Definition of Service: The Readmission Prevention Community Companion Services Benefit (“Readmission Prevention Benefit”) is available when an MSHO member (hereafter “member”) has been admitted to a hospital and meets the eligibility criteria outlined below. The benefit will provide the member with Community Companion Services provided by Lutheran Social Service of MN (hereafter “LSS”) upon discharge from the hospital. LSS will work closely with the member to identify any questions the member may have following his or her discharge, complete a home safety assessment of the member’s living setting, review discharge paperwork and identify all member medications, and provide the Medica Care Coordinator (hereafter “CC”) with documented information following each touch point with the member. This benefit supplements and supports the role of the CC during a member transition but does not replace the role of the CC or required activities the CC is responsible to complete. In providing Community Companion Services, LSS will provide the CC with multiple documented updates of the member’s progress and completion of required services. The Readmission Prevention Benefit will provide Medica members with immediate support in the home, and ongoing communication with the member’s CC, while working in a collaborative manner with the goal of reducing overall hospital readmissions.

Eligibility: A member is eligible when all of the following criteria are met:

- Member has a current hospital admission, and
- Member had a previous inpatient admission within the past (rolling) 90 days, and
- Member’s discharge plan is to return to a community living setting (e.g. long term skilled nursing facility or institutional placements are excluded), and
- Member appears on Daily Admission Report (DAR) with a readmission indicator.

Covered: 2019 Readmission Prevention Benefit includes:

- Up to four (4) phases of service within 30 days of member’s discharge (see table below);
- Non-waivered (i.e. Elderly Waiver-EW) members are eligible for short-term home delivered meals; and
- The benefit is limited to one service per calendar year for an eligible member

Not Covered:

- Member refuses to accept the benefit;
- Services that are not solely for the member;
- Services provided to the member while in an inpatient setting; or
- When there are other services or supports already in place that could equally meet the member’s need.

Referral Process:

Medica Care System
- Medica Care Systems members are referred directly from the Care Coordinator.
Care Coordination Delegates

• Medica provides LSS a list of eligible members using the DAR.
• LSS will contact the member within one (1) business day of DAR notification of discharge to home and present the member with the Readmission Prevention Benefit.
• If the member agrees to the Readmission Prevention Benefit, LSS requests the CC to complete the MSHO Readmission Prevention Community Companion Referral form and to send it to Medica.

Benefit Process:

• Readmission Prevention Community Companion Services require an authorization from Medica. The CC will complete a referral request form with Community Companion (HCPCS Code S5135 with modifier HC), four (4) phases (units), and submit it to the Medica Operation Associates* per current process.
• Following each phase, LSS will reach out to the CC with an update that includes the following:
  o **Phase 1** – Home Safety Assessment, Medication List review, home delivered meal order form assistance (only for non-EW members):
    • CC reviews Home Safety Assessment,
    • CC reviews Medication List, reconciles any concerns or questions, and makes an MTM referral if criteria are met,
    • For home delivered meals, LSS confirms with the member’s Care Coordinator that the member is eligible and then completes an order for two weeks of meals (when the member’s situation warrants, meals may be ordered on a one week basis) through LSS Home Delivered Meals.
      o The home delivered meals service includes a minimum of seven refrigerated or frozen meals (one meal per day), that equals one week of meals, up to a maximum of twenty-eight total meals or four weeks of meals.
      o Menu is currently available through print.
  o **Phases 2-4** – includes general updates from LSS to CC, who will document updates in case notes and follow up with members and providers as needed. When applicable, also included will be subsequent order(s) of home delivered meals.
• All review work CC completes is to be documented in case notes.

*MSHO care systems must submit to their operations associate
<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Phase 2</th>
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<th>Phase 4</th>
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<tbody>
<tr>
<td><strong>In-Home Visit #1</strong></td>
<td><strong>Phone Call #1</strong></td>
<td><strong>In-Home Visit #2</strong></td>
<td><strong>Phone Call #2</strong></td>
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<tr>
<td>Review Personal Health Record (PHR)</td>
<td>Well-being check-in</td>
<td>Review personal goals achievement</td>
<td>Well-being check-in</td>
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<tr>
<td>Set personal goals</td>
<td>Review personal goals achievement</td>
<td>Review plan for follow up appointments</td>
<td>Review of second in-home visit</td>
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<tr>
<td>Share well-being tips</td>
<td>Share pertinent community resources</td>
<td>Update PHR if needed</td>
<td>Referral to community resources (includes LSS)</td>
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<tr>
<td>Review discharge order</td>
<td>Complete home delivered meal menu selections and ordering, if applicable</td>
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</tbody>
</table>

**Plan follow up appointments**

**Review medication list(s),**

**Conduct home safety assessment**

**Complete home delivered meal menu selections and ordering, if applicable**

This table represents the activities LSS will be completing with the member starting with Phase 1. All four phases will be completed within 30 days of member’s discharge. If a member choses to opt out at any point within the benefit period, LSS will immediately notify Medica of the member’s choice and which phases were completed.

**When to Submit a Request for Benefit Exception:**

- No Benefit Exceptions – Members must meet eligibility criteria to receive this benefit

**Considerations:**

- This benefit does not replace any necessary or required visits/assessments that are to be completed by a Medica Clinical Care Coordinator.
- If the member is in need of any community resources or referrals the Medica Clinical Care Coordinator is responsible for those actions.

This Medica Benefit Guideline is for MSHO and is intended to guide service plan development. This reflects current interpretation of the product benefit set and/or parameters for obtaining services. Consult with Medica staff for further guidance or to vary from these recommendations.