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 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 programs provide 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 these programs 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 (Medicaid).

Eligibility

Members must be enrolled in the South Country Health Alliance (South Country) Minnesota Senior Care Plus (MSC+) or SeniorCare Complete, Minnesota Senior Health Options (MSHO) products. The member must be assessed face-to-face 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 face-to-face LTCC screening activities for applicable people under age 65 within 30 calendar days of enrollment.

Anyone may request an assessment for themselves by contacting the county they reside in. 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	Daily	T2031
Customized Living - 24 Hour	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 / Family Memory Care	15 Minutes	S5115 TG
Family Caregiver Coaching and Counseling (including assessment)	15 Minutes	S5115 TF
Family Caregiver Coaching and Counseling, Remote	15 Minutes	S5115 TF 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

Service Name	Service Unit	Procedure Code and Modifiers
Home Care Nursing - RN Complex, Extended	15 Minutes	T1002 TG UC
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	15 Minutes	H2015 U3
Individual Community Living Support (ICLS) - Remote - only	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

Service Name	Service Unit	Procedure Code and Modifiers
Transitional Services	Per Occurrence	T2038
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 face-to-face LTCC assessment activities for people age 65 and older.

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

Face-to-face 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
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 activity completed
2. Date the activity was completed
3. Name and role of the team member completing the activity
4. Amount of time spent on the activity

Provider Information

For providers rendering Elderly Waiver 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 Elderly Waiver services.

If a provider receives a new license, changes ownership, or any other situations where the state of Minnesota (example Customized Living Provider) issues a new NPI/UMPI or Tax ID; 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 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 that providers receive timely payments for services rendered.

Enrollment/Licensure/Certification

Certain HCBS providers, known as Tier 1 providers, must enroll with Minnesota Health Care Programs (MHCP) and South Country and must meet specific standards in order to bill and receive payment for waiver services. More information about provider enrollment can be found on the MHCP website. For other providers, known as Tier 2 or 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 utilize 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 do 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(ies) 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 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 Care Coordinator to initiate corrections.
2. If additional services are necessary, the provider must communicate with the Care Coordinator before providing any additional services.

Service Agreement Approvals

Providers are made aware of services they are approved to provide from the Care Coordinator through one of two ways.

1. Care Coordinator sends the full member care plan, if the member agrees to this or
2. 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 agreements. 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 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 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 Care Coordinator informs providers and the county financial worker of member status changes, such as the living arrangement, address, or phone number when known to the Care Coordinator.
2. The county financial worker notifies the Care Coordinator of any changes in the member's eligibility for Medical Assistance (Medicaid) or enrollment in South Country.
3. Providers and the Care Coordinator notify one another when a member is hospitalized so that a provider can bill around the dates of hospitalization.
4. County financial worker and the 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 Care Coordinator when a member's needs change. The Care Coordinator is responsible for reassessing the member and amending the community support plan, when appropriate, based on the member and/ or authorized rep preferences and consultation with the Care Coordinators .

Changes may include the following:

1. Change of provider

2. Increasing or decreasing services
3. Addition of a new service
4. Condition changed due to a major health event
5. An emerging need or risk
6. 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 members change in condition is not completed. EW Customized Living providers must also report improvement in the members conditions to the EW Care Coordinator.

Monthly Budget Caps. Based off the members 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 elderly waiver 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 elderly waiver 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 provider 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 documents the customized living service plans and rates. South Country has the authority to approve and authorize services needed to support the member following guidance of MN DHS and oversight by MN DHS. (MN Statutes Sec. 256S.201)

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

Wipes & 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)

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:

1. Example: 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 the service is a monthly service, and the member was absent in the middle of the month, enter one prorated unit for each span.
3. In addition, if the 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
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)
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

Definition

Days when a member is not receiving residential services are days a member is not in the residential setting.

Providers may not bill for full days on which 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
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 **G**uidance

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

4. All Assisted living facilities shall utilize person centered planning and service delivery processes.
    - Training is available for providers through MN DHS Self-paced online course person-centered training
5. 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.
6. All Assisted living facilities shall permit residents access to food at any time
7. 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.
8. 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.

9. 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 Elderly Waiver.
10. All Assisted living facilities shall offer to provide or make available daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large.

Customized Living/ Assisted Living and 24 hours Assisted Living/ Customized Living does not cover:

- socialization that is diversionary or recreational in nature or
- 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 the 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 may 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 retain the authority and responsibility to develop a written person-centered plan with the member. Member 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 members 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 never can 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 the State version of the Federal Medicaid Money Follows the Person project administered by the Minnesota Department of Human Services (DHS). The goal of MHM is to create 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 age 65 and over.

Participant Eligibility

South Country members that 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.

MHM Recipient Enrollment

Individuals may enroll for MHM services by contacting the Disability Hub MN Line® at **1-866-333-2466** or the Senior LinkAge Line® at **1-800-333-2433**. They may also complete the online MHM Intake Form (DHS-5032). The intake form can also be faxed to **1-651-431-7745** or mailed to:
Moving Home Minnesota
P.O. Box 64250
St. Paul, MN 55164-0250

An MHM enrollment specialist at DHS will work with the transition coordinator to confirm if the person meets eligibility requirements for MHM services. If the person is determined eligible for MHM, the person must complete the Moving Home Minnesota Informed Consent (DHS-6759I) and return it to DHS before the person can begin receiving MHM services.

Changes and Disenrollment from MHM

DHS must be notified with the Moving Home Minnesota Communication Form (DHS-6759H) by either the lead agency, transition coordinator, or Care Coordinator if a person approved to receive MHM services chooses not to utilize MHM services, or in any of the following situations during or after transition.

During transition the person:

1. Decides he/she wants to remain at the facility
2. Is transferred to a hospital
3. Passes away
4. Leaves the facility against medical advice and does not return

Post-transition during case management the person:

1. Decides he/she wants to return to the facility
2. Is transferred to a hospital
3. Passes away

4. Is unwilling to complete paperwork to maintain Medical Assistance (Medicaid). The person must be on Medical Assistance (Medicaid) while receiving MHM services.
5. Wants to disenroll from MHM case management
6. Relocates or moves to another state

Qualified Institution

A qualified institution can be any of the following:

1. Hospital
2. Nursing facility
3. Intermediate Care Facility for People with Developmental Disabilities (ICF/DD)
4. Institution for Mental Disease (IMD) to the extent that these services are covered by Medical Assistance (Medicaid) for individuals under age 21 or age 65 and over
5. Community behavioral health hospitals

Qualified Community Residences

Those receiving MHM services must live in a qualified community residence. These include the following:

1. A home owned or leased by the individual or his/her family
2. An apartment leased by the individual or his/her family in which there is lockable access and egress, including living, sleeping, bathing, and cooking areas
3. A community-based residential setting in which no more than four unrelated individuals reside (e.g., adult foster care)

MHM Transition Coordination

Eligible Providers

The transition coordinator can be any of the following:

1. Case manager
2. MCO care coordinator
3. Relocation services coordinator (RSC)
4. Other individual who meets the qualifications listed below.

Transition coordinators must meet the minimum qualifications of an RSC outlined in the MN Stat. sec. 256B.0621, subd. 5.

These services may be delivered by an organization or individual that is any of the following:

1. A lead agency (county, Tribal Nation, or MCO)
2. Under contract with a lead agency
3. Registered with the state

Transition Coordination Services

Transition coordination services are activities that help a person in a qualified institution access medical, social, educational, financial, housing, and other services and supports needed so they

can move to the community. The transition coordinator will begin meeting with the member in the institution and does all of the following:

1. Facilitates signing of enrollment and informed consent forms
2. Conducts assessment or arranges assessment within 30 days of assignment
3. Develops an individualized person-centered transition plan
4. Leads the transition planning process
5. Works with lead agency to arrange details of waiver services if appropriate
6. Works with the housing specialist to locate housing
7. Works with the Disability Linkage Line™ to identify appropriate employment supports (if necessary)
8. Sets up transportation to look for housing and/or employment for member
9. Coordinates details in order to set up home for participant
10. Coordinates meeting, medical follow-up appointment, delivery of medical equipment, etc.
11. Coordinates day of discharge. Transition coordinator is present the day of the move. Ensures medications and required services are in place.

The following are required forms for MHM enrollment and participation:

1. Intake Form: Must be completed and sent to DHS for an eligibility determination.
2. Informed Consent: Must be completed when the transition coordinator meets with the member. It is then forwarded to DHS. Once received at DHS, the member can begin to receive MHM services.
3. Moving Home Minnesota Transition Planning Tool: Must be completed with the member and the transition coordinator.
4. Communication Form: Must be completed and sent to DHS once the transition coordinator has an estimated date of when the member will be moving. DHS needs this information in order to schedule a quality of life survey with Vital Research before the member moves. The Communication Form needs to be completed a second time with the date the member moved as well as the housing information.

The transition coordinator ensures an orderly transition to the case manager, community providers, or to the member to coordinate the community services. If the member will have a different case manager after transition, the transition coordinator must facilitate an in-person meeting with the participant and the community case manager.

The case manager or community provider helps with issues that come up during the year of transition and arrange support for the member in the community.

The transition care plan is person-centered to ensure a member receives the right services and supports at the right time and according to his/her wishes and needs.

Providers must complete and submit Moving Home Minnesota – Transition Planning, Transition Coordination and Demonstration Case Management Providers – Applicant Assurance Statement (DHS-3879) if they want to enroll to provide transition planning and coordination and be authorized to pay for the following:

1. Furnishing, supplies, and costs for securing housing and environmental modifications
2. Durable Medical Equipment
3. Person Emergency Response Systems

4. Tools, clothing, and equipment necessary for employment

Providers of Other MHM Services

South Country allows any providers who are currently enrolled to provide services in the Covered Services section below to provide the same services to MHM recipients. Tier 1 waiver providers must be enrolled with MHCP and enrolled as a non-par provider with South Country.

Assessment for MHM Services

All MHM services require an evaluation to determine the member's needs and eligibility for MHM services. The assessment will be completed by the appropriate lead agency, using the appropriate home and community based screening tool. MHM will make the conversion to MnCHOICES at the time other services are converted.

Upon completion of the assessment, if approved for MHM services, the member will receive an authorization letter. The transition coordinator and the member develop a transition care plan. An individual may have been assessed prior to being referred to MHM.

People Age 65 and Over

For individuals age 65 and over who are enrolled in Minnesota Senior Health Options (MSHO) or MSC+, South Country is responsible for Elderly Waiver services and for relocation services. In this case, South Country will serve as the lead for transitions. South Country may arrange for another entity such as a private relocation services provider or a county agency to serve in this capacity.

For other individuals, the county or tribe will serve as the lead agency, regardless as to whether the person is enrolled in South Country. This includes those over the age of 65 enrolled in Special Needs BasicCare (SNBC) as well as individuals over the age of 65 who are excluded from South Country.

Re-Institutionalization

If an MHM participant returns to an institution for less than 30 days, they continue enrollment in the demonstration while in the institution.

If an MHM participant returns to an institution for more than 30 days, DHS will suspend them from the demonstration. However, such people may do the following:

1. Use any time left of their 12-month demonstration allotment once they return to their qualified community residence; or
2. Re-enroll in the demonstration if they continue to reside in a qualified institution for another 90 days

Covered Services

MHM covers services approved in the person's transition care plan.

Service Name	**Service Unit**	**Procedure Code and Modifiers**
Case Management, Demonstration	15 Minutes	T1016 U6
Comprehensive Community Support Services, MHM Only	15 Minutes	H2015 U6
Cost for Finding Housing/Employment, Ancillary Recipient Lodging	Actual Cost- Daily Maximum	A0180 U6

Service Name	Service Unit	Procedure Code and Modifiers
Cost for Finding Housing/Employment, Case Worker	Per Mile	A0160 U6
Cost for Finding Housing/Employment, Escort Lodging	Actual Cost- Daily Maximum	A0200 U6
Cost for Finding Housing/Employment, Escort Meals	Actual Cost- Daily Maximum	A0210 U6
Cost for Finding Housing/Employment, Parking Fees and Tolls	Actual Cost- Daily Maximum	A0170 U6
Cost for Finding Housing/Employment, Recipient Meals	Actual Cost- Daily Maximum	A0190 U6
Environmental Accessibility Adaptations, Home Assessment	Per Assessment	T1028 U6
Environmental Accessibility Adaptations, Home Install	Per Year	S5165 U6
Family Memory Care Intervention	15 Minutes	S5115 U6
Membership Fees (Exercise Classes, Health Club/Fitness Center)	Per Month	S9970 U6 U5
Overnight Assistance	15 Minutes	S5135 U6 UA
PERS Installation and Testing	Each Time	S5160 U6
PERS Monthly Service Fee	Per Month	S5161 U6
PERS Purchase	Each Time	S5162 U6
Post-Discharge Case Consultation and Collaboration, Home Care Training, Family	Per Session	S5111 U6
Post-Discharge Case Consultation and Collaboration, Home Care Training, Non-Family	Per Session	S5116 U6
Pre-Discharge Case Consultation and Collaboration	Per Session	H2000 U6
Respite Care Services, In Home	15 Minutes	S5150 U6
Respite Care Services, In Home	Daily (10 or more hours/ day)	S5151 U6
Respite Care Services, Out of Home	15 Minutes	S5150 U6 UB
Respite Care Services, Out of Home	Daily (10 or more hours/ day)	H0045 U6
Specialized Supplies and Equipment	Per Item	T2029 U6
Supported Employment Benchmark Incentive Payment	Daily	T2018 U6
Tools, Clothing and Equipment Necessary for Employment	Per Service	T1999 U6
Transition Coordination	15 Minutes	T1017 U6

Service Name	Service Unit	Procedure Code and Modifiers
Transition Coordination, Furnishings	Decremental	T2038 U6 U1
Transition Coordination, Moving Costs (Deposits, application fees, movers, transition coordination services on day of discharge, etc.)	Decremental	T2038 U6 UA
Transition Coordination, Supplies	Decremental	T2038 U6 U2
Transition Plan Development	Decremental	T2038 U6

MHM Services

South Country requires that individuals enrolled in MHM are provided MHM transition planning and transition coordination services, rather than some other form of case management or relocation coordination services. Note that only one type of case management can be billed for at any one time. Transition coordination costs such as furnishings, supplies, and expenses associated with securing housing may be paid under MHM so long as they are not available to the individual under a waiver. Costs for these items may be claimed upon the discharge of the individual.

It is not uncommon for an individual to have already exhausted their 180-day benefit relocation coordination services without being discharged. It is allowable to use MHM transition planning and transition coordination services for an additional 180 days.

The MHM program includes a range of services (see table above). The services listed here are available to individuals in addition to the State plan and waiver services they are eligible to receive and can be delivered without affecting an individual's waiver budget. They include the following:

1. Pre- and post-discharge case consultation
2. Comprehensive community supports
3. Certified Peer Specialist services for individuals with mental illness
4. Family memory care
5. Costs associated with finding housing or employment
6. Membership fees for health clubs or fitness centers
7. Overnight assistance

MHM services are not intended to duplicate, supplement, or extend services that are already covered within an individual's State plan or waiver benefit set. If the service is already available under the member's waiver, it is not available under MHM.

The following services are available only to members who are not on a waiver:

1. MHM demonstration case management
2. Environmental modifications
3. Durable Medical Equipment
4. Person Emergency Response Systems
5. Tools, clothing, and equipment necessary for employment (less than 65 years of age)

Authorization

All MHM services require an assessment when a person applies for MHM to determine the recipient's needs. Authorization is required for any combination of procedure codes T2019 (U6) and T2018 (U6) up to 180 days. Additional 90-day periods are allowed as needed with State approval to not exceed 360 total days.

Members must apply for MHM by completing an application and an informed consent form. The member will receive an authorization letter confirming his/her enrollment in the program. He/she will also receive a letter if he/she is determined to be ineligible for the MHM program. Once the individual is approved for the program, the transition coordinator and the member shall develop a transition care plan. The transition care plan is to be developed in a manner consistent with person-centered principles, which means that the member's preferences and choices shall be identified and reflected in the plan.

After the 12-month transition period, people continue to receive the same services through State plan or waiver. If demonstration services are needed for a limited time beyond the 12 months, DHS may cover the costs using State-only funds. The MHM Enrollment Specialist must authorize use of demonstration services beyond the 12-month enrollment period. These requests can be made by the individual receiving the services or anyone acting on the individual's behalf such as a transition coordinator or case manager.

Most of the MHM services require a service agreement, with the exception of those that occur prior to discharge, including the following:

1. Transition planning and coordination
2. Pre-discharge case consultation
3. Costs associated with finding housing or employment

Authorization Letters

Once services are approved, MHCP will provide the member, the provider of service(s), and the case manager a copy of an authorization letter. Both the provider and case manager letter will be placed into their prospective MN–ITS mailbox. The letter shows the services authorized through MHM. Providers must include a copy of the authorization number on their claims.

The provider and member are responsible for reviewing the authorization letter for accuracy before receiving or billing for services.

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.

South Country is responsible for EW services and for relocation services coordination for members age 65 and over who are enrolled in SeniorCare Complete or MSC+. In this case, South Country will serve as the lead agency for transitions. South Country may arrange for another entity, such as a private relocation services provider or a county agency, to serve in this capacity.

Payer Determination

All providers and local agencies are responsible to bill available payers for services. The order of payers is as follows:

1. Third party payers (e.g., large and small group health plans, private health plans, group health plans covering the member with End Stage Renal Disease [ESRD] for the first 18 months, workers' compensation law or plan, no-fault or liability insurance policy or plan)
2. Medicare and Medicare Advantage Plans (Medicare must always be billed unless the item is a Medicare non-covered service)
3. Minnesota Health Care Programs (South Country Health Alliance)
4. Waiver Programs

EW services must be billed using the 837P Professional claim transaction. Under no circumstances may a provider initiate and bill for service delivery prior to the full execution of a contract for waiver services. Before submitting a claim to South Country for EW services, the provider should verify that the Service Agreement is current. Providers of EW services should contact the member's Care Coordinator or South Country Provider Contact Center @ 1-888-633-4055 if they do not have a current Service Agreement.

It is recommended that providers verify the program eligibility of a member on a monthly basis. This can be completed through MN-ITS or the South Country Provider Portal.

Diagnosis Codes

South Country requires providers to enter the most current and most specific primary diagnosis code when submitting claims for EW services.

Service Authorization/Agreement letters to the provider will display the diagnosis code of the member if the diagnosis is required for billing. The diagnosis is captured from the primary diagnosis field on the last approved screening document.

Authorized Services vs. Non-Authorized Services

Services that require a Service Agreement cannot be billed on the same claim as services that do not require a Service Agreement. For example, services for Medical Assistance (Medicaid)-eligible members and home care therapy services (physical, occupational, respiratory, and speech therapy) do not require a Service Authorization and cannot be billed on the same claim form as a waiver service, such as adult day services.

South Country requires providers to obtain Service Agreements forms for EW services prior to the start of service in order to ensure prompt and accurate provider payment. There are many advantages for providers to coordinate their efforts with South Country in order to ensure that a member receives his/her necessary services and providers receive timely payments for services rendered.

Payment Rates

South Country utilizes and pays at the DHS HCBS waiver rates published DHS. CL and 24-Hour CL provider reimbursement rates are determined using the South Country State-approved rate tool.

Rates are a fixed charge per unit of a commodity or service.

DHS establishes upper rate limits for EW services. Service rates authorized and claimed may not exceed the DHS published maximum allowable service rates, and, for some market rate services must be determined based on the lowest cost-effective bid within the limits.

Information about service rate changes and limits for EW services are first made available through publication of Bulletins. Review the DHS Continuing Care Provider Rate and Grant Changes web page for the most up-to-date information about the current rate limits.

Members Leaving Nursing Facilities (Conversion Rates)

People receiving EW services may access a higher monthly budget if the person is a resident of a certified -nursing facility and has lived there for 30 consecutive days. Refer to DHS Bulletin #17-25-01 EW Monthly Conversion Budget Limits and Maintenance Needs Allowance Changes.

EW Obligation

Eligibility for EW is based on two income limits:

1. People with incomes equal to or less than the Special Income Standard (SIS) are eligible for EW without a Medical Assistance (Medicaid) spenddown. They must contribute any income over the maintenance needs allowance and other applicable deductions to the cost of services received under EW. This is known as the waiver obligation.
2. People with incomes greater than the SIS may still be eligible for EW but they may have a waiver obligation. The lead agency's financial assistance unit is responsible for determining the financial obligation of the EW member. The member is informed if he/she has a waiver obligation.

The waiver obligation is deducted from the cost of services received under EW, and the full amount of the waiver obligation does not have to be met each month. The member is responsible to pay the amount of the obligation toward the services that were utilized that month. This may be a portion of the waiver obligation or the entire waiver obligation.

Claims that are reduced due to the EW obligation will show claim adjustment reason code PR 142 on the remittance advice. South Country also receives reports on members who have waiver obligations. South Country has a process for informing providers regarding amounts of waiver obligations through the remittance advice.

Home Care Services Provided for Medical Assistance (Medicaid)-Eligible Members Receiving EW Services

All member receiving EW services must first access State plan Medical Assistance (Medicaid) home care services to the highest extent before adding EW services to the community support plan.

Medical Assistance (Medicaid) covers the following home care services:

- Home Health Aide visits
- Home Care Therapies (OT, PT, RT, ST)
- Skilled Nursing Visit
- PCA Supervision
- PCA
- Home Care Nursing

Extended Home Care Services – EW

Extended home care services include extended PCA, extended HHA, and extended home health nursing (RN/licensed practical nurse [LPN]).

1. A member must first access needed home care service benefits through Medical Assistance (Medicaid) home care before “extended home care” benefits may be approved.
2. Home care service needs that cannot be met within the Medical Assistance (Medicaid) home care limits may be approved and billed to EW as extended Medical Assistance (Medicaid) services within the budget limit available.

Billing Procedure Codes

Use the following billing guidelines to bill 15-minute procedure codes for time spent providing the service.

If the time for each service provided equals:	Bill this number of units:	Notes
8 – 22 minutes	1	Do not bill for services lasting less than 8 minutes. Bill services in 15-minute units. If you provide a service for at least 8 and through 22 minutes, bill that service as one unit. If you provide the same service for at least 23 minutes, bill that service for at least two units, etc. Billable units are determined by time spent providing the service; not by total allowed units on the Service Authorization. If more than 127 minutes, continue to follow the 15-minute increments and appropriate billing units.
23 – 37 minutes	2	
38 – 52 minutes	3	
53 – 67 minutes	4	
68 – 82 minutes	5	
83 – 97 minutes	6	
98 – 112 minutes	7	
113 – 127 minutes	8	

To bill for hourly procedure codes for time spent providing the service, a unit of time is attained when the length of time providing the service passes the hour mid-point. For example, an hour of billable time is attained when 31 minutes have elapsed. A second hour is attained when a total of 91 minutes has elapsed.

To bill for daily procedure codes, use daily or per diem codes found on your Service Authorization that do not have a timed component or unit assigned, regardless of the time spent.

To bill for monthly procedure codes, do the following:

1. Only use monthly procedure codes after the service has been provided for the month.
2. Bill for the dates on which the services were provided. If the service is a monthly service and the person was absent in the middle of the month, enter one prorated unit for each time span the services were provided. For example, if the person was hospitalized from January 15 – 25:
    a. Bill January 1 – 14 on line one of the claim
    b. Bill January. 26 – 31 on line two
    c. In this case, if the entire month was billed, the claim would be denied
3. If the waiver claim is paid before the hospital or long-term care facility claim is submitted, South Country will automatically take back the waiver payment when the hospital or long-term care facility claim is processed. The provider must then resubmit the claim.

Documentation Requirements

Home and community-based services (HCBS) service documentation requirements are Laws of Minnesota 2019, 1st Spec. Sess. chapter 9, article 2, sections 122-126.

Provider is eligible for reimbursement only if:

1. The provider is delivering a service that is authorized and defined under a federally approved waiver plan.
2. The service is provided on days and times specified on the operating license, as applicable.
3. The provider has documentation that staff who provides services have reviewed the following statement: "It is a federal crime to provide materially false information on service billings for medical assistance or services provided under a federally-approved waiver plan as authorized under Minnesota Statutes, sections 256B.0913, 256B.0915, 256B.092 and 256B.49." This is required upon employment and annually thereafter.

Note: Electronic signatures are permissible. According to Minnesota Statutes, 325L.02, *subdivision (h), an electronic signature is defined as "an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record."*

HCBS providers must maintain the following documentation of service delivery:

1. Providers collect and maintain readable documentation in English.
2. Documentation may be collected and maintained electronically or in paper form by providers and must be produced upon request by South Country.
3. For services authorized using an hourly or minute-based unit, the provider must document:
    a. Date of the documentation.
    b. Day, month and year the service was provided.
    c. Start and stop times with a.m. and p.m. designations (except for case management services).
    d. Service name or description.
    e. The name, signature and title, if any, of the person providing the service. If the service is provided by more than one staff, the provider may designate one staff member responsible for verifying services and completing the documentation required.
4. For services authorized using a unit other than hourly or minute-based (such as daily or per occurrence), the provider must document:
    a. Date of the documentation.
    b. Day, month and year the service was provided.
    c. Service name or description.
    d. The name, signature and title, if any, of the person providing the service. If the service is provided by more than one staff, the provider may designate one staff member responsible for verifying services and completing the documentation required.

Services with additional documentation requirements

Alongside the HCBS documentation requirements outlined above, three HCBS program services have additional documentation and billing requirements. These services are: waiver transportation, specialized equipment and supplies, and adult day services.

Waiver Transportation Service

A waiver transportation service is not covered if:

- The service is medical transportation under the Medicaid state plan
- It is a component of another waiver service.

Effective July 1, 2019, providers must also:

1. Maintain odometer and other records according to Minnesota Statutes, 256B.0625, subdivision 17b(b)(3) to distinguish an individual trip with a specific vehicle and driver when the service is billed directly by the mile. Common carrier transportation as defined by Minnesota Rules, part 9505.0315, subpart 1, item B, or a publicly operated transit system provider are exempt from this clause.
2. Maintain documentation demonstrating the vehicle and driver meet the transportation waiver service provider standards and qualifications according to the federally approved waiver plan.

Specialized Equipment and Supplies Documentation Requirement

Effective July 1, 2019, a specialized equipment and supplies waivered services provider must maintain documentation that shows:

1. The person's assessed need for the equipment or supply.
2. The reason why the equipment or supply is not covered by a Medicaid state plan.
3. The cost, quantity, type and brand of the equipment or supply delivered or purchased
4. If the item is rented or purchased.
5. The shipping invoice or documentation proving the date of delivery to the person, or receipt if purchased by the person.

Adult Day Service documentation and billing requirements

Effective August 1, 2019, an adult day service provider must maintain documentation that shows:

1. A needs assessment and current plan of care according to Minnesota Statutes, 245A.143, subdivisions 4-7 or Minnesota Rules, 9555.9700 for each person, as applicable.
2. Attendance records including the date of attendance with the day, month, year and pickup and drop-off time in hours and minutes with a.m. and p.m. designations.
3. Monthly and quarterly program requirements according to Minnesota Rules, 9555.9710, subpart 1 E and H, subpart 3, subpart 4 and subpart 6
4. Name and qualification of each registered physical therapist, registered nurse and registered dietitian who provides services to the adult day or nonresidential program.
5. Location of the service (if alternate location, must document: address, length of time with a.m. and p.m. designations and list of people who went to the alternative location).

For adult day services, if a provider exceeds its licensed capacity, DHS and/or South Country must recover all Minnesota Health Care Program payments (including Medical Assistance) for that date of service.