ Date _____
Comments:

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

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

ELDERLY WAIVER CDCS CONVERSION RATE REQUEST**COUNTY INFORMATION/HEALTH PLAN INFORMATION**

Contact:	
Address:	
FAX	Telephone:

CLIENT INFORMATION

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

Nursing facility where client resides:	
(Initial request - Attach the Medical Assistance remittance advice form showing client's NF per diem rate)	
<u>A</u>) Per diem rate: \$ _____ X 365 = _____ ÷ 12 =	\$ _____
Multiply <u>A</u> above by the Case Mix Percentage to determine MAX monthly CDCS conversion rate _____	\$ _____
Client's monthly cap limit using CDCS	\$ _____

Health Plan Initial: Approved _____ Denied _____
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Name of Managed Care Organization: _____
Signed: _____ Date _____
Comments:

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

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Bulletin #08-25-04

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