Moving Home Minnesota (MHM) Program Guidelines

Program Overview

Moving Home Minnesota (MHM) is a state program that helps adults with disabilities and adults 65+ who have lived in a nursing home or other qualifying institution for at least 60 days and who want to move back into the community. It's part of a federal initiative called **Money Follows the Person**, which aims to give people more choice about where they live and receive care. Blue Plus reserves MHM for members who either lack community residence or require substantial assistance.

Referral Process

MHM referrals can be initiated by anyone in the community, including Care Coordinators. Care Coordinators must consult with the Senior Housing Services Team before making a referral to DHS for determination of the MHM program. When deciding if MHM is right for a member, Care Coordinators must evaluate and prepare to first use services under the member's medical coverage and elderly waiver or other HCBS waiver.
For detailed guidance, refer to:

- Comparison of MHM and RCS-TCM
- At a Glance – Relocation Resources
- MHM Program Manual
- MHCP Provider Manual – MHM Section
- MHM Lead Agency Responsibilities
- DHS 3945 Long-Term Services and Support Service Rate Limits
- Transition services provider contact list

Eligibility Criteria

To qualify for MHM, a member must:

1. Reside in a qualifying institution (hospital, IMD, ICF/DD, or nursing facility) for 60 or more consecutive days.
2. Be enrolled in Medical Assistance (MA) before discharge and throughout participation.
3. Enroll in the Elderly Waiver or a disability waiver at the time of discharge (see eligibility exception below).
4. Transition to a qualifying community setting (e.g., private home, leased apartment, assisted living, or small residential setting).

***Eligibility exception:** eligible members discharging from a licensed IMD facility enrolled in the 1115 SUD reform demonstration are not required to access a waiver at discharge.

Service Planning

- When the same service is available under both MHM and MA/waiver, the Care Coordinator must authorize the service under MA and waiver services, respectively.
    - Example: EW Transitional Services, EAA, pre- and post-discharge services, respite, specialized supplies and equipment, etc.

- MHM services must be included in the members' MnCHOICES Support Plan.
- Eligible MHM transition services may be authorized for up to 180 days before discharge from a licensed facility.
- Eligible post-discharge MHM services may continue for up to 365 days.
- Assessments completed before 7/1/2025 must have been completed within 60 days before discharge to determine waiver eligibility.
- Assessments completed on or after 7/1/2025 can be used for up to 365 days to determine MHM and waiver program eligibility. Refer to the Initial Assessment Review (IAR) for community-based services (HCBS) for more details.
- If a waiver member had a temporary waiver exit up to 121 days and was not due for their reassessment during that time, they can be reopened to the waiver upon discharge. *An early reassessment due to a change in condition may be warranted.
- Upon discharge, the MHM Transition Coordination service component ends, and the member may be eligible for MHM Post Discharge Services. The member must be open to an Elderly Waiver or a disability waiver. (Refer to eligibility exception above.)
- Members open to any waiver must access Transitional Services through the waiver and not through MHM.
- DHS-approved MHM members will have access to post-transition services through the MHM program for up to 365 days (366 in a leap year).

- If a person successfully transitions and opens to a waiver after discharge, they can access MHM post-discharge services that are not available under EW for up to 365 days (or 366 in a leap year)
- Examples include (not all-inclusive):
    - Membership fees
    - Overnight assistance
    - Pantry Stocking
    - Transition integration fund for items not covered under EW
        - Tools, clothing, and equipment needed for employment (example: cell phones, tablets, etc., can be covered.)
- The following MHM services **would not** be available to EW members post-discharge:
    - Demonstration case management (DCM),
    - Overnight Assistance in addition to their waiver services,
    - PERS,
    - Respite Services,
    - Specialized Supplies & Equipment,
- For detailed information, please refer to the DHS CSBM | Moving Home Minnesota Services. To determine MHM and EW Interactions, you will need to click into each service under the "Table of Contents" to locate how they do or do not work together.
    - Services provided under the MHM program are not considered Elderly Waiver services and therefore do not count toward the Elderly Waiver case mix budget.

Ways to refer to a member

Note: BCBS will review referrals made by anyone other than the care coordinator for program appropriateness.

Referral source: Care Coordinator

1) The Care Coordinator requests a case consultation with the Senior Housing Services Team to assist in determining if the MHM referral is appropriate based on assessed needs and existing Care Coordination, MA, and EW services available.
2) Care Coordinators will verify the member has a MnCHOICES assessment completed within the last 365 days; if one has not been completed, the care coordinator must complete.
3) If the MHM referral is not appropriate, the Care Coordinator will work with the member/auth rep and facility to determine alternative options.
4) If an MHM referral is appropriate, the Care Coordinator will complete the DHS 5032 MHM intake form and submit it to DHS.
5) DHS will reach out to Blue Plus Senior Housing Services Team to obtain additional information or provide MHM program eligibility determination.
6) Once MHM has been approved by both DHS and Blue Plus, the Senior Housing Team will reach out to the Care Coordinator to notify them of approval. They will also direct the care coordinator to provide the member with the DHS list of approved MHM providers.
7) Once the member selects an MHM provider, the Care Coordinator will confirm with the selected provider that they have the capacity to work with the member.
8) The Care Coordinator will then use the DHS 6759H MHM Communication Form to inform DHS of the chosen provider.
    a. DHS will review and send out a communication to the Care Coordinator and the Senior Housing Services Team with the assigned MHM provider.
9) MHM providers should not begin services until they receive the approval letter from DHS.

Referral source: Community | anyone other than the care coordinator

1) The Senior Housing Team receives an MHM inquiry for more information or approval from the DHS MHM Team.
2) Senior Housing Team reaches out to Blue Plus Care Coordinator for more information and case consultation to determine if MHM referral is appropriate based on assessed needs and existing Care Coordination, MA, and EW services available.
3) Care Coordinators verify the member has a MnCHOICES assessment completed within the last 365 days. If one has not been completed, the Care Coordinator must complete one.
4) If the MHM referral is not appropriate, the Care Coordinator will work with the member/auth rep and facility and provide transition coordination assistance. The Senior Housing Team will communicate with DHS the reason for not pursuing MHM at this time via the DHS 6759H MHM Communication Form.
5) DHS will reach out to the Senior Housing Services Team to obtain additional information or provide the MHM program eligibility determination.

6) Once MHM has been approved by both DHS and Blue Plus, the Senior Housing Team will reach out to the Care Coordinator to notify them of approval. They will also direct the care coordinator to provide the member with the DHS list of approved MHM providers.
7) Once the member selects an MHM provider, the Care Coordinator will confirm with the selected provider that they have the capacity to work with the member.
8) The Care Coordinator will then use the DHS 6759H MHM Communication Form to inform DHS of the chosen provider.
    a. DHS will review and send out a communication to the Care Coordinator and the Senior Housing Services Team with the assigned MHM provider.
9) MHM providers should not begin services until they receive the approval letter from DHS.

After MHM services are approved:

- The Care Coordinator and Transition Coordinator will work collaboratively to develop a service plan and ensure there is no duplication in services.
- The Care Coordinator obtains a copy of the Transition Planning Tool from the MHM Provider to review and keep with the member's file.
- The MHM Provider must provide monthly updates along with applicable claims on an approved claims form.
    - These documents must be securely emailed to the Senior Housing Services Team.
    - If a provider does not have the approved claims form, they should reach out to the Senior Housing Services Team

Important Notes

- The MnCHOICES assessments must minimally be in one of the following statuses for MHM eligibility determination:
    - Completed – Ready for MMIS
    - Pending MMIS
    - Approved
- Minimally, the DHS 6759H MHM Communication Form must be used by the MHM Transition Coordinator or Care Coordinator to communicate the following to DHS:
    - the member discharges into the community and/or disenrolls from the program for any reason,
    - the member is re-institutionalized (hospital or nursing facility, even if it is only for one day) while accessing the MHM program, and/or
    - requires an extension beyond the 180 days of transition planning and coordination
- The MMIS system must display a "Y" in the MHM indicator field.

The Senior Housing Team will work closely with the Care Coordinator, provider, and Bridgeview to enter the required LTCC Case Mix Span and MHM service agreements into Bridgeview. *Care Coordinators do not enter MHM service agreements in Bridgeview unless requested by the Senior Housing Team.