Policy Title:	**Home Care**
Department:	**Government Programs**
Business Unit:	**State Public Programs**
Approved By:	**Director of SPP Products**
Approved Date:	**9/1/2021**
Original Effective Date:	**9/1/2021**
Review Date(s) (no changes)	
Revision Dates:	**5/30/2022**

PRODUCTS AFFECTED:

- Minnesota Senior Health Options (MSHO) – Medica DUAL Solution®
- Minnesota Senior Care Plus (MSC+) – Medica Choice Care℠ MSC+
- Special Needs BasicCare (SNBC) – Medica AccessAbility Solution®
- Special Needs BasicCare (SNBC) Integrated – Medica AccessAbility Solution® Enhanced

DEFINITIONS:

Home Care: Home care pertains to state plan home care and skilled home care services delivered to Medica members. It is an option that offers a range of medical care and support services provided in the member's home and community. Services range from simple assistance in activities of daily living to a level of care similar to cares provided in a hospital. Home Care Services referenced in this policy include home health aide (HHA), home care nursing (HCN) for MSHO and MSC+ only, skilled nurse visit (SNV), home care therapies and personal care assistance (PCA) for MSHO and MSC+ only.

Assessment: Assessment used to determine home care services. This may be the Long Term Care Consultation, MnCHOICES Assessment, Health Risk Assessment (HRA), PCA Legacy Assessment, Medical Assistance Home Care Nursing Assessment, or other assessment used to determine home care needs.

Care Coordinator (CC): An employee or delegate of Medica who creates a person-centered care plan with assigned members and then coordinates the provision of covered services for those members among different health and social services professionals and across settings of care, including home care.

County Waiver Case Manager: An employee or delegate of a county that provides members and their families with access to assessment, person-centered planning, referral, linkage, support plan monitoring, coordination and advocacy related to waiver services, resources and informal supports that are not necessarily funded through the waiver. The waivers referenced are Brain Injury (BI), Community Alternative Care (CAC), Community Access for Disability inclusion (CADI) and Developmental Disabilities (DD).

Network Provider: means any provider, group of providers, or entity that has a network provider agreement directly with Medica to render covered services under contract with Medica.

Out of Network Provider (OON): means the provider does not have an agreement to render covered services with Medica.

Waiver Managed by the County: Members with disabilities who need certain levels of care. These programs are available to members who choose to reside in the community and meet eligibility criteria. The county completes assessments to determine waiver eligibility. These waivers include the Brain Injury (BI) Waiver, Community Alternative Care (CAC) Waiver, Community Access for Disability Inclusion (CADI) Waiver, and the Developmental Disabilities (DD) Waiver

PURPOSE:
To ensure Care Coordinators authorize home care services that are the responsibility of Medica as determined by an assessment using network providers.

POLICY:
The care coordinator coordinates and authorizes home care services that are the responsibility of Medica using network providers.

GENERAL PROCEDURE:

1. Care Coordinator completes an assessment that determines a member's need for home care services.
    a. New members enrolled with Medica currently receiving PCA services, Medica will honor the current PCA authorization and not complete a new PCA assessment. The CC will only complete a new assessment at the time of the initial HRA if the CC is unable to obtain the most recent PCA assessment (contact the provider, member or assessor for the assessment), there is a change in condition or change in member's supports, member requests a new assessment, or the PCA authorization will end within 30 days of the HRA date. Additional information can be found on the Assessment Schedule MSHO/MSC+ Policy located on the Care Coordination Website.
2. Care Coordinator authorizes home care services with an in network provider. Resources to locate or determine if a provider is in network:
    a. Medica Customer Service at 952-992-2580, or 1-888-347-3630
    b. Contracted PCA and Home Health Agency List on the Care Coordination Website.
    c. Provider search function for each product on Medica.com for home care other than PCA
3. Care Coordinator completes Referral Request Form (RRF) if needed. Please reference the Referral Guidelines for Medica Members on the CC Website for home care services that require an authorization. The CC should verbally authorize home care services that do not require completing a RRF.
   Note: Home Care Nursing (Home Care Nursing formerly Private Duty Nursing) requires additional information per the Referral Guidelines for Medica Members and also refer to the Home Care Nursing Benefit Guideline for details.

ADDITIONAL PROCEDURE WHEN MEMBER ON A WAIVER MANAGED BY THE COUNTY:

1. The Care Coordinator (CC) will check MN-ITS to determine member's waiver status with enrollment, member transfers and at least annually when member is due for an assessment.
2. If the member is on another waiver, the CC will obtain the waiver case manager contact information. The CC will provide the waiver case manager with the CC's contact information. Correspondence will inform the waiver case manager that any home care services that are the responsibility of Medica must be with a network provider and services must be coordinated with the CC prior to start of care. The CC will document contact in the member record. This correspondence should occur at enrollment, with case transfers and at least annually when member is due for an assessment.
    a. The CC can use the DHS-5841 to communicate with the with the waiver case manager. The "special member concerns or other comments section" can be used to communicate this information.
    b. The CC can call the waiver case manager to communicate information and document this in the member record
    c. If the CC is not able to obtain the case managers contact information after a couple attempts, or the CC attempts to reach the case manager have failed, please request to speak to a supervisor. If those attempts fail, you can reach out to MedicaCCSupport@Medica.com
3. If the CC receives a request for home care services, the CC will obtain the assessment used to determine home care services from the waiver case manager and review to assure information aligns with CC's understanding of member's needs. The CC will confirm the home care provider is contracted with Medica and authorize home care services accordingly. The CC will make the referral for services if needed.
    a. The CC can use the DHS 5841 to provide documentation of the approval for home care services or provide other communication and include in the member's record.
    b. If the home care provider is not contracted with Medica, the CC will notify the case manager that CC cannot authorize home care services with an out of network provider. The CC is to assist in finding a network provider.

Out Of Network:

- An out of network provider for PCA services and HCN can only be authorized by the CC if the member is new to Medica currently using an out of network provider to provide continuation of care. Authorization is limited to 120 days from enrollment. It is the CCs responsibility to assure the OON provider is enrolled with Department of Human Services (DHS) to provide the service.
    - PCA Services: The CC will obtain the PCA Assessment and service agreement from the provider, member or assessor and complete the RRF and include the email address of the OON PCA provider. In the comment section the CC will indicate an out of network provider is authorized for 120 days for continuation of care. The authorization cannot extend beyond 120 days. The CC will assist the member to transition to an in network provider before the end of the 120 days.
    - HCN Services: The CC will obtain the previous authorization and completed DHS 4071 from the provider, case manager or care coordinator. The CC will complete the RRF and indicate in the comment section OON provider authorized for 120 days for continuation of care. The authorization cannot

extend beyond 120 days. CC will assist to transition member to an in network provider. Additional information regarding HCN services are available on the Home Care Nursing Benefit Guideline on the CC Website.

- All network providers are listed on the Contracted PCA and Home Care Listing. If they are not listed, they are not contracted at this time. Providers who are interested in being contracted can access information on Medica.com or the Medica Provider Service Center.
- Members new to Medica currently using an out of network home care agency for services other than PCA or HCN can contact Medica Customer Service to request continuation of care with the out of network provider.
- Requests for out of network providers outside of continuation of care are requested through the Prior Authorization process. In situations where there are no network PCA providers, the CC can use the Benefit Exception Inquiry (BEI) process to request an OON PCA provider. Please reference the BEI Policy for further direction.

Special Considerations:

- SNBC members turning 65 require the CC be aware of the home care services the member is receiving prior to turning 65. If the member is receiving home care services from an OON provider, they will need to transition member to a network provider when member enrolls in MSHO or MSC+.
- Non-integrated members receiving skilled care with an out of network provider will need to transition to a network provider when skilled services end if members home care needs continue and Medica is the payer.

If the CC has a specific case they would like to consult on or they need further direction, they can contact MedicaCCSupport@Medica.com.

CROSS REFERENCES:

Assessment Schedule Policy (MSHO, MSC+)
Benefit Exception Inquiry Request Policy
Benefit Guideline Home Care Nursing Service
Contracted PCA and Home Care Listing
DHS Community-Based Services Manual
DHS-5841
Referral Guidelines for Medica Members