Policy Title:	**Home Care Services**
Department:	**Markets Growth & Retention**
Business Unit:	**Medicaid and Special Needs Plan**
Approved By:	**Director, Medicaid & SNP Member Solutions and Innovations**
Approved Date:	**9/1/2021**
Original Effective Date:	**9/1/2021**
Review Date(s) (no changes):	
Revision Dates:	**5/30/2022, 1/4/2024**

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®
- Integrated Special Needs BasicCare (I-SNBC) Medica AccessAbility Solution Enhanced®

DEFINITIONS:

Assessment: An assessment used to determine home care services. This may be the DHS 3428 Minnesota Long Term Care Consultation Services Assessment Form (LTCC), MnCHOICES Assessment, DHS 3428H Health Risk Assessment, MnCHOICES HRA, DHS 3428D PCA Legacy Assessment Medical Assistance Home Care Nursing Assessment, or other assessment used to determine home care needs.

Care Coordinator (CC): A person who assesses the member, creates a person-centered care plan/support plan, and then coordinates the provision of services and supports for those members among different health and social services professionals and across settings of care.

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.

MN–ITS: The DHS billing system for providers enrolled in Minnesota Health Care Programs (MHCP). MN-ITS can be used to verify eligibility and/or waiver status.

Network Provider: 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): Any provider that does not have an agreement to render covered services with Medica.

Waiver Case Manager: An employee or delegate of a county that provides members and their families with access to assessment, person-centered care/support 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).

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:
Counties/Tribal Nations, Agencies, Care Systems, and internal Medica Staff that provide Care Coordination for Medica members must assess, coordinate, and authorizes home care services, that are the responsibility of Medica, using network providers.

GENERAL PROCEDURE:

1. CC completes an assessment that determines a member's need for home care services.
    a. If a newly enrolled member is currently receiving PCA/CFSS services
        i. Medica will honor the current PCA/CFSS authorization and not complete a new PCA/CFSS assessment.
        ii. The CC will only complete a new assessment at the time of the initial HRA if:
        iii. CC is unable to obtain the most recent PCA/CFSS assessment from the provider, member or assessor
        iv. There is a change in condition, change in member's supports, member requests a new assessment, or the PCA/CFSS authorization will end within 30 days of the HRA date. Refer to Assessment Schedule Policy for additional information

2. CC authorizes home care services with an in network provider. Resources to locate or determine if a provider is in network:
    a. Medica Customer Service
        i. MSHO and I-SNBC 1-888-347-3630
        ii. MSC+ and SNBC 1-877-379-7540
    b. Contracted PCA and Home Care Services resource on the CC Hub
    c. Provider search function for each product on Medica.com for home care other than PCA

3. CC completes Referral Request Form (RRF), if required.
    a. The Claims Referral Guidelines on the CC Hub includes home care services that require a referral. These guidelines also indicate when a letter is sent to the provider containing details related to the referral.

i. Home Care Nursing (HCN) requires additional information, refer to Claims Referral Guidelines & the Home Care Nursing Guideline to ensure all information is provided.

b. For home care services that do not require a RRF, the CC should verbally authorize home care services with the provider.

4. If there is a provider change, it is the CCs responsibility to coordinate by contacting both providers to communicate the end and start dates.

PROCEDURE WHEN MEMBER ON A WAIVER MANAGED BY THE COUNTY:

1. CC will check MN-ITS to determine member's waiver status with enrollment, case transfers, and at annual reassessment.
    a. If the member is on another waiver:
        i. CC will obtain the waiver case manager contact information.
        ii. CC will provide the waiver case manager with the CC's contact information.
        iii. CC 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.
        iv. CC will document waiver case manager correspondence in the member record with enrollment, with case transfers and at annual reassessment.
        v. 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.
        vi. CC can call the waiver case manager to communicate information and document this in the member record.
        vii. If the CC is not able to obtain the waiver case managers contact information or if attempts to reach the waiver case manager have failed, request to speak to a supervisor. If those attempts fail, you can reach out to MedicaCCSupport@Medica.com.

2. If the CC receives a request for home care services from the waiver case manager, 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 a network provider with Medica and authorize home care services accordingly.
    a. The CC will make the referral for services if needed.
    b. 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.
    c. If the home care provider is an OON provider with Medica, the CC will notify the waiver case manager that home care services cannot be authorized with an OON provider. The CC is to assist in locating a network provider.

PROCEDURE WHEN OUT OF NETWORK (OON) PROVIDER IS IDENTIFIED:

- An OON provider for PCA/CFSS 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 DHS to provide the service.

- PCA/CFSS Services:
  - The CC will obtain the PCA/CFSS Assessment and service agreement from the provider, member or assessor
  - Complete the RRF and include the email address of the OON PCA /CFSS provider. In the comment section the CC will indicate an OON provider is authorized for 120 days for continuation of care. The authorization cannot extend beyond 120 days.
  - 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.
  - 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. Refer to Home Care Nursing Benefit Guideline on the CC Hub for additional information.

- All network providers are listed on the Contracted PCA and Home Care Services on the CC Hub. 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 from the Medica Provider Service Center.
- Members new to Medica currently using an OON home care agency for services other than PCA/CFSS or HCN can contact Medica Customer Service to request continuation of care with the OON provider.
- Requests for OON providers outside of continuation of care are requested through the Prior Authorization process. In situations where there are no in network PCA/CFSS providers, the CC can use the Benefit Exception Inquiry (BEI) process to request an OON PCA/CFSS provider. Refer to the BEI Policy for additional information.

ADDITIONAL CONSIDERATION

- 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 to a network provider when member enrolls in MSHO or MSC+.
- Non-integrated members receiving skilled care with an OON 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 Services
DHS Community-Based Services Manual
DHS-5841
Claims Referral Guidelines

Rev. 1/24