Instructions for Completing and Entering the
Health Risk Assessment
Into MMIS for the Special Needs BasicCare (SNBC)

Developed by the Aging and Adult Services Division
Of the Continuing Care Administration
Department of Human Services
August 2019
Introduction

The information in this manual beginning with the July 2018 version, focuses on using the Health Risk Assessment form 3428H and the Health Risk Assessment Screening Document form DHS-3427H. An online version of this manual is on eDocs by searching for form DHS-5020A.

This manual provides information, technical assistance, and referrals for navigation, inquiry and entering data from the Health Risk Assessment screening document into the Medicaid Management Information System (MMIS). Updates to this manual since July 2018 are identified in the below table and in italic in the manual.

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| Terms and Definitions | | Added:
| | • Fee-for-service
| | • State Medical Review Team
| | • Social Security Administration
| | Changed:
| | • Fiscal year
| | • Health risk assessment
| | • Managed care organization
| One | 101.06 | Corrected the email link for the provider helpdesk
| Three | 301.01 | • Added more eligibility information for SNBC
| | | • Identified product codes
| | | • SLL role for PAS screenings
| | | • New bulletin
| | | • Changed contact period beginning 1/1/2020
| | 301.04 | Added PAS screenings to the Activity Type and Assessment Result section.
| | | Updated activity types 01 and 02.
| | 301.06 | Added the mandatory fields for preadmission screenings in the nursing facility
| | 301.14 | Added the PAS bulletin 19-25-02 to activity type 01.
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DHS Staff Contacts

Special Needs BasicCare (SNBC) Program (651) 431-2516

MSHO and MSC+ Project Coordinator (651) 431-2517

The Community Based Services Manual is a resource for administering home and community-based services programs (HCBS).

Send questions regarding the policies and procedures of the HCBS programs to the Disability and Aging PolicyQuest. Lead agencies (county, tribal, and managed care organization) have an administrator who may give you access to submit questions. All questions and answers are searchable by the public. For more details, please see the PolicyQuest page in the Community Based Services Manual.

Resource Center

What we do:
• Assist staff to resolve edits and error messages on screening documents
• Assist staff with policy and technical issues related to screening documents entry into MMIS

The Resource Center encourages E-mail as the primary method of contact for the following types of requests. On all e-mails include:
• Contact name and phone number (required)
• Explanation of issue (required)
• PMI (Personal Master Index) number and last 3 digits of screening document (as applicable)
• Edit number or MMIS message posting (as applicable)

Contact the Resource Center
DHS.ResourceCenter@state.mn.us
Resource Center staff is available Monday through Friday from 6:30 a.m. to 4:30 p.m.

Contacts for Identifying Care Coordinators
To identify the name of the care coordinator for an individual, please reference form DHS-6581A.

Use the Managed Care Organization/County/Tribal Agency Communication form DHS-5841 to facilitate communication between the disability waiver case manager and the MCO staff.
Terms and Definitions

Alternative Care Program (AC). A state program that pays for home and community-based services for people aged 65 and older who require the level of care a nursing facility provides, and who, if they enter a nursing facility, will be eligible for Medical Assistance within 180 days of admission.

Assessment. The process of identifying a person’s strengths, preferences, functional skills, natural supports, and need for support and services.

BI. BI (Brain Injury) is a Medical Assistance program that funds home and community-based services (HCBS) for people under age 65 who require the level of care provided in a nursing facility or neuro behavioral hospital, and who choose to reside in the community. This program provides funding for children and adults who have an acquired or traumatic brain injury. BI Waiver services may be provided in a person’s own home, in his/her biological or adoptive family’s home, in a relative’s home (e.g. sibling, aunt, grandparent etc.), in a family foster care home, in a corporate foster care home, in a board and lodging facility or in an assisted living facility. If married, a person may receive BI Waiver services while living at home with his or her spouse.

CAC. Community Alternative Care is a Medical Assistance home and community-based services program that pays for health care and other services for an individual who requires the level of care of a hospital.

CADI. Community Access for Disability Inclusion is a Medical Assistance program that funds home and community-based services for people under age 65 who require the level of care provided in a nursing facility, and who choose to reside in the community. The name of this program changed from Community Alternatives for Disabled Individuals to Community Access for Disability Inclusion effective August 1, 2016.

Care Coordinator for MSHO Members. An individual who coordinates the provision of all Medicare and Medicaid health and long-term care services for MSHO members, and who coordinates services to an MSHO member among different health and social service professionals and across settings of care. This individual must be a social worker, public health nurse, registered nurse, physician assistant, nurse practitioner, or physician.

Care Management for SNBC. The overall method of providing on-going health care in which the MCO manages the provision of primary health care services and behavioral health services with additional appropriate services provided to a member. See section 6.1.3 of the Contract.
**Care Plan.** The document developed in consultation with the member, the member’s treating physician, health care or support professional, or other appropriate individuals, and where appropriate, the member’s family, caregiver, or representative that, taking into account the extent of and need for any family or other supports for the member, identifies the necessary health and Home and Community-Based services to be furnished to the member.

**Case Manager.** A county or tribal case manager (also referred to as a Services Coordinator) is a social worker, a registered nurse or public health nurse employed by or under contract with the local lead agency to provide case management.

**Case Management for SNBC.** The assignment of an individual who coordinates Medicare and Medicaid health services for a member.

**Case Manager for MSC+ Members.** An individual who coordinates Medicaid health and long-term care services for an MSC+ members receiving Elderly Waiver Services among different health and social service professionals and across settings of care.

**County Based Purchasing.** CRP is a managed care organization operated by a county or group of counties. The CBP entity purchases or provide health services to MA and MinnesotaCare recipients residing in their counties. The Minnesota Legislature authorized this program.

**DRG.** Diagnosis-Relation Group is a classification of procedures used to sort hospital patients by discharge diagnosis into categories that are medically similar and have approximately equivalent lengths of stay. Medical Assistance and the Community Alternative Care program utilized DRGs.

**Elderly Waiver Program (EW).** A Medical Assistance program that funds home and community-based services for people 65 and older who require the level of care provided in a nursing facility, and who choose to reside in the community.

**Fee-for-Service (FFS).** A payment model in which providers receive fees for each separate service they provide, essentially paying providers for volume and quantity of service provided.

**Fiscal Year.** A period of time established for budgetary and accounting purposes. The state fiscal year is July 1st to June 30 of the following year. The federal fiscal year is October 1st to September 30 of the following year.

**Health Risk Assessment (HRA).** A questionnaire that assists to identify a person’s health care needs, health status, and health risk factors. The purpose of the HRA is to help care coordinators set up health related appointments and needed services as soon as possible with a member.
Home Care Provider. An individual, organization, association, corporation, unit of government or other entity that is regularly engaged in the delivery, indirectly or by contractual agreement, of home care services for a fee. At least one home care service must be provided directly, although additional home care services may be provided by contractual agreement.

Information Transfer System (ITS). A PC computer-based system that allows forms such as screening documents, service agreements, prior authorizations, and claim forms to be “batched entered” into the MMIS.

Instrumental Activities for Daily Living (IADL). Activities necessary for independent functioning including shopping, cooking, doing housework, managing money, and using the telephone. Measurement of the functional capacity to perform these activities is frequently used to determine aspects of cognitive and social functioning.

Long Term Care Consultation Services (LTCC). LTCC provides assistance to people with long term or chronic care needs. State statutes mandates providing assessment and services planning to all citizens. The process of screening and assessment of an individual applying for nursing home admission or home and community-based services is part of eligibility determination for publicly funded long-term care.

Managed Care Organization (MCO). An entity that has, or is seeking to qualify for, a comprehensive risk contract, and that is: (1) a Federally Qualified HMO that meets the advance directives requirements of 42 CFR 489.100-104; or (2) any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: a) makes the services it provides to its Medicaid members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid Recipients within the area served by the entity, and b) meets the solvency standards of 42 CFR 438.116, section 2.37. All Minnesota MA/Minnesota Care health plans meet MCO requirements. In MN, MCO serving Medicaid enrollees are currently all non-profit organizations.

MAXIS. The online computer system which records the data that determines a person’s financial eligibility for various public programs.

Medicaid. The national program which funds health care services to low-income individuals authorized under Title XIX of the Social Security Act.


Medical Assistance (MA). Minnesota’s state plan program which funds health care services under the provisions of Title XIX of the Social Security Act and Minnesota Statutes, Chapter 256B.
Medicare. The national program which funds health care services authorized under Title XVIII of the Social Security Act for certain Social Security beneficiaries (aged, disabled, certain dependents).

Minnesota Eligibility Technology System (METS). Minnesota Eligibility Technology System is the public health portion of MNsure. MNsure is the online health insurance exchange the state developed under the Affordable Care Act. Applicants use MNsure to obtain health care coverage through the state’s public health care programs, including Medical Assistance and MinnesotaCare.

MinnesotaCare (MNCare). MNCare is a publicly subsidized health care program for Minnesotans with low income who do not have access to affordable health care coverage. Members obtain health care service through a health plan.

Minnesota Health Care Programs (MHCP). The collective term for Minnesota’s various health care programs: Senior Drug, Minnesota Senior Health Options, Medical Assistance, Prepaid Medical Assistance Program, General Assistance Medical Care, MnCare, and for purposes of this manual, the Alternative Care program.

Minnesota Health Care Programs Provider (MHCP) Manual. Sometimes referred to as the MA billing manual. Used by providers for claims and billing information and located on the DHS webpage under eDocs.

Minnesota Senior Care Plus (MSC+). A program in which the State contracts with health plans to cover and manage health care and Elderly Waiver services for Medical Assistance enrollees age 65 and older.

Minnesota Senior Health Options (MSHO). A program offered by the Minnesota Department of Human Services and health plans for seniors eligible for both Medicare and Medical Assistance and also provides Elderly Waiver services.

OBRA Level I. The term used to describe one of the activities included in preadmission screening and required under state and federal law to occur prior to any admission to certified nursing or boarding care facility. A Long Term Care Consultant uses a series of questions to “screen” individuals for the presence or possible presence of mental illness or developmental disability, and makes referrals to other qualified professionals on the basis of the result of this screening. This screening and necessary referrals are also required as part of LTCC community assessments.

OBRA Level II. The activities carried out by other qualified mental health or developmental disabilities professionals at referral under OBRA Level I. These professionals further evaluate and make determinations about mental illness or developmental disability, including recommendations for specialized services and psychiatric or ICF/DD level of care.
**Person Master Index (PMI) Number.** The number permanently assigned to an individual for identification in MMIS. Also called “Recipient ID” or “Person ID”.

**Preadmission Screening.** A federally mandated process for all persons entering a certified nursing or boarding care facility to screen for mental illness or developmental disability and determine the need for nursing facility level of care.

**Prepaid Medical Assistance Program (PMAP).** PMAP is Minnesota’s Managed Medicaid Program for Medical Assistance recipients. This program funded with state and federal funds. It is the largest of Minnesota’s publicly funded health care programs providing coverage for an average of 900,000 people each month. Various PMAP programs enroll children, families, single adults, people age 65 or older, and people who have disabilities.

**Recipient.** A person determined to be eligible for Medical Assistance or other Minnesota Health Care Program.

**(LTC) Screening Document.** The document that records in MMIS the outcome of a screening and assessment, or case management activity carried out under the HCBS programs. This document used for community, nursing facility, telephone screenings, health risk assessments (HRA), and the refusal of the HRA.

**Service Agreement.** The document that is entered on-line into MMIS which identifies services, providers, and payment information for a person receiving home care, waiver, Essential Community Supports, Moving Home Minnesota, or Alternative Care services. The on-line service agreement allows providers to bill for approved services and allows DHS to audit usage and payment data.

**State Medical Review Team (SMRT).** The SMRT team completes disability determinations for people not certified disabled by SSA. SMRT certifies a person’s disability using the same disability criteria as SSA.

**Social Security Administration (SSA).** SSA is a U.S. government agency that administers social programs covering disability, retirement, and survivors’ benefits.

**Special Needs BasicCare (SNBC).** A voluntary managed care program that provides Medicaid services and/or integrated Medicare and Medicaid services to Medicaid eligible people with a SSA or SMRT certified disability who are ages 18 through 64. This program is available in all counties provided by six different health plans. People receiving home and community based waiver services or state plan PCA/ HCN services are eligible for SNBC, however, these services will continue to be paid fee-for-service, the health plan is responsible for all basic state plan services costs. Please see the SNBC brochure DHS-6301 on eDocs.
Chapter 1

101.01 Introduction to MMIS

MMIS is the acronym for Medicaid Management Information System. Implementation of the current MMIS occurred in June 1994. It is the largest public health care payment system in Minnesota storing three years of online billing history.

MMIS is comprised of several integrated subsystems that are used to process health care claims and payments to providers including managed care capitation payments to the DHS-contracted managed care organizations (MCO). MMIS is the system of record for provider, authorization, third-party liability and payment data. The federal government reimburses DHS at a rate between 75 percent and 90 percent of the cost of MMIS operations, maintenance and development.

The system incorporates:

• Health Insurance Portability and Accountability Act (HIPAA) compliant, standard national billing formats to increase uniformity with other Minnesota health care payers.
• A web-based system to enable providers to determine recipient eligibility, submit claims, obtain claim status and get their remittance advice free and online. More than 99 percent of MHCP non-pharmacy fee-for-service claims are submitted electronically via MN-ITS.
• Phone-based, batch and real-time eligibility verification systems.
• A pharmacy point-of-sale system to enable prompt, electronic processing of 99.9 percent of all drug claims.
• Interfaces with other systems and feeds nightly into the DHS Data Warehouse to ensure incorporation of claims and payment information into DHS reports and decision-making.

The MMIS is composed of various subsystems, including:

Claims
This subsystem processes payment or denial of health care claims for services provided through public programs with all other subsystems supporting it. In fiscal year 2017 MMIS processed approximately 37 million fee-for-service claims, 50 million encounter claims, and 28 million capitation payments to managed care providers. DHS paid almost $11.7 billion to more than 69,000 providers, counties, tribes, and managed care organizations. Medical claims are received through an electronic mailbox system called MN-ITS. Drug claims are also received using “point of sale” software which returns an immediate approval/denial message to the submitting pharmacy or pharmacy biller.
Recipient

In 2017, approximately 1.496 million persons receive services through Minnesota Medicaid, MinnesotaCare, and state-funded health care programs. The Recipient Subsystem contains recipient health care program eligibility determination for both state supervised and county administrated programs such as Medical Assistance, MnCare, Alternative Care, etc. Financial eligibility for most public programs is determined through MAXIS for seniors and people with disabilities. Other populations may use METS for determining health care eligibility. For individuals eligible for health care, some information transfers from MAXIS or METS to MMIS, and additional information entered by state and county financial workers.

Provider

This subsystem maintains provider eligibility information for the 236,000 providers enrolled in Minnesota who provide services to persons participating in public programs. Types of data include demographics, licensing information, and approved or restricted services. Included is care coordinator information.

Reference

This subsystem contains all of the necessary information regarding procedure codes, diagnosis codes, drug codes and DRG codes (aka PDDD). For example, a procedure code record includes the code, a description, restrictions (age, gender) and the dollar amount MMIS will pay someone for providing that service. It also includes an indicator as to whether or not a procedure requires prior authorization.

Prior Authorization

The purpose of this subsystem is the:

- Processing and identification of those fee-for-service (FFS) services needing prior authorization prior to claim payment; and
- Screening documents entered for the health risk assessment (HRA) for SNBC services through the health plan and nursing home into this subsystem.

Data Security

This subsystem controls access to MMIS information through mainframe software (ACF2) and application software written specifically for MMIS. ACF2 prevents unauthorized access to the “front door” of MMIS, while the application security prevents unauthorized access to specific data elements or screens. MMIS security staff work with security liaisons located in each lead agency and each division within DHS central office to ensure access when needed.

Managed Care

This subsystem supports the processing of capitated payments to MCOs. Provider, contract, eligibility periods, and rate information is identified here.
Reports
There are thousands of reports generated by MMIS. These reports are stored and accessible through Infopac; a mainframe report distribution software. Infopac is set up to retain multiple iterations of each report, and can "section" a report by agency (such as county or health plan) to prevent one agency from viewing another agency’s section of a report. Reports generated by MMIS on a regular schedule depending on need include daily, bi-weekly, monthly, quarterly, annually or on request.

101.02 MMIS Interfacing with MAXIS
MMIS depends on MAXIS for person eligibility determination functions and maintenance of all person information. This interface is through the Recipient Subsystem. Some information entered into MAXIS by the financial worker transfers to MMIS while other information must be entered into both systems.

The Recipient Subsystem collects the information from MAXIS and controls person demographic or health care program eligibility determination for state supervised, county administrated programs.

MAXIS assigns the recipient's ID number (also called Person ID number or PMI) to each person applying for most programs. It is a unique eight digit lifetime number that identifies the person in the system. This ID number does not change when the person changes programs, loses eligibility, or moves to another lead agency. Assignment of more than one PMI number requires one of the numbers made inactive.

The PMIN Function assigns the PMI number when there isn't a financial worker involved in the person’s case. Examples are those people screened through the preadmission screening program and not receiving services through a public program, or those people receiving services through the Alternative Care, Essential Community Supports, or MNCare programs who are not eligible for services through any other type of public program. Changes to the birth date, name, and marital status for ID numbers obtained through the PMIN Function do not need the assistance of a financial worker. The information automatically transfers to MMIS.

MAXIS data is changed in MAXIS by the financial worker. The change transfers to MMIS.

101.03 MMIS Access and Security Features
Their supervisor and the MMIS security officer in each lead agency determine assignment of a logon ID and security group for MMIS access. The security group will control access and actions to subsystems through the Main Menu Screen. The security group for managed care staff will have limited subsystems to view as shown on the Main Menu screen.

The security liaison submits a request to DHS for the logon ID to gain access to MMIS. This person will also contact DHS for suspended logon IDs due to password violations,
terminated access due to no activity within 45 days, or assigning a temporary password. Please view Session 2 of the MMIS Training Series for more information on how to log into the system and use your password, as well as how to add MMIS to your computer or laptop. Use this link to download BlueZone.

101.04 Prior Authorization Subsystem Overview
The FFS Prior Authorization subsystem processing involves the entry, maintenance, and approval of the following:
- Designated medical services, dental services, drugs, and supplies covered by the Medical Assistance (MA) program.
- Home care authorizations for state plan services.
- Screening documents for community, nursing home, waiver, Alternative Care (AC), Essential Community Supports (ECS), Moving Home Minnesota, HRAs, and the MA Home Care programs.
- Service agreements for persons who are eligible for the above programs as well as the Day Training and Habilitation (DT&H) services (non-waiver pilot program), Special Needs services (Rule 186 funding), and the Insurance Extension Program.
- Screening documents for the Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), and Special Needs Basic Care (SNBC) programs.

101.05 Recipient Subsystem Overview
The primary objective of this subsystem is to identify all persons eligible for Minnesota Health Care Programs, or screenings and assessments through the Long Term Care Consultation Services (LTCC) Program.

This subsystem is the source of all eligibility determination data for MMIS, whether generated by DHS public assistance programs, the Social Security Administration, the Department of Health (MDH), or MAXIS. The information contained here supports claims processing, management and administrative reporting, surveillance and utilization review reporting, and third party liability processing. It is also responsible for maintaining person benefit limits, controlling the buy-in process, and generating various reports.

Person eligibility, program, and demographic data obtained from the MDH, screening documents, the Children's Health File, and MAXIS.

Updates to the Recipient Subsystem provided on a daily basis from MAXIS. Information updated in the Recipient Subsystem used for service agreement editing to ensure eligibility continues.

The Recipient Subsystem maintains a single record for each person. Waiver, ECS program, and AC eligibility history is created and maintained by using information from the LTC or DD screening documents. The information obtained from the screening document is:
• Waiver program eligibility. Includes program type, eligibility begin and through dates, and last screening action date on the RWVR screen.
• Case manager or care coordinator. Includes case manager and care coordinator name, number, and begin and end dates on the RMGR screen.
• AC and ECS program eligibility. Includes the eligibility begin and end dates as well as the county of financial responsibility on the RELG screen.
• Medicare/MBI program eligibility. Includes the eligibility spans for Medicare/MBI Parts A and/or B on the RMCR screen for persons open to the AC program.

Accessing and Viewing Data in the Recipient Subsystem
Session 5 of the MMIS Training Series provides instructions on how to log into this subsystem, navigate to the screens, read data that may cause edits to post on screening documents as well as an explanation of different screens.

101.06 Provider Subsystem Overview
This subsystem provides comprehensive provider related information on all providers enrolled to support claims processing, management reporting, and surveillance and utilization review functions. It supports the processing of online provider enrollment applications and information changes.

Case Manager/Care Coordinator/Certified Assessor Provider Number Type 23
Assignment of a provider type 23 number for every county or tribal case manager identifies that the person is case managing the care plan. This number used on the screening document and on the ASA1 screen of the service agreement.

Care Coordinator Provider Number Type 27
Contracted county staff with health plans to provide care coordination activities for waiver persons enrolled in managed care, as well as care coordinators employed by health plans, identify on the screening documents as a care coordinator – provider type 27. In some cases, this will be in addition to their provider number type 23 as a county/tribal case manager. Assignment of only one provider number 27 even if the care coordinator contracts with more than one health plan.

MCO staff with the appropriate MMIS security will enter information on the PADD screen of the Provider Subsystem to obtain a new nine-digit provider number under provider type 27. Do not add the number to the screening document until the status changes from "pend" to "active - no pay". The effective date should be the approval date to provide care coordination activities.

Creating a New Provider Number Type 27
1) Select the “PROVIDER FILE APPLICATION” from the Main Menu screen
2) On the Provider Key Panel (PKEY) screen, enter an "A" in the ACTION CODE field
3) On the PADD screen, enter the following information:
   • PROV TY (Provider Type) is 27
• SSN is a required field; this is a federal requirement; the social security number field is not viewable by others except by DHS provider eligibility and compliance staff, as needed; it is used for numerical comparison only
• NAME is the case manager's name, first, MI, last
• PRAC ADDRESS is the name of your agency
• CORR DATE RECD (request date, if able to get in to this field)
• Line (1) is the street address. This needs to be the physical address, not just PO Box
• City, state, zip
• TEL is the car coordinator’s business phone number with area code (do not add dashes in between any of the numbers). NOTE: it is important to keep this field updated. CNTY is the county code number preceded by a zero (3-digits)
• TYPE PRAC field is the type of practice. Enter 01
• FAX is a number that is accessible/used by the case manager
• APP DT field is the application date. Use the current date
• SORT NAME is the case manager's name, it is entered last name first (phone-book style) – no punctuation

4) Note that the status is “pending”. The Provider Eligibility and Compliance Unit receives a daily report showing new provider entries. They will activate the record. You can also send a request to activate the number by emailing dhs_mhcp_provider_enrollment@state.mn.us. Include the provider number, full name, agency name, and provider type. Until this is finished, the care coordinator number type 27 cannot be used on the screening document or receiving reports in their MN-ITS mailboxes.

5) Save your entry by using F3.

A message will appear on the screen stating “Date of birth is required”. It is actually not required for these provider types. Hit F3 again and advance past it.

A message will appear on the screen when you use F3 if you are adding a duplicate person to the same agency who already has a provider type 23 or 27 number. This message is “Duplicate SSN found on Provider File. Provider = XXXXXXX 00”. A review of the number to verify that it is not a duplicate.

A Health Care Case Coordinator (provider type 27) can have more than one active UMPI at a time if they are working for more than one health plan.

Changes to the Case Manager PADD Screen
If a care coordinator leaves the agency, the provider number is terminated by manually adding a new span for one of the below statuses and the effective date.
• H – Deceased
• J – Voluntary Termination
You may also contact dhs_mhcop_provider_enrollment@state.mn.us to request adding this termination type and date to the provider type 27 record. Include the NPI number, full name, agency name, termination date, and provider type.

Any changes needed for health care case coordinator provider type 27 record such as name, telephone number, address, or status, must be completed by the MHCP Provider Call Center at 651 431-2700 or 1-800-366-5411.
Chapter 2

201.01 Minnesota Health Risk Assessment (HRA) Form DHS-3428H

Purpose
Form DHS-3428H developed by the DHS in 2018 to record health risk assessment (HRA) information for members eligible for the Special Needs BasicCare (SNBC) as well as the Minnesota Senior Care Plus (MSC+) and Minnesota Senior Health Options (MSHO) programs. For the SNBC program, the HRA screening document records the required individual's health care needs including ADL and IADL information at time of initial enrollment, annually thereafter, and when the member changes products or health plans. This information is transferred to the Health Risk Assessment Screening Document form DHS-3427H for data entering into the MMIS.

Health plans may adopt this form or use it to develop their own form for assessments. Either way, complete all fields shown with an asterisk and entered into the MMIS screens under Document Type H.

Do not complete this form when a member is not located, refuses the HRA, or there is a change of care coordination. Enter the information from the HRA Screening Document DHS-3427H into the MMIS under Document Type H. See Section 301.06 for the mandatory fields for these actions.

Mailed Surveys or Online Entry
Locate the form on the department's website under eDocs. Use it as a mailed survey, telephone assessment, or a visit. The care coordinator should complete these fields before sending to the member. Do not expect the member to complete these items:

- Name
- Recipient ID/PMI #
- Health Plan Reference Number (if any)
- Activity Type (use 01)
- Counties (COS, COR, CFR, and LTCC)
- Care Coordinator UMPI Number
- Assessment Team
- Assessment Result (use 35)
- Program Type

The Effective Date of the Assessment field is normally the same day as the person completed the form.

Downloading the form to your H drive or disc and used electronically to answer the fields is an option. See the form's front page on the correct Adobe Acrobat software, how to complete and save the form. Depending on the type of software you use, it is also possible to merge the fields to the HRA Screening Document Form DHS-3427H.
Chapter 3

301.01 Special Needs Basic Care Program

The Special Needs Basic Care (SNBC) is a voluntary Medicaid managed care program for persons ages 18 – 64 who have a SSA or SMRT certified disability or a person with developmental disabilities receiving services from the DD waiver. In order to enroll in SNBC people must be eligible for Medical Assistance with or without Medicare. Some SNBC health plans give people the option to enroll in a plan to integrated their Medicare Parts A, B, and D if they are Medicare eligible.

The SNBC product IDs are MA17 (integrated Medicaid and Medicare services) and MA37 (non-integrated - Medicaid only service). If the member is receiving services in an Institution for Mental Disease (IMD) for more than 15 days within the month, the person’s major program will change from Medicaid to IM, and the product IDs are IM17 or IM37.

SNBC offers all medically necessary Medicaid state plan services with the exception of HCBS waivers, personal care assistant (PICA), and home care nursing (HCN). If an enrollee is Medicare eligible and chooses to enroll in an integrated SNBC plan (MA17), the health 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.

Nursing Home Screenings

The LTC telephone screening document form DHS-3427T records preadmission screening (PAS) of all persons entering certified nursing or certified boarding care facilities as required under Minnesota Statutes, 256.975 (PAS) and under federal OBRA legislation (Public Law 101 and 103). The completion of preadmission screening determines the appropriateness of the institutional placement of all persons entering a certified nursing or certified boarding care facility.

Managed care organizations continue to conduct PAS for members, and the Senior LinkAge Line® (SLL) staff conduct screenings for persons not enrolled with managed care. The SLL will forward information received through the online PAS site to the appropriate lead agency staff who are then responsible for all additional PAS-related activity. See bulletin 19-25-02 for policy information.

Health Risk Assessments (HRA)

A HRA is necessary at the initial contact within 30 days (after January 1, 2020 this will be 60 days) after enrollment, on an annual basis, and if the member changes products or health plans. HRAs conducted may be entered into the MMIS before, during, or after the member is open on the waiver program. The screening activity type date can overlap with a waiver program if:

- The activity type is 01, 02, 05, or 07
- The activity type date is on or after September 1, 2017
- The assessment result is 35, 39, 50, or 98
• The program type is 28

Under these circumstances, the document type field on the MMIS Key Panel screen will be an "H". The Selection screen shows saved documents as type L-H. These HRA documents do not follow the same rules as the type L documents. Enter HRA documents in any date or assessment result order. Delete the HRA document without the need to delete a type L document. It is not necessary to delete a type L document before entering a type H document when the dates are out of order with each other. See Session 8b of the MMIS Training Series for instruction on entering the HRA into MMIS.

Payment of Nursing Facility Services
Because this document plays a critical role in establishing payments for a variety of long term care services, including nursing facility services, each agency must ensure timely submission of the LTC screening document information into MMIS. No more than fourteen (14) calendar days should lapse between completion of any HRA, LTCC, or case management activity and the submission of the data into MMIS.

Data Collection, Quality Assurance, and Management Reporting
A variety of program evaluation purposes, including quality assurance and management reporting, uses information in the HRA screening document in combination with other data.

Related LTCC Program Documents
View, retrieve, or print these forms from the DHS webpage through eDocs.

<table>
<thead>
<tr>
<th>Form Number</th>
<th>Form Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHS-2497</td>
<td>Long Term Care Consultation Brochure</td>
</tr>
<tr>
<td><strong>DHS-3214D</strong></td>
<td>Notice about your rights and responsibilities for the Special Needs BasicCare program</td>
</tr>
<tr>
<td>DHS-3361</td>
<td>Nursing Facility Level of Care Brochure (people under age 21)</td>
</tr>
<tr>
<td>DHS-3426</td>
<td>Level 1: Screening for Mental Illness or Developmental Disability</td>
</tr>
<tr>
<td>DHS-3427H</td>
<td>Health Risk Assessment Screening Document for MSC+, MSHO, and SNBC</td>
</tr>
<tr>
<td>DHS-3427T</td>
<td>LTC Screening Document: Telephone Screening</td>
</tr>
<tr>
<td>DHS-3428H</td>
<td>Health Risk Assessment</td>
</tr>
</tbody>
</table>

301.02 Accessing the MMIS Prior Authorization Subsystem
If you do not have the correct security to access the prior authorization subsystem, a message will appear on the Main Menu screen when you select Screenings. Contact your agency’s MMIS security liaison to change your security group.
The MMIS Training series provides instruction on how to use the MMIS for the LTC and HRA screening documents. Session 1 is mandatory. New staff working with the MMIS should review sessions 2 – 5. Other sessions that includes the HRA screening are 7, 7a, 8b, 12, and 13. These sessions are located on TrainLink.

- Session 1 – MMIS Overview
- Session 2 – MMIS Security Log in and Passwords
- Session 3 – Basic Navigation in MMIS
- Session 4 – Using Programming Function (PF) Keys
- Session 5 – The Recipient Subsystem
- Session 6 – Introduction to the LTC Screening Document
- Session 7 – Viewing the LTC and HRA Screening Document
- Session 7a – Using Activity Types
- Sessions 8, 8a – Data Entering the LTC Screening Document
- Session 8b – Data Entering the Health Risk Assessment (HRA) Document into MMIS
- Session 9 – The LTC screening document for the MSHO and MSC+ Programs
- Session 10 – Coding the LTC Screening Document for Other Services
- Session 11 – DHS Approval of the LTC Screening Document
- Session 12 – Locating Suspended Documents for Correction or Deletion
- Session 13 – Deleting the LTC and HRA Screening Document

301.03 Screening Document Fields
This chart shows a field by field description on the MMIS screens ALT1 – ALT5. See section 201.07 for the mandatory fields for each assessment result.

<table>
<thead>
<tr>
<th>Form DHS-3427H and MMIS screens</th>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section A and the ALT1 Screen</td>
<td>Member Last Name</td>
<td>System Entered</td>
</tr>
<tr>
<td></td>
<td>Member First Name</td>
<td>System Entered</td>
</tr>
<tr>
<td></td>
<td>Middle Initial</td>
<td>System Entered</td>
</tr>
<tr>
<td></td>
<td>PMI Number (Person Master Index)</td>
<td>System Entered from the Key Panel screen</td>
</tr>
<tr>
<td></td>
<td>Reference Number</td>
<td>To identify the individual by the MCO's unique numbering system</td>
</tr>
<tr>
<td></td>
<td>Date Submitted</td>
<td>System Entered. The date the screening document is entered and saved in MMIS</td>
</tr>
<tr>
<td></td>
<td>Birth Date</td>
<td>This field must match the birth date on the Recipient Subsystem.</td>
</tr>
<tr>
<td></td>
<td>Sex</td>
<td>System Entered</td>
</tr>
<tr>
<td></td>
<td>Referral Date</td>
<td>The date of original referral for screening or assessment.</td>
</tr>
<tr>
<td></td>
<td>Next NF Visit</td>
<td>The purpose of this field is to identify the date of</td>
</tr>
<tr>
<td>Field Name</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>the next annual visit for persons under age 65. The date that is populated is 1095 days after the activity type date of the most recent activity type 04. While the initial visit is mandatory, the annual visit may be delayed up to three years. <strong>A protected field.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity Type Date</td>
<td>The date the above activity occurred.</td>
<td></td>
</tr>
<tr>
<td>COS, COR, CFR</td>
<td>County of Service, County of Residence and County of Financial Responsibility. MMIS changes the manually entered information if there is a financial worker involved with the case. COS refers to the county providing financial worker service for MA eligibility or re-determination. COR is where the member lives. For private pay and all others without financial workers, assume the COS, COR and CFR are the same (i.e. where a member lives).</td>
<td></td>
</tr>
<tr>
<td>LTCC County</td>
<td>The health plan who completed the screening or assessment. The values are: UCM = A5658136 00 (UCare MN) MED = A4057139 00 (Medica) MHP = A9657134 00 (Metropolitan Health Plan replaced by HHP). No longer valid as of 2015. BPH = A0658138 00 (Blue Plus) HPH = A5857139 00 (Health Partners) IMC = A1060139 00 (Itasca Medical Care) PWH = A1551183 00 (Primewest Health System) SCH = A0137073 00 (South Country Health Alliance) HHP = A836618200 (Hennepin Health for SNBC only)</td>
<td></td>
</tr>
<tr>
<td>Form DHS-3427H and MMIS screens</td>
<td>Field Name</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td>Legal Representative Status</td>
<td>Records guardianship or legal representative status as determined by a court. <strong>Keep field blank for HRA screenings.</strong></td>
</tr>
<tr>
<td></td>
<td>Primary Diagnosis</td>
<td>The primary diagnosis that underlies the need for services and care. <strong>Keep field blank for HRA screenings.</strong></td>
</tr>
<tr>
<td></td>
<td>Secondary Diagnosis</td>
<td>The secondary diagnosis that may affect the need for care or services. Also, see above. <strong>Keep field blank for HRA screenings.</strong></td>
</tr>
<tr>
<td></td>
<td>Is there a history of a DD diagnosis?</td>
<td>Records if there is a history of a developmental disability or related condition diagnosis. (Y/N). <strong>Keep field blank for HRA screenings.</strong></td>
</tr>
<tr>
<td></td>
<td>If so, what is the diagnosis</td>
<td>Indicates the DD diagnosis. <strong>Keep field blank for HRA screenings.</strong></td>
</tr>
<tr>
<td></td>
<td>Is there a history of a MI diagnosis?</td>
<td>Records if there is a history of a mental illness diagnosis (Y/N). <strong>Keep field blank for HRA screenings.</strong></td>
</tr>
<tr>
<td></td>
<td>If so, what is the diagnosis</td>
<td>Indicates the MI diagnosis. Use diagnosis codes obtained from medical records. <strong>Keep field blank for HRA screenings.</strong></td>
</tr>
<tr>
<td></td>
<td>Is there a history of a BI diagnosis?</td>
<td>Records if there is a history of a traumatic brain injury diagnosis (Y/N). <strong>Keep field blank for HRA screenings.</strong></td>
</tr>
<tr>
<td></td>
<td>If so, what is the diagnosis?</td>
<td>Indicates the BI diagnosis. Use diagnosis codes obtained from medical records. <strong>Keep field blank for HRA screenings.</strong></td>
</tr>
<tr>
<td></td>
<td>Case Manager/Care Coordinator/Certified Assessor Name</td>
<td>System Entered</td>
</tr>
<tr>
<td></td>
<td>Case Manager/Care Coordination/Certified Assessor NPI/UMPI Number</td>
<td>The provider number of the health plan coordinator. It is a provider type 27.</td>
</tr>
</tbody>
</table>

**Section B and the ALT2 Screen**

<p>|                                  | Present at Screening/Assessment | Identifies different types of people who were present at the assessment. <strong>Keep field blank for HRA screenings.</strong> |
|                                  | Informal Caregiver | Answers if the member has an informal caregiver who provides regular services. <strong>Keep field blank for HRA screenings.</strong> |
|                                  | Marital Status | Legal marital status. <strong>Keep field blank for HRA screenings.</strong> |</p>
<table>
<thead>
<tr>
<th>Form DHS-3427H and MMIS screens</th>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason(s) for Referral</td>
<td>Why the member or family is requesting a screening or assessment. Use up to two different values. <strong>Keep field blank for HRA screenings.</strong></td>
<td></td>
</tr>
<tr>
<td>Current Living Arrangement</td>
<td>Identifies whom the member lives with. Value 04 is an institution setting.</td>
<td></td>
</tr>
<tr>
<td>Planned Living Arrangement</td>
<td>Identifies whom the member will live with. Value 04 is an institution setting. <strong>Keep field blank for HRA screenings.</strong></td>
<td></td>
</tr>
<tr>
<td>Assessment Team</td>
<td>Identifies who completed the assessment or screening. Use values 02 or 03.</td>
<td></td>
</tr>
<tr>
<td>Hospital Transfer</td>
<td>Field asks if the member being admitted to a long term care facility (nursing or certified boarding care facility) from an acute hospital. (Y/N). <strong>Keep field blank for HRA screenings.</strong></td>
<td></td>
</tr>
<tr>
<td>OBRA Screening Level 1</td>
<td>Was an OBRA Level 1 screening completed? (Y/N). <strong>Keep field blank for HRA screenings.</strong></td>
<td></td>
</tr>
<tr>
<td>Current Housing Type</td>
<td>The setting where the member lives.</td>
<td></td>
</tr>
<tr>
<td>Dental Concerns</td>
<td>Y – yes, N – no, C – choose not to answer</td>
<td></td>
</tr>
<tr>
<td>Do you have a dentist?</td>
<td>Y – yes, N – no, C – choose not to answer</td>
<td></td>
</tr>
<tr>
<td>Planned Housing Type</td>
<td>The setting where the member will live. <strong>Keep field blank for HRA screenings.</strong></td>
<td></td>
</tr>
<tr>
<td>Current Program License</td>
<td>The program license of the housing setting, where the member is currently living, if any. Foster care, or nursing facility, e.g. <strong>Keep field blank for HRA screenings.</strong></td>
<td></td>
</tr>
<tr>
<td>Planned Program License</td>
<td>The license of the housing setting where the member is planning to live, if any. Foster care, or nursing facility, e.g. <strong>Keep field blank for HRA screenings.</strong></td>
<td></td>
</tr>
<tr>
<td>OBRA Level 2 Referral</td>
<td>Indicate “y” if a referral was required and made as determined through the Level 1 screening, or a competed Level 2 screening prior to the Level 1 screening. <strong>Keep field blank for HRA screenings.</strong></td>
<td></td>
</tr>
<tr>
<td>BI/CAC Referral</td>
<td>Indicates whether a referral was required and made according to BI and CAC program requirements. <strong>Keep field blank for HRA screenings.</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Section C and the ALT3 Screen | • Dressing  
• Grooming  
• Bathing  
• Eating | Records information obtained during assessment about the member’s strengths and areas for support and past health care utilization. |
<table>
<thead>
<tr>
<th>Form DHS-3427H and MMIS screens</th>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
</table>
|                                  | • Bed Mobility  
• Transferring  
• Walking  
• Behavior/Emotional  
• Toileting  
• Self-Evaluation  
• Hearing  
• Vision  
• Phone Calling  
• Shopping  
• Preparing Meals  
• Light Housekeeping  
• Management of Medications/Other Treatment  
• Insulin Dependent  
• Money Management  
• Transportation  
• Falls  
• Hospitalizations – number within last year  
• Emergency Visits – number within last year  
• NF Stays – number within last three years  
• Family Planning Needs  
• Sexually Active  
| The IADLS fields | Unless noted below, the fields will have these values for Activity Type Date 8/1/18 and greater:  
• 00 – needs no assistance  
• 10 – yes, needs assistance, met by current supports or help from others or equipment  
• 11 – yes, needs assistance, not met by current supports, help from others, or equipment  
• 12 – chose not to answer  
|                      | Emotional (shown on the MMIS screen as Behavior)  
• 05 - poor  
• 06 - fair  
• 07 - good  
• 08 – excellent  
• 12 – chose not to answer  
|                      | Self-Evaluation  
• 00 – no response  
• 01 – poor  
• 02 – fair  
• 03 – good  
• 04 – excellent  
• 12 – chose not to answer  
|                      | Hearing  
• 00 no hearing impairment or impairment corrected with hearing aides  
• 01 – hearing difficulty at level of conversation  
• 02 – hears only very loud sounds  
• 03 – no useful hearing  
• 04 – not determined  
• 12 – chose not to answer  
|                      | Vision  
• 00 – no impairment of vision or impairment corrected with glasses, contacts  
• 01 – has difficulty seeing at level of print  
<p>|</p>
<table>
<thead>
<tr>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Money Management</td>
<td>02 – difficulty seeing obstacles in environment 03 – no useful vision 04 – not determined 12 – chose not to answer</td>
</tr>
<tr>
<td>Transportation</td>
<td>10 – yes, needs assistance, met by current supports or help from others or equipment 11 – yes, needs assistance, not met by current supports, help from others, or equipment 12 – chose not to answer</td>
</tr>
<tr>
<td>Communication</td>
<td>00 – excellent 05 – good 06 – fair 07 – poor 08 – unable to answer 12 – chose not to answer</td>
</tr>
<tr>
<td>Medication Management</td>
<td>01 – need no help or supervision 05 – do not take medications 06 – only need someone to set up my medications 07 – only need someone to remind me to take medications 08 – need medication setups and reminders 09 – need someone to help me take them 12 – choose not to answer</td>
</tr>
<tr>
<td>Insulin Dependent</td>
<td>01 – not diabetic 02 – no insulin required, diet controlled only 03 – oral medication 04 – sliding scale insulin and oral medications 05 – scheduled daily insulin 06 – scheduled daily insulin plus daily sliding scale</td>
</tr>
<tr>
<td>Falls</td>
<td>see instructions that follows this chart.</td>
</tr>
<tr>
<td>Do you have any family planning needs?</td>
<td>Y – Yes, N – No, C – choose not to answer. Note: if answer = N or C then the sexually active field can be blank.</td>
</tr>
<tr>
<td>Form DHS-3427H and MMIS screens</td>
<td>Field Name</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>------------</td>
</tr>
</tbody>
</table>
| Sections D and F and the ALT4 Screen | Assessment Results and Exit Reasons | Field 75A: The outcome of the assessment activity. Choices are:  
- 35 – the health risk assessment visit  
- 39 – used when the member refused the health risk assessment  
- 50 – member cannot be located for the health risk assessment  
- 98 – used with activity type 05 to show a change in care coordinator  
Field 75B: Only used when member is exiting from the waiver, AC, or ECS program to indicate what will happen to them, **Keep field blank for HRA screenings.** |
| | Effective Date | The effective date of the outcome identified in field 75A. The date cannot be more than 60 days after the Activity Type Date for Activity Types 01 and 02. For SNBC, the date must fall within a major program MA (Medical Assistance) span. |
| | Relocating to Community | Y – yes, N – no, C – choose not to answer  
*Complete only if the Current Housing Type is 02 or 11.* |
<p>| | Informed Choice | This field indicates that the member received information about and understands their rights regarding a choice between institution and community services, their right to a choice in services and providers, and the member has signed the Community Support Plan, DHS Forms 2925, 4166, or 6791B. <strong>Keep field blank for HRA screenings.</strong> |
| | Person Choice | The member’s choice of services and setting. <strong>Keep field blank for HRA screenings.</strong> |
| | Guardian Choice | The choice of the member’s guardian, if any. <strong>Keep field blank for HRA screenings.</strong> |
| | Family Choice | The family’s choice of services and setting for the member. <strong>Keep field blank for HRA screenings.</strong> |
| | LTCC/IDT Recommendation | The assessor’s recommended services and setting for the member. <strong>Keep field blank for HRA screenings.</strong> |</p>
<table>
<thead>
<tr>
<th>Form DHS-3427H and MMIS screens</th>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Care</td>
<td>The assessor’s determination of various levels of institutional need for care. <strong>Keep field blank for HRA screenings.</strong></td>
<td></td>
</tr>
<tr>
<td>NF Track Number</td>
<td>Used for telephone screens in the nursing home. <strong>Keep field blank for HRA screenings.</strong></td>
<td></td>
</tr>
<tr>
<td>Case Mix Amount</td>
<td><strong>Keep field blank for HRA screenings.</strong></td>
<td></td>
</tr>
<tr>
<td>Reasons for NF Continued Stay/CDCS Ending</td>
<td>This field shows: 1) The reason(s) why the member remains in an institution after a relocation assessment is completed. Use up to two different values. 2) The reasons the member ends the CDCS option. Use up to two different values. 3) State the reasons why a member is on a CADI or BI waiting list. Use value 01 when the lead agency has no money in their allocation to serve the member. Use values 03 – 10 as reasons for planning in the waiver management system. <strong>Keep field blank for HRA screenings.</strong></td>
<td></td>
</tr>
<tr>
<td>Professional Conclusions</td>
<td>Summary statements regarding the basis of “level of care” decisions as determined by assessors. Use Y or N. <strong>Keep field blank for HRA screenings.</strong></td>
<td></td>
</tr>
<tr>
<td>Waiver/AC Eligibility Criteria</td>
<td>Was waiver eligibility criteria reviewed and met? Use Y or N. <strong>Keep field blank for HRA screenings.</strong></td>
<td></td>
</tr>
<tr>
<td>Program Type</td>
<td>SNBC program type is 28.</td>
<td></td>
</tr>
<tr>
<td>MHM IND</td>
<td>Moving Home Minnesota. Add “Y” if member elected this program when screened in the institution. Document will remain in suspense and route to DHS for approval. <strong>Keep field blank for HRA screenings.</strong></td>
<td></td>
</tr>
<tr>
<td>CDCS (Y or N)</td>
<td>An indicator of the CDCS option. <strong>Keep field blank for HRA screenings.</strong></td>
<td></td>
</tr>
<tr>
<td>CDCS Amount</td>
<td>The monthly dollar cap for the CDCS services. <strong>Keep field blank for HRA screenings.</strong></td>
<td></td>
</tr>
<tr>
<td>Service Codes</td>
<td>Records formal services, informal care giving, quasi formal services and identifies the bundled services for Elderly Waiver customized living services. (C) – EW customized living services provided by the CLS provider. (F) - Formal services are paid through funding sources such as the waiver, Alternative Care,</td>
<td></td>
</tr>
</tbody>
</table>
**Form DHS-3427H and MMIS screens**

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medical Assistance, Medicare, or private insurance. (I) - Informal services are unpaid services (Q) - Quasi-formal services require a small payment such as a stipend. (M) - Moving Home MN services (O) – Offered Update this section at any time using Activity Type 05. Keep field blank for HRA screenings.</td>
</tr>
</tbody>
</table>

**Falls Question:**

1. Have you experienced any falls . . . 00____No 01____Yes  
   a. If 1. = 01, go to 3.  
   b. If 1. = 00, go to 2.  
2. If no, does concern about your balance or falling . . . 00____No 02 _____Yes  
   a. If 2 = 00, 00 is code for 3427H and in MMIS.  
   b. If 2 = 02, 02 is code for 3427H and in MMIS.  
3. Fall with fracture in last 12 months? 00 ____No 03____Yes  
   a. If 3. = 00, 01 is code for 3427H and in MMIS.  
   b. If 3. = 03, 03 is code for 3427H and in MMIS.

**301.04 Using Activity Types**

The activity type identified in Section A of the HRA screening document DHS-3427H indicates the type of screening or assessment. The activity types for SNBC are 01, 02, 05, or 07. See Session 7A, Using Activity Types, in the MMIS Training Series for detailed information on the different activity types and when to use them.

**Activity Type 01 - Telephone Screen**

Use this activity type for nursing facility admissions. MCO staff complete PAS for their enrolled members. The information is entered into MMIS using form DHS-3427T. Please see bulletin 19-25-02 Preadmission Screening – Activity Required for MA-Certified Nursing Facilities for complete information.

Also, use this activity type to record the HRA conducted by telephone or mailed survey. Form DHS-3428H records the results of the HRA, and form DHS-3427H records the mandatory information into the MMIS. A HRA for persons enrolled with the SNBC program must be conducted within 30 (60 calendar days after January 1, 2020) calendar days of enrollment and annually thereafter.
Activity Type 02 - Person to Person HRA Visit
This activity type represents the completion of a face-to-face HRA. Health risk assessments for persons enrolled with the SNBC program must be conducted within 30 (60 calendar days after January 1, 2020) calendar days of enrollment and annually thereafter. Use form DHS-3428H to record the HRA and form DHS-3427H is the screening document to enter the mandatory information into MMIS.

Activity Type 05 - Document Change Only
This activity type supports the need to make limited changes to an approved screening document. The changes show on a new screening document rather than the document initially entered.

Use Assessment Result 98 at any time (except for the initial screening document) when updating the care coordinator NPI number.

Activity Type 07 - Administrative Activity
This activity type identifies administrative activities. It is to be used to record members not found for the HRA or that the member refused the HRA.

Activity Type and Assessment Result Combinations
Edits will check if the activity type in field 11 on the ALT1 screen is correct with the assessment result in field 75a on the ALT4 screen. The below information shows the correct combinations.

- **Activity type 01 is a completed preadmission screening conducted by a telephone call by the Senior LinkAge Line® staff.**
  - Assessment result 04
- Activity type 01 is a completed health risk assessment conducted through a telephone call or mailed survey.
  - Assessment result 35
- Activity type 02 is a completed health risk assessment conducted through a face-to-face visit.
  - Assessment result 35
- Activity type 05 is a document change to change the care coordinator provider number.
  - Assessment result 98
- Activity type 07 records that the health risk assessment was not successful due to the member declining to complete.
  - Assessment result 39
- Activity type 07 records that the health risk assessment was not successful due to the member was not located.
  - Assessment result 50
301.05 Screening and Assessment Scenarios
This chart identifies a scenario in the first column and types of screening documents.

<table>
<thead>
<tr>
<th>Case Type – SNBC Member Admitted to Nursing Facility</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person A. Screened in the nursing facility</td>
<td>Use form DHS-3427T</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Case Type: SNBC member remains in community with or without waiver services</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person A: Member enrolls with SNBC</td>
<td>Complete a health risk within 30 days after enrollment.</td>
</tr>
<tr>
<td>Person B: Member remains on SNBC after 12 months.</td>
<td>Complete a health risk assessment on an annual basis.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Case Type: Change in care coordination</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person A – Assignment of a different care coordinator from same health plan</td>
<td>New care coordinator will enter a screening document with activity type 05 and assessment result 98 and change the CM/HP/CA provider number field.</td>
</tr>
<tr>
<td>Person B – Member enrolls with a different health plan</td>
<td>A new health risk assessment is completed that includes the new care coordinator’s provider number</td>
</tr>
</tbody>
</table>

301.06 Mandatory Fields
Non-mandatory fields are protected on the MMIS screen. Below are the fields that are mandatory when using assessment result 35.

Nursing Facility Screening Using Form DHS-3427T

Section A/ALT1 Screen
- Reference Number field is not mandatory
- All other fields are mandatory except for primary diagnosis
- Note: the care coordinator provider number is mandatory for the CM/HP/CA field on the ALT1 screen but it is not listed on this form

Section B/ALT2 Screen
- All fields are mandatory

Section C/ALT3 Screen
- All fields are mandatory

Section D/ALT4 Screen
• All fields are mandatory
  o Assessment result is 04
  o Level of care is 02

Section E/ALT4 Screen
• Mandatory question

Section F/ALT4 Screen
• Mandatory question

Completed Health Risk Assessment Using Form DHS-3427H

Section A/ALT1 Screen
• Reference Number (may be left blank if there isn't an alternative MCO number)
• Date of Birth
• Referral Date
• Activity Type
• Activity Type Date
• COS, COR, and CFR (must be completed but fields will change to values on the Recipient Subsystem)
• LTC County (the managed care organization provider number)
• Care Coordinator U MPI Number

Section B/ALT2 Screen
• Current Living Arrangement
• Assessment Team
• Current Housing Type
• Dental Concerns
• Do you have a dentist?

Section C/ALT3 Screen
• ADL Fields (dressing, grooming, bathing, eating, bed mobility, transferring, walking, behavior/emotional, toileting, and self-evaluation)
• Hearing
• Communication
• Vision
• IADL Fields (phone calling, shopping, preparing meals, light housekeeping, medication management, insulin dependent, money management, and transportation)
• Falls, Hospitalizations, ER Visits, NF Stays, Family Planning, and Sexually Active

Sections D and F/ALT4 Screen
• Assessment Results
• Effective Date
• Relocating to the Community (if current housing is 02 or 11)
• Program Type

Below are the fields that are mandatory when using assessment results 39, 50, or 98.

**Incomplete Health Risk Assessment**

**Member Declines to Complete, Member Is Not Located or Care Coordinator Change**

**Section A/ALT1 Screen**
- Date of Birth
- Activity Type
- Activity Date
- County fields
- CM/HP/CA Number

**Section B/ALT2 Screen**
- No fields are to be completed

**Section C/ALT3 Screen**
- No fields are to be completed

**Section D/ALT4 Screen**
- Assessment Result
- Effective Date

**Section E/ALT4 Screen**
- No fields are to be completed

**Section F/ALT4 Screen**
- Program Type

**Coding Examples for Section B: Living Arrangement and Housing Type**

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Field Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member living and will continue to live in foster care</td>
<td>• Current Living Arrangement = 04</td>
</tr>
<tr>
<td></td>
<td>• Current Housing Type = 05</td>
</tr>
<tr>
<td>Member lives alone and will continue to live alone in an apartment or other home. Living alone means no one else lives with the member.</td>
<td>• Current Living Arrangement = 01</td>
</tr>
<tr>
<td></td>
<td>• Current Housing Type = 09</td>
</tr>
<tr>
<td>Member lives in an apartment where assisted living services are provided. An apartment is a self-contained unit that includes <em>private</em> space for</td>
<td>• Current Living Arrangement = 03</td>
</tr>
<tr>
<td></td>
<td>• Current Housing Type = 09</td>
</tr>
</tbody>
</table>
**Scenario** | **Field Coding**
---|---
sleeping, cooking, dining, living, and a bathroom. *They have a roommate.* | 
Member lives in an assisted living building with several others. Each person has a bedroom with an attached bath. All other space for living, dining, cooking is shared accommodation. | • Current Living Arrangement = 04  
• Current Housing Type = 04  
Member lives in a nursing facility and will return to the community to an assisted living in an apartment with spouse. | • Current Living Arrangement = 04  
• Current Housing Type = 11

301.07 Telephone Screening Document for NF Screenings
Use form DHS-3427T to record a telephone screening for a member admitted to the nursing home. See section 301.01. Three programs use this form: fee-for-service using program type 00, MSHO and MSC+ members using program type 18; and SNBC members using program type 28. When entering this form into the MMIS, use Document Type L on the Key Panel screen.

301.08 Navigation
The MMIS Training Series includes navigation in most of the sessions. The following sessions focuses more on navigation: See Section 3 for using the keyboard keys and the Next field. Session 4 explains and demonstrate the purpose and use of the programmable function (PF) keys. Session 7 explains and demonstrates using Inquiry on the screening document.

301.09 Editing the Screening Document
Instructions on how to edit the HRA screening document once data is entered, how to use the edit line with the PF keys, and which MMIS screens should be referenced to assist in resolving the edits is explained in the MMIS Training Series, Session 8b.

301.10 Deleting the Screening Document
Session 13 of the MMIS Training series explains the reasons and steps to delete the LTC and HRA screening documents.

301.11 Retrieving and Resolving Suspended Screening Documents
See Session 12 of the MMIS Training Series for the steps to locate suspended screening documents by:
- your agency’s queue
- care coordinator provider number
- Infopac report
401.01 Resources

Publications, Forms, and Resources Webpage

The Publications, forms, and resources webpage gives access to the following:

- DHS manuals including:
  - Community-Based Services Manual (CBSM)
  - How to Enter the Long Term Care Screening Document into MMIS for the MSHO and MSC+ Programs
  - How to Enter the Long Term Care Screening Document and Service Agreement into MMIS
  - Guidelines to the Investigation of Vulnerable Adult Maltreatment
- Bulletins from the last three years
- eDocs for DHS forms and brochures

Adults

The Adult webpage includes the following:

- Adult protection
- Deaf and hard of hearing
- Seniors
- People with disabilities

Email Subscriptions to Listservs

DHS provides subscriptions to public email lists. This page shows the Aging and Adult Services Lead Agency listserv which provides information about the Elderly Waiver, Alternative Care, LTCC programs as well as new bulletins, policy information, and MMIS changes. Access archive memos here also.

You can also register for the Aging and Adult Services Video Conferencing listserv to receive announcements of new video conference training sponsored by the Aging and Adult Services division.

Aging and Adult Services Division Trainings

The division provides trainings by video conferences to provide program policy and quality improvement information. Online modules accessible through TrainLink provide instruction on using the MMIS for the LTC screening document and service agreement. See more information to access these trainings on the Aging Training page.
Send questions from care coordinators, their delegates, and MMIS staff regarding enrollment, contract, HRA, or product/program questions to their health plan contacts.
401.03 Management Reports

These reports are available for viewing online using Infopac. Most MCOs can also print the reports. Infopac holds a history of past report versions and allows the printing of the entire report, selected pages, or a custom design of pages. The report is a "snapshot" of data. The user cannot change the data or the date parameters.

If you are interested in viewing or having the reports print directly at your health plan, contact your Infopac administrator.

The following reports are available to health plan, county, and tribal staff:
- PWMW9200-R2453 Screening Documents Approved
- PWMW9200-R2455 Suspended LTC Screening Document
- Client Eligibility Change Report

The following report is available to county and tribal staff:
- 185L-R0507 MSHO/MnDHO/SNBC New Enrollee Report

If you have questions regarding the managed care reports, please contact the managed care organization.

<table>
<thead>
<tr>
<th>Report Number</th>
<th>Report Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9200-R2453</td>
<td>Screening Documents Approved</td>
<td>Shown are approved screening documents within the reporting period for the case manager or health care coordinator on the screening document. It is not a cumulative report. Use this report to track when screening documents were data entered and approved during the reporting period. If the last waiver claim payment date is very old, the provider(s) may be having problems submitting claims or the person is no longer receiving services.</td>
</tr>
<tr>
<td>9200-R2455</td>
<td>Suspended LTC Screening Document</td>
<td>This is a weekly report for the county, tribal agency, health plan, or county based purchasing entity associated with the</td>
</tr>
<tr>
<td>Report Number</td>
<td>Report Name</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td>CM/HP/CA number. The report goes to the agency identified in the LTCC County field when the CM/HP/CA number field is blank.</td>
<td>It identifies the LTC or HRA screening documents that are in suspense for more than two weeks and the number of days since they were data entered. Delete the screening document or enter a new document that corrects the problem that is keeping the document in suspense. This is a cumulative report. See Session 12 of the MMIS Training Series for instructions on how to find these documents in MMIS.</td>
</tr>
<tr>
<td></td>
<td>Client Eligibility Changes</td>
<td>This report provides timely notifications of eligibility changes for persons receiving case management services for case managers and care coordinators. Changes in eligibility have an impact on home and community based services, care planning, and service delivery. This report is another tool to provide that information. This report will not replace the Case Manager/Financial Worker Communication form DHS-5181.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The report is not cumulative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• It is sorted by the case manager or care coordinator provider number</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Labeled “Report” and placed in the CML folder of the following MN-ITS accounts:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Provider type 23 case managers – sent to the county or tribal lead agencies’ MN-ITS mailbox</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Provider type 27 health care coordinators – individual MN-ITS mailbox.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Includes a page to explain data and suggest possible actions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Provided on a weekly basis each Friday for persons with a change in one or more of the following:</td>
</tr>
</tbody>
</table>
|               |               |   • Medical Assistance major program begin date, end date, or
<table>
<thead>
<tr>
<th>Report Number</th>
<th>Report Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>county of financial responsibility</td>
<td>county of financial responsibility (CFR)</td>
</tr>
<tr>
<td></td>
<td>(CFR)</td>
<td>o Alternative Care major program begin date, end date, or county of financial responsibility (CFR)</td>
</tr>
<tr>
<td></td>
<td>o Medicare Part A and or Part B</td>
<td>o Medicare Part A and or Part B begin or end date</td>
</tr>
<tr>
<td></td>
<td>begin or end date</td>
<td>o PPHP Enrollment begin date, end date, health plan, product ID, or disenrollment reason</td>
</tr>
<tr>
<td></td>
<td>o Living Arrangement type, begin</td>
<td>o Living Arrangement type, begin or end date</td>
</tr>
<tr>
<td></td>
<td>or end date</td>
<td>o LTC Ineligibility type, begin or end date</td>
</tr>
<tr>
<td></td>
<td>o Waiver type, begin or end date</td>
<td>o Waiver type, begin or end date</td>
</tr>
<tr>
<td></td>
<td>o Date of death</td>
<td>o Date of death</td>
</tr>
<tr>
<td>PWMW185L-R05070</td>
<td>MSHO/MnDHO/SNBC New Enrollee Report</td>
<td>Generation of the report is after capitation and identifies people who enrolled in managed care (MSHO, MSC+, and SNBC) the following month. It is sorted by the service location and then by health plan. Use the report to identify new enrollees who are also on a waiver or Essential Community Supports program.</td>
</tr>
</tbody>
</table>