Elderly Waiver (EW) and Housing Stabilization (HSS) Providers

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MEDICA®

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Overview: Housing Stabilization Services (HSS)

Overview: Housing Stabilization Services (HSS)

What are Housing Stabilization Services (HSS)?

- Housing Stabilization Services are a MN Medical Assistance benefit that assist people with disabilities (including mental illness and substance use disorder) and seniors to find and keep housing

- The goals (outlined by DHS) of HSS are to:
  - Support an individual's transition to housing (Housing Transition Services)
  - Increase long-term stability in housing (Housing Sustaining Services)
  - Avoid future periods of homelessness or institutionalization (Housing Sustaining Services)

Overview: Housing Stabilization Services (HSS)

Benefit Details:

- This benefit went into effect on 7/20/2020

- Available for all Medicaid members that meet eligibility criteria:
  - Medica Dual Solution (MSHO): Group # 07XXX
  - Minnesota Senior Care Plus (MSC+): Group # 59XXX
  - Medica AccessAbility Solution (SNBC): Group # 05XXX
  - Medica AccessAbility Solution Enhanced (SNBC SNP): Group # 08XXX

Overview: Elderly Waiver (EW) Services

Definition- Elderly Waiver (EW) Services

- Elderly Waiver (EW) services are part of a program that funds home and community-based services for people age 65 and older who require the level of care provided in a nursing home and choose to live in the community

- EW promotes community living and independence with services and support that address each persons individual needs and choices that go beyond what is available through Medical Assistance

Elderly Waiver Providers

- The following provider types can bill Elderly Waiver Codes:
  - Skilled Nursing Facility (SNF)
  - PCA Agency
  - Home Health Care Agency
  - Elderly Waiver (non-contracted)
  - Durable Medical Equipment providers

- Providers must meet home and community based services (HCBS) billing and service documentation requirements for these services
  - See DHS provider manual for more information

Elderly Waiver Overview

Medica Plans with Elderly Waiver benefits:

- MSC+ (Minnesota Senior Care Plus)
  - Members are 65+, Medicaid plan only. Some plans have Medicare as Primary, some do not
  - Group # 59XXX

- MSHO (Dual Solution)
  - Members are 65+, replaces both Medicare and Medicaid
  - Group # 07XXX

Non-Par Provider Setup for HSS and EW Services

Non-Par Provider Setup for HSS and EW Services

Provider Requirements

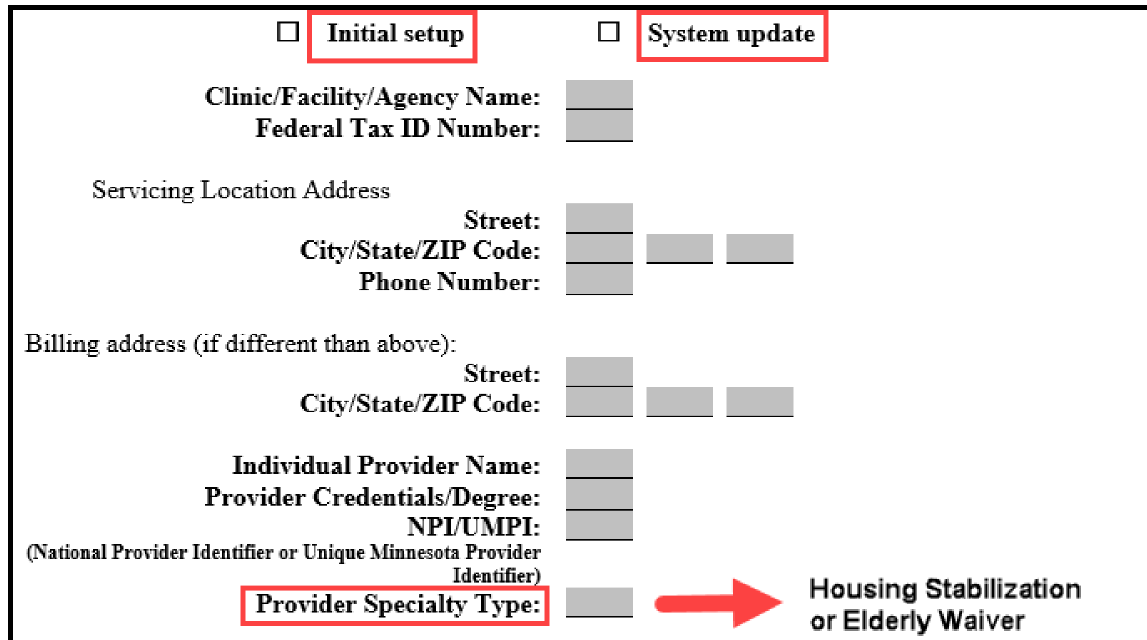
- In order to be set up as a Medica provider, you need to be registered with the Minnesota Department of Human Services (DHS)
- Just because a provider is set up to bill EW or HSS services does not mean they are contracted with Medica
- When looking for an Elderly Waiver provider, the Medica Care Coordinators use the Waiver Services search on the DHS resource: MnHelp.info

Non-Par Provider Setup for HSS and EW Services

Setup at Medica

- Providers should call the Provider Service Center (PSC) to be set up as a non-contracted provider
  - Do not ask to be “contracted” with Medica, it is not necessary for EW or HSS Services
- Once initial contact is made with the PSC, the provider will need to fax a copy of their W9 and an Out-of-Network Provider Setup Form to the PSC representative
  - Medica.com-> For Providers-> Administrative Resources-> Claim Tools: Electronic Claim Submission/Out-of-Network Provider Setup Form section
- The PSC rep will have the provider information added to the Medica system. Once the provider is set up (typically 10-14 business days), they can begin submitting claims

Out-of-Network Provider Setup Form:


☐ Initial setup ☐ System update

Clinic/Facility/Agency Name:
Federal Tax ID Number:

Servicing Location Address
Street:
City/State/ZIP Code:
Phone Number:

Billing address (if different than above):
Street:
City/State/ZIP Code:

Individual Provider Name:
Provider Credentials/Degree:
NPI/UMPI:
(National Provider Identifier or Unique Minnesota Provider Identifier)
Provider Specialty Type:

Note: The fastest and easiest way to get set-up is by contacting the Provider Service Center at **1-800-458-5512; then fax the necessary forms directly to the representative you spoke with

Role of the Care Coordinator

Role of the Care Coordinator

Overview

Care Coordinators are responsible for:

- Conducting an annual assessment and creating a person centered care plan
- Assisting with paperwork, housing, local food banks, emergency funding, and other activities
- Coordinating medical, mental health and dental appointments
- Organizing specialists needed for various medical conditions
- Coordinating transportation to and from appointments with Medica Provide-A-Ride and other sources
- Disease prevention management and education
- Determining EW/HSS services needed and authorizing accordingly
- Working collaboratively with providers or county waiver workers (CAC, CADI, BI, DD)

Role of the Care Coordinator

Identifying a Care Coordinator

- All MSHO and MSC+ members are assigned a Care Coordinator who is familiar with the area where the member lives
- The Care Coordinator could be directly with Medica, one of our County Partners, Care Systems, or Agencies
- To identify a Care Coordinator, contact the Provider Service Center at **1-800-458-5512**
- Additional Contact Information: County Partners, Care Systems and Agencies- Phone and Fax Numbers

EW and HSS Authorizations

Elderly Waiver Authorization Requirements:

- Care Coordinators are responsible for authorizing Elderly Waiver services prior to administration

- Some services require written prior authorization for claims to pay, while others only require verbal authorization from the Care Coordinator

- Medica's Utilization Management team does not answer questions related to EW authorizations, always address directly with the Care Coordinator

EW and HSS Authorizations

Housing Stabilization Service Authorization Requirements:

- The HSS provider will work with the Care Coordinator to develop a plan and submit to Department of Human Services (DHS)

- Approval/Denial will be made by DHS and sent to Medica. You will get two approval letters- one from DHS upon approval, another from Medica when the referral has been entered into our system (within 10 days of approval)

- If a member changes providers, or their plan changes, DHS will send Medica the updated information so it is listed under the current policy

Additional Housing Stabilization Tips:

- HSS services are set up as Out-of-Network, even if you have a contract with Medica for other services (such as behavioral health)
- HSS provider listed on the DHS letter must match the provider billing for services or claims will not be processed
- Notification of HSS approval is also sent to the Care Coordinator for awareness
- All provider setup, benefit and claim questions are to be discussed with the Provider Service Center (PSC), not the Care Coordinator

Claim Submission Process

Claim Submission Process

Overview

- A claim is submitted either on paper or electronically to Medica
  - Electronic claims are accepted through clearinghouses, who then forward to Medica
  - MN providers are required to submit all claims electronically
- All claims must follow MN Administrative Uniformity Committee (AUC) Guidelines
- Once a claim is submitted to Medica, it is either accepted or rejected

Claim Submission Process

What is a Clearinghouse?

- A clearinghouse allows you to submit secure claims electronically. They scrub the claim for errors, then securely transmit the electronic claim to the insurance payer

- MN E-Connect is a free clearinghouse established to meet AUC guidelines for MN electronic billing requirements

- For additional information on electronic claims submission, or to register with MN E-Connect, go to Medica.com-> For Providers-> Administrative Resources-> Claim Tools: Electronic Claims Submission

Claim Submission Process

Medica Claims Address:

P.O. Box 30990

Salt Lake City, UT 84130-0990

Electronic Payer ID: 94265

**Note: Medica has several claim addresses and Payer ID’s. For all plans with Elderly Waiver or Housing Stabilization services, the address above is correct

Claim Types

- There are two different types of claims:
  - CMS-1500: Physician claim forms
  - UB-04: Facility claim forms

- A sample CMS-1500 claim form and How to Complete the UB-04 can be found on medica.com: For Providers-> Administrative Resources-> Claim Tools: Claim Forms

Claim Submission Process

Accepted Claims Process

- Once a claim is accepted, it goes through claim edits that are required by CMS and DHS based on correct coding guidelines
- Medica uses Coverage Policies, Reimbursement Policies and Utilization Management Policies to determine if and how a claim should pay
- For authorized services, claims will pay per the instruction on the Prior Authorization

Claim Submission Process

Rejected Claim Process

- If a claim is rejected, a letter will be sent with an explanation
- Rejected claims are typically not on file at Medica
- When a claim is rejected for missing/invalid information, provider should work with the Provider Service Center (PSC)
  - PSC will confirm if an image of the claim is on file
  - Demographic and claim information will be reviewed for accuracy
  - If you have not completed the non-par setup process with Medica, your claim will reject

Claim Payment

- Providers will receive a Provider Remittance Advice (PRA) that explains how much we are paying on each claim line, along with any denial reasons
- If you would like to question/dispute how a claim processed, contact the Provider Service Center to discuss
- Care Coordinators do not have any details related to the processing or denial of claims

Claim Appeals and Adjustments

Claim Appeals and Adjustments

Claim Appeal Tips:

- Make sure you understand the details of a denial before submitting an appeal
- Submit the appeal using the Claim Adjustment or Appeal Request Form found here under the Adjustment and Resubmission Processes section
  - Include explanation and supporting documentation
  - Indicate where to find relevant details in the documentation
- If an appeal is denied and you have new information, submit a second level (final) appeal
- Call the PSC with any questions about the status of an appeal

Claim Adjustments

- An adjustment is requested when you are changing information that was initially submitted on a claim
- This can be submitted on the Claim Adjustment or Appeal Request Form, or as a Corrected Claim electronically
- Generally, adjustments are submitted to correct coding errors that were originally submitted

Timeframes

- There is a 12 month limit for adjustments on both rejected and adjudicated claims
  - For rejected claims, the clean claim must be resubmitted and received within 12 months of the date of the denial or rejection
  - For adjudicated claims, the request must be received within 12 months of the check date on the PRA

- If a request for more information is received, the corrected claim or additional information must be received within 60 days of the date on the letter from Medica

Claim Appeals and Adjustments

Timeframes, continued

Adjustments due to: (1) Coordination of Benefits recovery; (2) payments subject to subrogation recovery; (3) duplicate claims payments; and (4) retroactive terminations due to a retroactive determination of a member's eligibility for a government program or subsidy, are not considered corrective adjustments and may be made at any time

Resources and Training

Electronic Payments and Statements

- Out-of-Network (OON) providers can sign up directly with Optum Health for Medica Electronic Payments and Statements (EPS)
- Registration page at Optum: https://provider.linkhealth.com/#/
- Signing up with this website gives you the option to review all Explanation of Benefits (EOB's) and Provider Remittance Advice (PRA's) online

Provider Training

- Calendar of upcoming trainings on Medica.com:

  Medica.com-> For Providers-> Training

  - We are constantly updating trainings on various administrative topics. The most recent training for each topic is also posted on the training page

  - An FAQ for Housing Stabilization Services is also listed on the training page

  - Suggestions are always welcome for new training topics!

    Email providercollege@medica.com

Need Further Assistance? Contact the Medica Provider Service Center

- Providers can reach the Provider Service Call Center by calling 1-800-458-5512

- Call Center hours (CST):
  - Monday 7:00 a.m. to 5:00 p.m. (Closed 8:00 a.m. to 9:00 a.m. for department meetings)
  - Tuesday-Friday 7:00 a.m. to 5:00 p.m.

- PSC is the first point of contact for providers with eligibility, benefit, claim payment and claim process questions

Housing Stabilization Services:

- DHS Website Resource: https://mn.gov/dhs/partners-and-providers/policies-procedures/housing-and-homelessness/housing-stabilization-services/housing-stabilization-services.jsp

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