Chapter 32

Home and Community Based Services

(HCBS) Elderly Waiver

NOTE: *Please review the following detail for specific processes and expectations with South Country Health Alliance (South Country). South Country may vary from the MHCP Manual and Minnesota Department of Human Services Guidelines. For additional detail on this chapter, please go to the Minnesota Health Care Programs Provider Manual at* MHCP Provider Manual.

Billing Information – Please review the South Country Provider Manual Chapter 4 Provider Billing for general billing processes and procedures.

Overview

The Elderly Waiver (EW) is a federal Medicaid waiver program that funds home and community-based services (HCBS) for people ages 65 and over who require the level of care provided in a nursing home but choose to reside in the community. The program provides services and supports for people to live in their homes or a community setting and may delay or prevent nursing facility care. The purpose of the EW program is to promote community living and independence with services and supports designed to address each person's individual needs and choices. In the case of EW, the additional services go beyond what is otherwise available through Medical Assistance (MA/Medicaid).

Eligibility

Members must be enrolled in the South Country Minnesota Senior Care Plus (MSC+) or SeniorCare Complete (Minnesota Senior Health Options (MSHO)) products. The member must be assessed in person using the long-term care consultation (LTCC) or MnCHOICES assessment. The member must choose and receive at least one (1) waiver service in addition to case management through EW. If no additional waiver service beyond case management is authorized, EW can only stay open sixty (60) days. If the reason for not authorizing an additional waiver service is the result of a transition between providers, services or settings, an additional sixty (60) days can be allowed. If the waiver service is not authorized during this time frame, the member must exit the waiver until determined eligibility and additional waiver services can be authorized. The member must have a community support plan that can reasonably assure health and safety, within the individual budget established by the member's case mix classification. The member must pay a waiver obligation, if applicable, as determined by the county financial eligibility teams.

The local agency must complete all in person LTCC screening activities for applicable people under the age of 65 within 30 calendar days of enrollment.

Anyone may request an assessment for themselves by contacting the county in which they reside. The county, along with South Country, determines eligibility for EW.

EW Covered Services

Service Name	Service Unit	Procedure Code and Modifiers
Adult Companion Services	15 Minutes	S5135
Adult Companion Services, Remote	15 Minutes	S5135 U5
Adult Day Services	15 Minutes	S5100
Adult Day Services - FADS	15 Minutes	S5100 U7
Adult Day Services Bath	15 Minutes	S5100 TF
Case Management	15 Minutes	T1016 UC
Case Management Aide (Paraprofessional)	15 Minutes	T1016 TF UC
CDCS Background Check	Per Print	T2040
CDCS Mandatory Case Management	15 Minutes	T2041
Chore Services	15 Minutes	S5120
Consumer Directed Community Supports (CDCS)	Per Month	T2028
Customized Living (CL)	Daily	T2031
Customized Living - 24 Hour (24 Hour CL)	Daily	T2031 TG
Environmental Accessibility Adaptations / Home Assessment	Per Assessment	T1028
Environmental Accessibility Adaptations / Home Install	Per Waiver Year	S5165
Environmental Accessibility Adaptations / Vehicle Assessment	Per Assessment	T2039 UD
Environmental Accessibility Adaptations / Vehicle Install	Per Waiver Year	T2039
Family Caregiver Coaching and Counseling (including assessment)	15 Minutes	S5115 TF
Family Caregiver Coaching and Counseling, Remote	15 Minutes	S5115 TF U4
Family Caregiver / Family Memory Care	15 Minutes	S5115 TG
Family Caregiver / Family Memory Care Remote	15 Minutes	S5115 TG U4
Family Caregiver Training and Education	15 Minutes	S5115
Family Caregiver Training and Education, Remote	15 Minutes	S5115 U4
Foster Care, Adult Family	Daily	S5140
Foster Care, Adult, Corporate	Daily	S5140 U9
Home Care Nursing - LPN Complex, Extended	15 Minutes	T1003 TG UC
Home Care Nursing - LPN Regular, Extended	15 Minutes	T1003 UC
Home Care Nursing - LPN Shared 1:2 Ratio, Extended	15 Minutes	T1003 TT UC
Home Care Nursing - RN Complex, Extended	15 Minutes	T1002 TG UC

Service Name	Service Unit	Procedure Code and Modifiers
Home Care Nursing - RN Regular, Extended	15 Minutes	T1002 UC
Home Care Nursing - RN Shared 1:2 Ratio, Extended	15 Minutes	T1002 TT UC
Home Delivered Meals Day	One Meal Per	S5170
Home Health Aide, Extended	15 Minutes	T1004
Homemaker / Assistance with Personal Cares	15 Minutes	S5130 TG
Homemaker / Cleaning	15 Minutes	S5130
Homemaker / Home Management	15 Minutes	S5130 TF
Homemaker / Home Management, Remote	15 Minutes	S5130 TF U4
Individual Community Living Support (ICLS) - In-person/Remote	15 Minutes	H2015 U3
Individual Community Living Support (ICLS) - Remote	15 Minutes	H2015 U3 U4
PERS Installation and Testing	Each Time	S5160
PERS Monthly Service Fee	Per Month	S5161
PERS Purchase	Each Time	S5162
Personal Care Assistance (PCA) - 1:1 Ratio, Extended	15 Minutes	T1019 UC
Personal Care Assistance (PCA) - 1:2 Ratio, Extended	15 Minutes	T1019 TT UC
Personal Care Assistance (PCA) - 1:3 Ratio, Extended	15 Minutes	T1019 HQ UC
Personal Care Assistance (PCA) - Complex, 1:1 Ratio, Extended	15 Minutes	T1019 TG UC
Personal Care Assistance (PCA) - Complex, 1:2 Ratio, Extended	15 Minutes	T1019 TG TT UC
Personal Care Assistance (PCA) - Complex, 1:3 Ratio, Extended	15 Minutes	T1019 HQ TG UC
Personal Care Assistance (PCA) - RN supervision	15 Minutes	T1019 UA
Post-Discharge Case Consultation and Collaboration, Home Care Training, Family or Non-Family	Per Session	S5111 U6
Respite Care Services, In Home	15 Minutes	S5150
Respite Care Services, In Home	Daily	S5151
Respite Care Services, In Home, Remote	15 Minutes	S5150 U4
Respite Care Services, Out of Home	15 Minutes	S5150 UB
Respite Care Services, Out of Home	Daily	H0045
Respite Certified Facility	Daily	H0045
Respite Hospital, 24 hours	Daily	H0045
Specialized Supplies & Equipment	Per Item	T2029
Transitional Services	Per Occurrence	T2038

Service Name	Service Unit	Procedure Code and Modifiers
Transitional Services, Remote	Per Occurrence	T2038 U4
Transportation	One Way Trip	T2003 UC
Transportation, Mileage (Commercial Vehicle)	Per Mile	S0215 UC
Transportation, Mileage (Non-commercial Vehicle)	Per Mile	S0215 UC

Rates are found in the eDoc DHS-3945.

Billing for Long-Term Care Consultation (LTCC) Assessments

Counties/tribes must submit electronic claims using the 837P claim format for completed in person LTCC assessment activities for people age 65 and older.

1. All in person assessment activities eligible for payment must be combined into one claim.
2. The date of service must match the date of an approved in person assessment.
3. If more than one LTCC team member is involved in the assessment process, combine the units of time into one claim.

In person assessment activities are eligible for payment, including time spent by LTCC team member(s) for the following:

1. Arranging assessment(s),
2. Preparing screening document(s) before assessment,
3. Time actually spent conducting the assessment, and
4. Time spent in approval of the screening document.

For each activity in the member's file, the LTCC team member must document the following:

1. Specify the activity completed,
2. Date the activity was completed,
3. Name and role of the team member completing the activity, and
4. The amount of time spent on the activity.

Provider Information

For providers rendering EW services to submit claims, a provider will have to submit non-contracted provider paperwork as directed on our website: South Country Non-Contracted Providers. Providers are not contracted with South Country directly for EW services. We utilize the Minnesota Department of Human Services (DHS) list of contracted providers for these services. Even though providers may be contracted with South Country for other services, they will be considered non-contracted for EW services.

If a provider receives a new license, changes ownership, or any other situations where the state of Minnesota issues a new NPI/UMPI or Tax ID (e.g., a customized living provider), they will need to revise/update/resubmit their South Country non-contracted provider paperwork via the website link mentioned above as soon as the new NPI/ UMPI or Tax ID is issued. The provider must also notify the EW care coordinators of the members they serve to update the EW care plan/service agreement.

There are many advantages for both providers and local agencies to coordinate efforts to ensure that a member receives necessary services and providers receive timely payments for services rendered.

Enrollment/Licensure/Certification

Certain HCBS providers are known as DHS Enrollment Required (formally Tier 1) providers. They must enroll with Minnesota Health Care Programs (MHCP) and South Country and must meet specific standards to bill and receive payment for waiver services. More information about provider enrollment can be found on the MHCP website. For other providers: Direct Delivery Services (formally Tier 2) and Purchased Items Services (formally Tier 3) providers, enrollment with MHCP and South Country is optional. Refer to the DHS Community Based Services Manual.

South Country works in partnership with our local counties to allow access to direct delivery services (Tier 2) and purchased items services (Tier 3) providers. South Country requires our counties to ensure the provider is qualified and utilizes the required DHS 7004A Approval-Option Service Vendor Tracking Log or a spreadsheet that has all components of the DHS 7004A tracking log. South Country counties keep logs of the direct delivery services and purchased items services and provide the logs to South Country upon request. We have some counties that will act as a pass-through biller for direct delivery services and purchased items services.

Providers must also determine which program services they are qualified to provide utilizing an applicant assurance statement. Specific provider qualifications are found in this manual within each service description. Complete information is found in the HCBS Waiver Services section of the DHS Provider Manual. Some waiver services require proof of one or more of the following:

1. License(s) and or registrations from DHS or the Minnesota Department of Health (MDH).
2. Medicare certification.
3. Other certification or registration as applicable.

For more information, please refer to one or more of the following:

1. Community-Based Services Manual (CBSM).
2. The lead agency that serves the county/counties in which you will be providing services.
3. DHS Licensing at **1-651-431-6500.**
4. Minnesota Department of Health at **1-651-201-5000** for general information.

Provider Quick Reference

Service Agreement Changes

The EW care coordinator is responsible for any changes made to the service agreement of any member.

1. If the rate, procedure code(s), or begin and end dates on the service agreement are incorrect, contact the EW care coordinator to initiate corrections.
2. If additional services are necessary, the provider must communicate with the EW care coordinator before providing any additional services.

Service Agreement Approvals

Providers are made aware of services they are approved to provide from the EW care coordinator through one of two ways.

1. The EW care coordinator sends the full member support plan/care plan, if the member agrees to this, or
2. The EW care coordinator sends a summary letter with services, if the member agrees to this.

If the member chooses to not provide the care plan or summary letter to the provider, the provider must go on the Provider Portal (South Country Provider Portal) and pull up member's service agreement. Service agreements are housed under the EW Service Agreements section in the Provider Portal. If you are not seeing the Service Agreement Authorization within the system, that means the EW service agreement has not gone through the complete approval process. Please recheck the system in 3-5 business days for the approved document. If the EW service agreement authorization still does not show up, connect with the specific member's EW care coordinator.

Receipt of a service agreement with your provider NPI or UMPI number on it does not ensure you will be able to submit claims. As described under *Provider Information*, you must have your organization complete the non-contracted paperwork with South Country in order to submit claims.

Multiple Providers Providing the Same Service at the Same Time

More than one provider may be authorized to provide the same service for the same member. Each provider has a separate line item on the member's service agreement.

Some services may also be provided by more than one provider, on the same date of service, except if the service has a daily or monthly procedure code.

If two providers are providing the same service to one member, services must be coordinated.

1. Each provider bills for the actual dates of service.
2. Use date spans on claims when services are provided on consecutive days.

In addition, the EW care coordinator should contact all providers who will bill for the same daily or monthly procedure over the same period to coordinate services.

Changes in the Status of a Member

1. The EW care coordinator informs providers and the county financial/eligibility worker of member status changes, such as the living arrangement, address, or phone number when known to the EW care coordinator.
2. The county financial/eligibility worker notifies the EW care coordinator of any changes in the member's eligibility for Medical Assistance (Medicaid) or enrollment in South Country.
3. Providers and the EW care coordinator notify one another when a member is hospitalized so that a provider can bill around the dates of hospitalization.
4. The county financial/eligibility worker and the EW care coordinator notify one another when a member is admitted to a long-term care facility so the financial worker can update the living arrangement and appropriate changes can be made to the service agreement line items.

Change in Member Need

Providers need to contact the EW care coordinator when a member's needs change. The EW Care Coordinator is responsible for reassessing the member and amending the community support plan/service agreement, when appropriate, based on the member and/or authorized representative preferences and consultation with the EW care coordinators.

Changes may include the following:

1. A change of provider,
2. Increasing or decreasing services,
3. The addition of a new service,
4. Condition changes due to a major health event,
5. An emerging need or risk, and
6. A worsening health condition.

A change in condition may be initiated by the county, the member, or may be requested on the participant's behalf by another party, such as a service provider. The EW care coordinator will complete a change-in-condition reassessment no later than 20 calendar days from the date of a request. EW care coordinators will expedite the request based on their clinical judgement based on the members need and risk if the change in condition is not completed. EW customized living providers must also report improvement in conditions to the EW care coordinator.

Monthly Budget Caps — Based off the assessment completed by the EW care coordinator a case mix level is determined and DHS sets the monthly budget cap. The monthly total cost for all EW services authorized for a member must not exceed the member's monthly case mix budget cap. The monthly total cost must include the monthly cost of all EW services and state plan home care services. (MN Statutes Sec. 256S.18)

Documented Need — South Country, along with our EW care coordinators with input from the provider of customized living services and within the parameters established by the commissioner, shall ensure that there is a documented need for all authorized customized living or 24-hour customized living component services. Customized living providers need to provide proof documentation to EW care coordinators when requested to add or increase a service component. (MN Statutes Sec. 256S.20)

Customized Living Rate — Each member will have a monthly rate established based on the customized living service plan developed within the parameters established by the commissioner and specified in the customized living service plan, which delineates the amount of each component service included on each members customized living service plan. South Country and our county partners develop the customized living rate utilizing the DHS developed tool and document the customized living service plans and rates. South Country has the authority to approve and authorize services needed to support members following guidance of the MN DHS and oversight by MN DHS. (MN Statutes Sec. 256S.201)

Personal emergency response system (PERS) — If a member receives 24-hour customized living under EW, the provider must provide a way for the person to summon assistance. The member cannot receive monitoring technology as a separate waiver service for use inside the setting. (CBSM-Customized living)

Wipes and gloves for continence care — Wipes and gloves for continence care cannot be billed for separately. The cost of these wipes and gloves are included in the reimbursement for the covered component service of continence care. (CBSM-Customized living)

Elderly Waiver Services in an Institutional Setting

Waiver services are not covered during a hospital, nursing facility, or ICF/DD stay. Providers may bill South Country for waiver services provided on the date of the admission and the date of discharge, if services were provided prior to the time of admission or after the time of discharge, except when EW allows payment for respite care services provided in a hospital or long-term care facility utilizing respite care procedure codes.

It is important to bill for the dates on which services were provided. For example:

1. If a member was hospitalized from January 15 through January 25, bill January 1 through January 14 or 15 on line one of the claim and January 25 or 26 through January 31 on line two. In this example, if the entire month is billed, the claim will be denied.
2. If a service is a monthly service and the member was absent in the middle of the month, enter one prorated unit for each span.
3. If a waiver claim is paid before the hospital or long-term care facility claim is submitted, DHS will automatically take back the waiver payment when the hospital or long-term care facility claim is processed. The provider will need to resubmit their claim.

Waiver Services in a Residential Setting

The following waiver services are covered in a residential setting:

1. Customized living,
2. 24-hour customized living, and
3. Adult foster care.

Waivers do not pay for room and board. Room and board may be covered by other sources such as the following:

1. The member's income,
2. Social Security Disability Insurance (SSDI),
3. General Assistance (GA), and
4. Supplemental Security Income (SSI).

When the above sources do not cover the total cost of room and board, housing support supplemental services funding may be accessed up to the base rate. The county financial worker must determine all appropriate payment sources for room and board.

Billing and Absences from a Residential Setting

Providers may not bill for full days when members are absent from the residential service setting regardless of the reason for the absence. An overnight absence of more than 23 hours is a noncovered day. An absence of less than 23 hours on the first day is covered if the day does not overlap with a long-term care facility's admission. After the first 23 hours, each time the clock passes midnight counts as another noncovered day. Pro-rate billing to reflect noncovered days during the month.

Examples of days absent:

Leave	Return	Number of days absent
4:30 p.m. Friday	11:30 a.m. Saturday	0 (Less than 23 hours)
4:30 p.m. Friday	5:00 p.m. Saturday	1 (More than 23 hours)
4:30 p.m. Friday	8:00 p.m. Sunday	2 (More than 23 hours; past midnight once)
4:30 p.m. Friday	7:30 a.m. Monday	3 (More than 23 hours; past midnight twice)

Regardless of calculating absence, a residential service provider may not bill for dates of service that overlap with a long-term care facility admission date.

South Country may only make payment for waiver services actually provided to an eligible person. This does not include leave days. The overhead expense of days when the person is away from a residence is accepted by Centers for Medicare and Medicaid Services (CMS) as part of a waiver provider's cost of doing business. Overhead expenses may be factored into a provider's rate.

This policy affects the following HCBS services:

1. Customized living, and
2. Foster care.

Process and Procedure

Consider a variety of overhead expenses when the rate is established using the approved rate tools. A portion of the cost of absences may be considered an overhead expense. The authorized individual monthly limits and case mix caps for the individual still apply.

Daily Rates

1. The residential services tool has predictable absent days built into the tool formula.
2. Using the daily procedure code, enter the authorized service rate per day (unit) on the line item of the service agreement. If applicable, adjust the rate at the end according to the process outlined in the contract.
3. Claims for the previously mentioned community services cannot include periods that overlap with a period of hospital admission, nursing facility stay, or other periods defined as "residential absence days."

Claims must include only one line item that represents the adjusted authorized daily service rate as identified in the rate tool.

The CMS policy states Medicaid payment is made for services actually provided to an eligible member.

Customized Living Specific Guidance

Customized living/assisted living providers must meet the minimum requirements identified below and as outlined in MN Statutes Sec. 144G.41.

1. All assisted living facilities shall utilize person-centered planning and service delivery processes.
    - Training is available for providers through the MN DHS self-paced online course person-centered training.
2. All assisted living facilities shall provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week.
3. All assisted living facilities shall permit residents access to food at any time.
4. All assisted living facilities shall develop and implement a staffing plan for determining its staffing level that ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis.
5. All assisted living facilities shall offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables.

6. The facility cannot require a resident to include and pay for meals in their contract because this component is included as part of the residential services tool paid through EW.
7. All assisted living facilities shall offer to provide or make available daily programs of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that create opportunities for active participation in the community at large.

Customized living/assisted living and 24 hours assisted living/customized living does not cover:

1. Socialization that is diversionary or recreational in nature, or
2. Transportation to health care services available through Medical Assistance state plan services.

Providers may not request supplemental payment for covered services based on MN Statutes Sec. 256S.20. For example, a provider may not bill or otherwise charge a person on a waiver, or the person's family, for additional units of any allowable component service beyond those available under the service rate limits for that service or additional units of any allowable component service beyond those approved in the service plan by South Country along with our county partners.

Documentation from Customized Living Provider

With the permission of the member being assessed or the member's designated or legal representative, the member's current or proposed provider of services should submit a copy of the provider's nursing assessment, clinical monitoring documents, service plan, DHS 6790G, or written report outlining its recommendations regarding the member's care needs.

The EW care coordinator conducting the assessment must notify the provider of the date by which this information is to be submitted. This information must be provided to the EW care coordinator conducting the assessment **prior** to the assessment to be considered while the EW care coordinator is creating the customized living rate.

Although providers may give written input to the EW care coordinator, with the member's permission, prior to the assessment, South Country in partnership with our EW care coordinators, retains the authority and responsibility to develop a written person-centered plan with the member. For members residing in customized living, this includes the rate-setting process of the residential services tool. (MN Statutes Sec. 256B.4912 & Provider Documentation Requirements)

Member Choice: EW care coordinators ensure the member's choice is incorporated into their plan. This includes when a member receives customized living, and it may cover a service or task, but the member elects to have another service or provider meet their need. Members may also choose to not have a need met within their care plan. EW customized living providers can never limit a member's choice. (HCBS Rights Modification Support Plan- DHS-7176H & MN Statutes Sec. 144G.911)

Moving Home Minnesota (MHM)

Overview

Moving Home Minnesota (MHM) is a federal demonstration project with the goal of creating opportunities for Minnesotans to move from institutions to their own homes in the community. MHM promotes the development and implementation of transition plans that reflect the preferences of those receiving services and the opportunity to receive services in the most integrated setting.

The MHM recipient will have a transition coordinator to assist with planning the transition from a qualified institution to the community and to create a transition plan. South Country covers MHM for members who are 65 years of age and over.

Eligible Providers

MHM services may be delivered by an organization or individual that is one of the following:

1. A lead agency (county of financial responsibility (CRF), tribal nation or managed care organization);
2. Under contract with a lead agency; or
3. A Minnesota Health Care Programs (MHCP)-enrolled provider of a service identified on the Moving Home Minnesota Demonstration and Supplemental Services Table.

For instructions on how to enroll to become a new MHCP MHM provider or add MHM services to an existing MHCP-enrolled MHM provider enrollment record, refer to the MHM Provider Enrollment manual page.

Providers wanting to provide overnight assistance must complete an Overnight Assistance Provider Assurance Statement (DHS-6808).

Qualified Institution

A qualified institution can be any of the following:

1. The Child and Adolescent Behavioral Health Hospital (CABHH) in Willmar;
2. Community behavioral health hospitals (CBHH);
3. Hospitals;
4. An institution for mental diseases (IMD), such as Anoka Metro Regional Treatment Center.
    - A member residing in an IMD is eligible to the extent that the services are covered by federally funded Medical Assistance, as referenced in the Eligibility Policy Manual: Program for People Living in Institutions for Mental Diseases (section 2.5.4).
5. IMD facilities enrolled as participants in the 1115 Substance Use Disorder (SUD) System Reform Demonstration;
6. Intermediate care facilities for persons with developmental disabilities (ICF/DD);
7. Nursing facilities; or
8. Psychiatric residential treatment facilities (PRTF) for children and adolescents.

Qualified Community Residence

Members participating in MHM must transition to a qualified community residence to maintain eligibility to receive MHM community-based services. These residences should honor personal choice and control of the member's home and afford opportunities for independence and community integration and include:

1. A home owned or leased by the member or the member's family member;
2. An apartment with an individual lease and living areas over which the member or member's family has domain and control;
3. An assisted-living residence that provides an apartment with separate living, sleeping, bathing and cooking areas, lockable entrance and exit doors; or

4. A home in a residential setting in which no more than four unrelated individuals live.

Lead Agency Responsibilities

1. To receive MHM services, a MnCHOICES assessment or applicable screening document must be completed by the lead agency to determine program eligibility and provide the member with informed choice. Applicants must meet the hospital or institutional level of care to be eligible to receive MHM services. See the Instructions for Completing and Entering the LTCC Screening Document and Service Agreement into MMIS (DHS-4625) document located in the Community-Based Services Manual (CBSM) for additional information on entering assessments into Medicaid Management Information System (MMIS).
    - If the person has had a MnCHOICES or long-term care consultation (LTCC) assessment, the lead agency can authorize MHM within 365 days from the date of the assessment.
    - If the person has had a developmental disabilities (DD) screening, the lead agency can authorize MHM within six months from the date of the assessment.
2. If a member screens eligible for and chooses to receive MHM services, a MHM Intake Form (DHS-5032) must be submitted to DHS to confirm the member meets federal eligibility requirements. The MHM service begin date, which is the date the member consents to begin receiving MHM transition coordination services, identified on the intake form cannot be a date during which the member is currently receiving any other form of targeted case management (TCM). Refer to noncovered services section for a list of TCM services considered to be duplicative.
3. The lead agency is responsible for assigning a MHM transition provider if the lead agency will not be providing the transition coordination services. The lead agency is also responsible for identifying if the member is eligible for waiver services and will assign a waiver case manager to assist the member when they transition into the community. See more information on MHM community-based services in the community-based participation and transition to the community - service authorization sections.

Who acts as Lead Agency?	
Health Care Product	Acting Lead Agency
Enrolled in SNBC (under or over age 65)	County of Financial Responsibility (CFR) or Tribal nation
Enrolled in Families and Children	CFR or Tribal nation
Fee-for-Service MA (not enrolled in Managed Care)	CFR or Tribal nation
Enrolled in MSHO or MSC+ (age 65 and older)	Managed Care Organization

See the lead agency responsibilities for MHM section of the Moving Home Minnesota Program Manual for additional information

Member Enrollment

South Country members who are age 65 and over who receive MHM services must be transitioning from a qualified institution where they have resided for 90 days or more to a qualified community residence. Members may begin the enrollment process to receive MHM

transition services at any point during their institutional stay by completing the online MHM Intake Form (DHS-5032). The intake form can also be faxed to 651-431-7745 or mailed to:

Moving Home Minnesota
P.O. Box 64250
St. Paul, MN 55164-0250

The Senior LinkAge Line® (800-333-2433), Disability Hub MN™ (866-333-2466), the member's county or tribal human services agency, or the member's care coordinator are also available to help provide information on assistance with enrollment in MHM.

MHM eligibility and enrollment will provide notification of program eligibility and approval determinations to all pertinent parties via encrypted email to lead agencies and transition coordination providers and via paper copies delivered to the member's most current address upon confirming the following:

1. A lead agency assessor has completed an assessment showing the person is eligible for and has elected to receive MHM services.
    - If the person has had a MnCHOICES or long-term care consultation (LTCC) assessment, the lead agency can authorize MHM within 365 days from the date of the assessment.
    - If the person has had a developmental disabilities (DD) screening, the lead agency can authorize MHM within six months from the date of the assessment.
2. DHS receives an MHM Intake Form (DHS-5032) and reviews it for federal eligibility criteria. The MHM service begin date, which is the date the member consents to begin receiving MHM transition coordination services, identified on the intake form cannot be a date during which the member is currently receiving any other form of TCM. Refer to the noncovered services section for a list of TCM services considered to be duplicative.

Contact MHM eligibility and enrollment at movinghomemn.mfp@state.mn.us or 651-431-3951 for questions.

Transition Coordinator Responsibilities

If a transition coordinator is not already working with a member approved to receive MHM services, the lead agency will assign one.

The transition coordinator must complete and keep on record the following forms:

1. The Moving Home Minnesota Informed Consent Form (DHS-6759I) to review the member's rights and responsibilities.
2. The Moving Home Minnesota Transition Planning Tool (DHS-6759J) to assist in identifying what's important to and for the member as part of the planning for the member's transition to a qualified residence in the community.
3. The Moving Home Minnesota Housing Transitions Worksheet (DHS-6759G) to assist the member in choosing a qualified residence.

When a residence in the community has been selected, the transition coordinator must submit the online Moving Home Minnesota Communication Form (DHS-6759H) and select the option "Assurance of Qualified Community Residence" for the "Reason for Communication." The transition coordinator must provide the information requested and submit the form to MHM for review to ensure that the location is a qualified residence. If the transition coordinator is certain that the location the participant will be moving to is not considered to be a qualified community residence, select the option "other" for the "Reason for Communication" and notify MHM of the planned move to an unqualified residence.

For questions about how to complete the Moving Home Minnesota Communication Form (DHS-6759H), please contact MHM eligibility and enrollment at movinghomemn.mfp@state.mn.us or 651-431-3951.

Community-Based Participation

When the member has successfully transitioned to the community, the transition coordinator must notify MHM eligibility and enrollment by submitting the online Moving Home Minnesota Communication Form (DHS-6759H). Select the option "Participant has transitioned to the community" for the reason for communication and provide the information requested and submit the form. When the member moves into a qualified residence, the move-in date will serve as the start date for the member's 365 days of MHM community-based service eligibility.

When a MHM member is not receiving waiver case management, the lead agency will assign a MHM Demonstration Case Management (DCM) provider. The MHM DCM provider will complete the MHM service authorization (SA) using the Community Support Plan with Coordinated Services and Supports Plan (DHS-6791B) located on the Long-Term Services and Supports (LTSS) Forms page in the CBSM and submit this via secure email to MHM eligibility and enrollment at movinghomemn.mfp@state.mn.us.

If MHM comprehensive community support services (CCSS) are provided, the CCSS provider must be a different provider than the case management provider. The CCSS provider must communicate and collaborate with the assigned case management provider to incorporate the CCSS services into the MHM service authorization.

Changes and Ending Enrollment with MHM

If a member receiving MHM services has a change in provider or case manager, or chooses not to utilize MHM services at any point in time after they have been approved and enrolled in MHM, the lead agency, transition coordinator, or case manager must notify MHM eligibility and enrollment of the change using the Moving Home Minnesota Communication Form (DHS-6759H). For specific examples of when this notification must occur, please refer to the Moving Home Minnesota Program Manual.

Re-institutionalization During MHM Participation

A member receiving MHM community-based services may need to return to an institution for short or long-term care, such as hospital or nursing facility rehabilitation. In these situations, the lead agency, transition coordinator or case manager must notify MHM eligibility and enrollment of the change using the Moving Home Minnesota Communication Form (DHS-6759H). Select the option "Moving Home Minnesota participant has been re-institutionalized". Ongoing MHM participation will be affected depending on the length of stay:

- If 30 days or less: MHM participation and eligibility spans will not be interrupted but MHM services will not be reimbursed during this period.
- If more than 30 days: MHM participation will be suspended; however, people may:
    - Use any time left on their 365-day eligibility span after they return to the qualified community-based residence; or
    - Re-apply for MHM services, if they have continuously resided in a qualified institution for 60 or more days.

Covered Services

MHM services coverage is time limited. Members are eligible for MHM services during the following time spans and circumstances:

- 180 days of eligibility for transition planning and transition coordination services while in a qualified institution.
- Eligible and approved members may begin utilizing select transition services at any point during their stay in a qualified institution. Please refer to the Moving Home Minnesota Demonstration and Supplemental Services Table for additional information on services allowable prior to the 60 day institutional stay requirement.
- The 180-day limit starts with the service date of the first paid claim.
- 365 days of eligibility for community-based demonstration and supplemental services while in a qualified residence.

While other forms of TCM and MHM transition planning and transition coordination services can be used alternately, South Country does not recommend this practice. South Country recommends using one type of TCM service for the duration of the relocation effort.

Transition providers and lead agencies must work closely to avoid claim denials due to ended eligibility, exceeded service limits, or duplication of services.

Refer to the Moving Home Minnesota Demonstration and Supplemental Services Table for a complete list of MHM services, including identification of whether or not the service(s) can be provided in addition to HCBS waiver program services.

MHM may grant extensions to the 180-day transition planning and transition coordination eligibility span under certain circumstances. A transition coordinator may request an extension by submitting the Moving Home Minnesota Communication Form (DHS-6759H) and selecting the "Transition Coordination Extension Request" option from the Reason for Communication drop-down menu. The transition coordinator must provide the information requested and submit the form to MHM eligibility and enrollment for review and approval.

All claims for MHM transition coordination services provided through an approved extension must be submitted using the standard claims process for MHM services. These claims will initially show a result of "denied" and the transition coordination provider will need to call the Provider Resource Center to inform them that there is an approved extension. The Provider Resource Center will then send the claim to MHM for review. MHM will ensure there is an approved extension in place and will approve the denied claims for payment.

Noncovered Services

This section of noncovered services is not all-inclusive. Receiving MHM services does not make the member ineligible to receive any state plan services, as long as the services are not duplicative or supplanting any other state plan or waiver services.

Only one type of targeted case management service can be billed at any one time. A member cannot receive MHM transition planning and transition coordination services at the same time as they are receiving any of the following services:

- Relocation service coordination (RSC);
- Targeted case management for vulnerable adults and adults with developmental disabilities (VA/DD-TCM);
- Waiver, alternative care (AC) and essential community supports (ECS) case management;
- Child welfare targeted case management (CW-TCM);
- Adult mental health targeted case management (MH-TCM);
- Children's mental health targeted case management (CMH-TCM);

- Behavioral health home (BHH) comprehensive transitional care; or
- Housing stabilization services (HSS) transition services.

Service Authorization Letters (SAL)

After services are approved, MHCP will provide the member, the provider of service(s), and the case manager with a copy of the service authorization letter. The provider and the case manager will each receive the SAL in their MN–ITS SAL mailbox.

This letter shows the services authorized through MHM. Providers must enter the service authorization number when submitting claims.

The lead agency and the MHM provider are responsible for reviewing the SAL for accuracy before rendering and billing for services.

Pre-Transition

MHM services requires a service authorization with the exception of those that occur prior to discharge from the qualified institution, including the following:

- Transition planning and coordination;
- Pre-discharge case consultation;
- Costs associated with finding housing or employment; and
- Furnishing, supplies and expenses associated with securing housing.

Transition to the Community - Service Authorization

All MHM services require a MnCHOICES assessment or applicable screening document as identified in the screening documents and service agreements page in the CBSM to determine the member's service needs.

The member's living arrangement must be updated to show the member has moved to the community for community-based claims to pay. Refer to the Moving Home Minnesota Demonstration and Supplemental Services Table for additional guidelines and instructions on entering time spans for MHM service authorizations.

When a member is not participating in a waiver program, the lead agency may choose to assign a provider to deliver MHM DCM services in place of a lead agency waiver case manager. MHM DCM providers are required to complete a Community Support Plan with Coordinated Services and Supports Plan (6791B) located on the Long-Term Services and Supports (LTSS) Forms page in the CBSM and submit this via secure email to MHM eligibility and enrollment at movinghomemn.mfp@state.mn.us. MHM enters service authorization information for non-waiver participants only.

MHM covers the cost of both waiver and non-waiver services during the 365 days of eligible community-based placement.

Follow the Billing for Waiver and Alternative Care (AC) Program guidelines for MHM services approved through the HCBS waiver programs. Refer to the Moving Home Minnesota Demonstration and Supplemental Services Table for additional guidelines and instructions on entering time spans for MHM service authorizations.

Billing

1. Submit MHM services approved on a waiver authorization and all other MHM services using the Professional (837P) claim transaction.

2. Enter the diagnosis code on the claim.
3. Submit claims only after the services have been delivered.
4. Submit claims for MHM services according to the additional instruction in the table above.

Bill only for services already provided to the member and approved on the SA, when required.

Bill claims for MHM services according to the Moving Home Minnesota Demonstration and Supplemental Services Table.