DEPARTMENT OF HUMAN SERVICES

Managed Care Service Authorization Process for Home and Community-Based Services

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Introduction to Managed Care Minnesota Health Care Programs (MHCP)

The Minnesota Department of Human Services (DHS) offers several publicly funded health care programs to people who qualify for them, based on program rules and income and asset limits. This document provides instruction to providers and county and tribal case managers when seeking authorization and payment of home and community-based services for people enrolled in a managed care organization (MCO). Use this document in conjunction with the Waiver Service Authorization template (DHS-7704) (PDF). DHS contracts with MCOs to provide health care and some home and community-based services.

Families and Children: A Minnesota Medical Assistance (MA) pre-paid managed health care program for low-income single adults, families and children. Enrollment is mandatory for people on MA under age 65, unless the member is excluded from managed care because of program regulations. A brief summary is in the MHCP brochure (DHS-3182) (PDF), and in the Reference Guide at the end of this document.

The families and children's managed care program covers the following: comprehensive primary and acute medical, hospital, preventive, diagnostic, therapeutic, behavioral, rehabilitative, medication, immunization, dental, eye exam and home care services.

More information is available in the MCHP Summary of Coverage, Cost Sharing and Service Limits (DHS-3860) (PDF).

Minnesota Senior Care Plus (MSC+): A Minnesota managed health care program for people 65 years old and older, who are eligible for Medical Assistance (MA). Enrollment in MSC+ is mandatory for people age 65 or older on MA, unless the member chooses to enroll in the Minnesota Senior Health Options program (MSHO) or is excluded from managed care because of program regulations. For more information, see the Enrollment in MSC+ (DHS-3354) (PDF) section in the guide.

MSC+ combines the following programs and services into one seamless package:

- Medical Assistance
- For those eligible, Elderly Waiver
- The first 180 days of nursing facility care

MSC+ covers the following: comprehensive primary and acute medical, hospital, preventive care, diagnostic, therapeutic, behavioral, rehabilitative, immunization, dental, eye exam, home care, care coordination, long-term care (Elderly Waiver if eligible, and nursing facility care) and support services, and medications not paid by the Medicare Part D program.

- MSC+ is similar to MSHO in the long-term care services it covers but does not include Medicare services or Medicare Part D drugs
- Seniors enrolled in MSC+ must obtain their Medicare Part D drugs through a separate Medicare prescription drug plan

Minnesota Senior Health Options (MSHO): A voluntary Minnesota managed health care program for people 65 years old and older, who are eligible for Medical Assistance (MA) and Medicare Parts A and B. Enrollment in MSHO is voluntary as seniors can choose to enroll in MSHO or stay in MSC+. For more information, see the Enrollment in MSHO DHS-3354 (PDF) section in the guide.

MSHO integrates the following programs and services into one seamless package:

- Medicare Parts A, B, and D
- Medical Assistance
- For those eligible, Elderly Waiver
- The first 180 days of nursing facility care

MSHO covers the following: comprehensive primary and acute medical, hospital, preventive care, diagnostic, therapeutic, behavioral, rehabilitative, medication, immunization, dental, eye exam, home care, care coordination, and long-term care (Elderly Waiver and nursing facility) and support services.

Special Needs BasicCare (SNBC): A voluntary Minnesota Medical Assistance (MA) pre-paid managed health care program for people with disabilities ages 18 through 64 who are eligible for MA. If a person is eligible for Medicare, he or she must have both Medicare Parts A and B to enroll in SNBC. People may request to enroll or disenroll at any time.

SNBC program covers the following: comprehensive primary and acute medical, hospital, preventive care, diagnostic, therapeutic, behavioral, rehabilitative, medication, immunization, dental, eye exam, home care, care coordination, and up to 100 days of nursing facility care. Some SNBC plans also integrate Medicare covered services for people with Medicare coverage. Contact the MCO for more information.

Nursing facility services exceeding more than 100 days are paid by MA fee-for-service.

Home-care nursing (HCN) services, personal care assistance (PCA), or home and community-based waiver services (HCBS) are paid by MA fee-for-service.

SNBC members may have a care coordinator or navigator to help them access health care and support services. SNBC MCOs coordinate with other payers including Medicare Parts A, B and D coverage for members who have that coverage. SNBC MCOs coordinate with the lead agency when an SNBC member is on a home and community-based services (HCBS) waiver.

MA state plan home care services

Managed care programs cover specific MA State Plan home care services as stated in the contract between MCOs and DHS. Each MCO provides benefit coverage and prior authorization information on their website (see page 9 for web addresses), in member materials and through their Member Services staff.

MCO prior authorization may be required for certain state plan home care services including:

- Home health aide services
- Personal care assistance (PCA) services
- Home care nursing (HCN) services
- Skilled nursing visits
- Tele-home care visits

- Equipment and supplies
- Home care therapies

The online Community-Based Services Manual (CBSM) includes MA policy criteria on MA State Plan services.

Home and community-based programs

Information about Minnesota's home and community-based programs can be found online in the CBSM Manual.

Extended state plan home care (waiver services)

People on a waiver program use Medical Assistance (MA) State Plan services up to the designated limits. If a person is assessed and found to need more services than the state plan services provides, services may be authorized through the waiver program.

- Extended waiver home care services exceed the amount, duration or frequency specified for the MA State Plan home care service description. The scope of the service is the same as defined in the state plan.
- Extended waiver personal care assistance (PCA) services exceed the amount, duration or frequency of the MA State Plan PCA service. The services provided are the same as the services defined in the state plan.

MCO Additional or in Lieu of Services

The MCO may provide additional services beyond services covered in the DHS contract. The MCO may also pay for “in Lieu of Services” for the MA-covered services described in the contract with DHS if such services are medically appropriate and cost effective as determined by DHS.

Tribal Provided Services

For purposes of this document, "tribal provided services" are services other than those paid for by MA, a waiver program or the MCO, that the tribe has determined are necessary and appropriate for the person.

A tribe may have been providing, arranging and paying for some services for people who did not have MA eligibility, or services for MCO members in addition to those services paid for through the MCO.

- When an MCO learns a member is or may be receiving tribal-provided services, the MCO should contact the tribal case manager for information on those services, to coordinate services and avoid duplication of services.
- When a tribe learns a person is enrolled in an MCO and the tribe has services in place, the tribal case manager should contact the MCO care coordinator and any lead agency case manager to coordinate services and avoid duplication of services.

Service Authorization for State Plan Home Care Services

The purpose of authorization of medical services is to evaluate and determine the necessity and appropriateness of a medical service based on criteria, medical necessity and benefit coverage.

Medical necessity criteria does not apply to authorization determinations for home and community-based waiver services.

When a Minnesota Health Care Programs (MHCP) member is enrolled in a Minnesota managed care organization (MCO), there must be communication between the member, the MCO, the other lead agency(ies), and providers.

When a member is on a waiver for people with disabilities, there must be communication between the waiver case manager and the MCO to ensure authorization of payment for certain state plan services.

Providers may have to obtain a service authorization from the MCO before providing certain services. MCOs have information on their websites about their authorization request process, and they have staff to answer questions and give technical support.

Additional information for service authorizations:

- Each MCO may have different authorization processes.
- Providers must follow the MCO billing policy guidelines.
- The member must be eligible for coverage at the time the service is provided for the MCO to pay the claim. Receiving an approval for a service authorization request does not automatically guarantee payment.
- Requests for authorization after the service has been provided follow the same utilization review criteria as those requests that are received before the service is provided.

MCO Decisions on Authorization Requests

Information on MCO decisions on authorization requests include:

- Authorization decisions on services are based on the member's needs, the appropriateness of the care or the service requested, and the member's benefits.
- The MCO makes a decision on the authorization request to fully approve, partially approve or deny the service or item. The MCO sends a notice to the provider and to the member with the authorization decision.
- Approval of an authorization request does not guarantee payment, as payment is subject to the member's eligibility status at the time of the service and the covered program benefits.
- The member, or a provider acting on behalf of the member with the member's written consent, may make an appeal to the MCO for review of a decision. Information on how to appeal is included in the notice of denial, termination or reduction (DTR).
- Members may contact or speak to the MCO appeals unit or the Ombudsman for Public Managed Health Care Programs about filing an appeal.
- Members must appeal to the MCO before filing a state appeal. See the Evidence of Coverage or Member Handbook as a reference to the Program Rights brochure for MSHO, MSC+ and SNBC.

County, Tribe and MCO Communication

Service authorizations for members on home and community-based waivers for people with disabilities depend on the program.

For Special Needs BasicCare (SNBC), and Families and Children (F&C) programs:

- The county or tribe, when working with an individual on a waiver for people with disabilities (CAC, CADI, BI or DD) must communicate the need for an authorization for state plan home care services to the MCO using the DHS-5841 form.
- The MCO returns the DHS-5841 form to the county or tribe about the determination of their authorization for state plan home care services.

For MSHO and MSC+ programs:

- The MCO is responsible for authorization and payment for EW and state plan home care services.
- The county or tribe, when working with an individual on a waiver for people with disabilities (CAC, CADI, BI or DD) must communicate the need for an authorization for state plan home care services to the MCO using the DHS-5841 form.
- The MCO returns the DHS-5841 form to the county or tribe about the determination of their authorization for state plan home care services.

Links to MCO service authorization grids

Blue Plus service authorization processes DHS-7412A (PDF)

HealthPartners service authorization processes DHS-7412B (PDF)

Hennepin Health service authorization processes DHS-7412C (PDF)

Itasca Medical Care (IMCare) service authorization processes DHS-7214D (PDF)

Medica service authorization processes DHS-7214E (PDF)

PrimeWest Health service authorization processes DHS-7214F (PDF)

South Country Health Alliance (SCHA) service authorization processes DHS-7214G (PDF)

UCare service authorization processes DHS-7214H (PDF)

Glossary

Additional services: Any services beyond those covered under the MCO program contract that the MCO voluntarily provides to the members.

Approve: Make a determination or a recommendation that a requested service or item is medically necessary or otherwise eligible for payment.

Care coordinator or care navigator: A person who facilitates the assessment, care planning, and medical and supportive services a member needs. Care coordination is the responsibility of the MCO or its designee, and must be provided in accordance with the contract with DHS.

County or tribal case manager: A lead agency staff that assists members to access, coordinate and monitor needed services as they relate to the member's assessed needs, regardless of the funding source. This lead agency staff is referred to as the waiver case manager when the member has a home and community-based services (HCBS) waiver.

DTR (Notice of Action): If the MCO denies, reduces or terminates services or claims that are 1) requested by a member; 2) ordered by a participating provider; 3) ordered by an approved, non-participating provider; 4) requested by a care manager; or 5) ordered by a court, the MCO must send a Denial, Termination, or Reduction (DTR) Notice of Action to the member. The MCO must notify the provider of the action. See the DHS Model Contract, Article 8 for details.

- **Deny:** Make a determination that a requested service or item is not medically necessary or otherwise not eligible for payment. See MN Stat §62M.05 and §62M.09.
- **Terminate:** Make a determination that a previously authorized service or item is now not medically necessary or otherwise not eligible for payment.
- **Reduce:** Make a determination that a previously authorized service or item is not medically necessary or otherwise not eligible for payment at the level of the previous authorization, so a lesser amount or frequency is authorized.

Extended home care services: Services that exceed the amount, duration or frequency specified for the MA State Plan home care service description. The scope of the service is the same as the state plan home care service. Extended home care services are not covered services when MA State Plan home care services have not been fully authorized and used.

In Lieu of Services: Services or settings used in place of services and settings covered under the state plan. In Lieu of Services must be medically appropriate and cost effective as determined by the state. The approved In Lieu of Services are identified in the MCO program contract.

Lead agency: A county, tribal health entity or a participating MCO that is responsible to put into effect appropriate home and community-based waiver functions as delegated by the state, for any member who meets waiver program eligibility criteria. The lead agency may or may not be the local agency.

Local agency: A county, multi-county or tribal agency that is authorized to determine a person's eligibility for Medical Assistance.

Managed care organization (MCO): An entity that has, or is seeking to qualify for, a comprehensive risk contract, and that is 1) a federally qualified HMO that meets the advance directives requirements of 42 CFR §489.100-104; or 2) any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: a) makes the services it provides to its Medicaid recipients as accessible (in terms of timeliness, amount, duration and scope) as those services are to other Medicaid recipients within the area served by the entity; and b) meets the solvency standards of 42 CFR §438.116 (PDF).

Medical necessity and medically necessary: Pursuant to Minnesota Rules, Part 9505.0175, subpart 25, a health service that is 1) consistent with a person's diagnosis or condition; 2) is recognized as the prevailing standard or current practice by the provider's peer group; and 3) is rendered according to one of the following:

- In response to a life threatening condition or pain
- To treat an injury, illness or infection
- To treat a condition that could result in physical or mental disability
- To care for the mother and unborn child through the maternity period
- To achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition
- Is a preventive health service defined under Minnesota Rules, Part 9505.0355

Prior Authorization: An approval by the MCO or its designee prior to the delivery of a specific service, treatment, item or medication. Prior authorization requests require a clinical review by qualified, appropriate professionals to determine if the service, treatment, item or medication meets the following criteria:

- Medically necessary
- An eligible expense
- Appropriate, less expensive alternatives have been considered

Recommend: Provide information to the MCO or its delegate in support of authorizing or providing a requested service or item.

Request: Ask for a service or item to meet the needs of a member. A request can come from the member, guardian or legal representative, family member, medical professional, service provider or other person.

Utilization Review (UR): A formal evaluation of the medical necessity, appropriateness and efficacy of the use of health care services, procedures and facilities. A person or entity other than the attending health care professional completes the review to determine the medical necessity of the service or admission. See model contract(s) for more details.

Waiver programs: Federally approved home and community-based services programs that include services that exceed limitations of the regular Medical Assistance program but do not exceed the comparable cost of institutionalization.

References

- The annual DHS contract with health plans to provide managed care for people receiving services through a Minnesota Health Care Program (MHCP).
- The online Community-Based Services Manual / Disability Services Program Manual.
- The Code of Federal Regulations.
  The online Prepaid Minnesota Health Care Programs Manual.