Minnesota Senior Health Options (MSHO) and Minnesota Senior Care (MSC+)

Product Overview

Minnesota Senior Care (MSC+)

- Overview
  - Medica product name: Medica Choice Care
  - DHS product name: MSC+ (Minnesota Senior Care Plus)
  - Eligibility
    - 65+ years old
    - Eligible for Medical Assistance
    - May have Medicare
  - MSC+ is the default program

Minnesota Senior Health Options (MSHO)

- Overview
    - Medica product name: Dual Solution
    - DHS product name: MSHO (Minnesota Senior Health Options)
    - Eligibility
        - 65+ years old
        - Eligible for Medical Assistance
        - Has Medicare A and B
    - MSHO is a voluntary program; member must elect

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New Member Packet

The MSHO Member Resource Guide (MRG):

- welcome letter
- privacy notice
- women’s cancer rights notice
- advance directive
- also includes summaries of other benefits and services

Member ID card arrives in a separate mailing

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MSC+ BENEFITS

- Medical
- Pharmacy
  - Medicaid covered medication
  - Over the Counter (OTC)
- Dental-Delta Dental
  - CC contact number ONLY: 1-866-303-8138
- Vision- Eye Kraft (ask for Jeannie 320-281-2617)
- Behavioral Health (Medica Behavioral Health-MBH): 800-848-8327
  - Consults: when calling MBH identify yourself as a Medica CC, ask to speak to a Care Advocate or Clinical Supervisor
- Care Coordination
- Up to 180 days institutional care

MSHO BENEFITS

- Medical
- Pharmacy
  - Medicare Part B & D
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- Care Coordination
- Up to 180 days institutional care

MSC+ BENEFITS (CONTINUED)

- Transportation
  - Cab, Volunteer, Metro Mobility, bus passes, etc.
  - Special Transportation
  - Certificate of Need (CON)
- Elderly Waiver Services (if applicable)
- 24/7 Nurse Line – Health Advocate
- Health Support Programs
- Pharmacy
  - Medication Therapy Management (MTM)
- State Plan Services (Home Health Aid, Nurse Visits, MA Transportation, Supplies & Equipment within MA limits)

*See MSC+ Plan Documents

Medicaid Plan Documents | Medica

MSHO BENEFITS (CONTINUED)

- Transportation
  - Cab, Volunteer, Metro Mobility, bus passes, etc.
  - Special Transportation
  - Certificate of Need (CON)
- Elderly Waiver Services (if applicable)
- 24/7 Nurse Line – Health Advocate
- Health Support Programs
- Pharmacy
  - Medication Therapy Management (MTM)
- State Plan Services (Home Health Aid, Nurse Visits, MA Transportation, Supplies & Equipment within MA limits)
- Added benefits: refer to CC Hub for current list

*See MSHO Plan Documents

Medicaid Plan Documents | Medica

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MEMBER TRANSPORTATION

- Medica Provide-A-Ride – 952-992-2580/888-347-3630
  - Cab, volunteer driver, Metro Mobility, bus passes
  - Waiver Transportation (EW ONLY) grocery store, bank, etc.

- Transportation to medical appointments

- Special Transportation Service (STS)
  - Requires Certificate of Need (CON)

- Transportation **not** covered:
  - Transportation to a provider outside of the Medica network unless approved through the Prior Authorization process at Medica.
  - Transportation outside of 30/60 mile radius without going through process.
- QRyde
  - Transportation scheduling platform
  - Available for internal Medica staff and delegates
  - Training available online
  - Member portal where members can view their rides and cancel their rides

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HEALTH SUPPORT PROGRAMS

- Disease Management/Chronic Care Management
  - Diabetes
  - Asthma
  - Cardiac Disease/High blood pressure
  - Weight management (MSHO only)
- Tobacco Cessation
  - No cost
- How members get involved?
  - Preselected/Referred/Self-Refer
  - Complex Case Management Health Support Referral Form

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PHARMACY

- Pharmacy Benefits

  Plan includes pharmacy benefits that cover certain:

  - Drugs covered by Medical Assistance
  - Drugs covered by Medicare Part B or Part D (MSHO only)
  - Medication Therapy Management services
  - Certain over-the-counter (OTC) drugs
  - 2023 MSHO List of Covered Drugs (Formulary) – (PDF)
  - 2023 MSC+ List of Covered Drugs (Formulary)

- Overrides
  - PCP must complete Prior Authorization Request and Exception paper form or online
  - PCP will be notified of decision
  - Member will receive letter regarding decision

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INTERDISCIPLINARY TEAM

Interdisciplinary Team (IDT)

- IDT
  - Opt-in process
  - Provided every 3rd Wednesday of the month
  - Delegates sign-up for a time that works for them (schedule is in Sharefile).
  - 30 min slots provided from 9am-noon
  - Case consultations are conducted with Clinical Liaisons and a mental health professional

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Care Coordination HUB

Care Coordination resources

Medica DUAL Solution® (HMO D-SNP) (MSHO) ›

Medica Choice Care℠ MSC+ ›

Medica AccessAbility Solution® (SNBC) ›

Medica AccessAbility Solution® Enhanced (HMO D-SNP) ›

Manuals, policies + processes

- Care Coordination Manuals
- Policies and Processes

Guidelines

- Benefit and Clinical Guidelines
- Transition of Care
- Personal Care Assistance (PCA)
- Denial, Termination, Reduction (DTR's) and Benefit Exceptions

Templates, tools, and additional resources

- Letter Templates
- Tools and Forms
- Transportation

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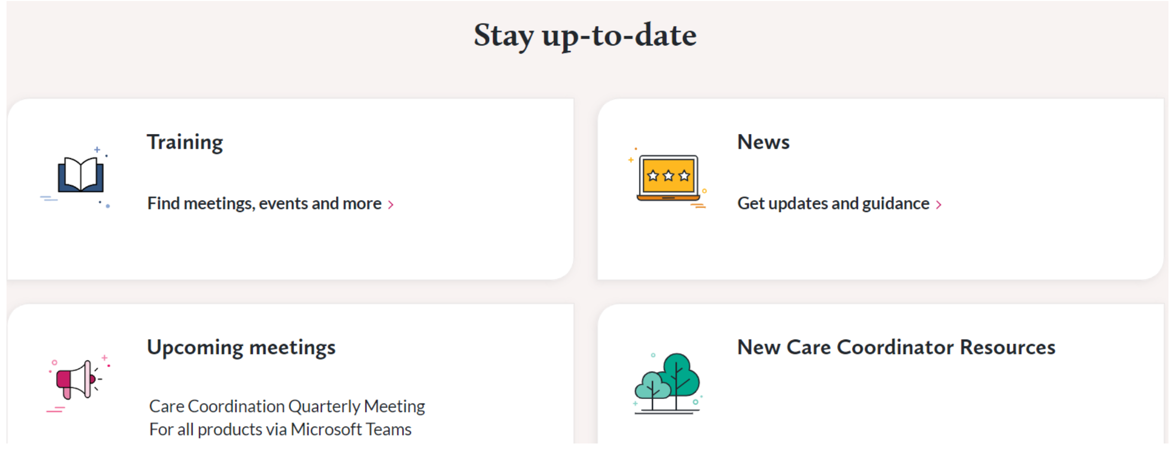
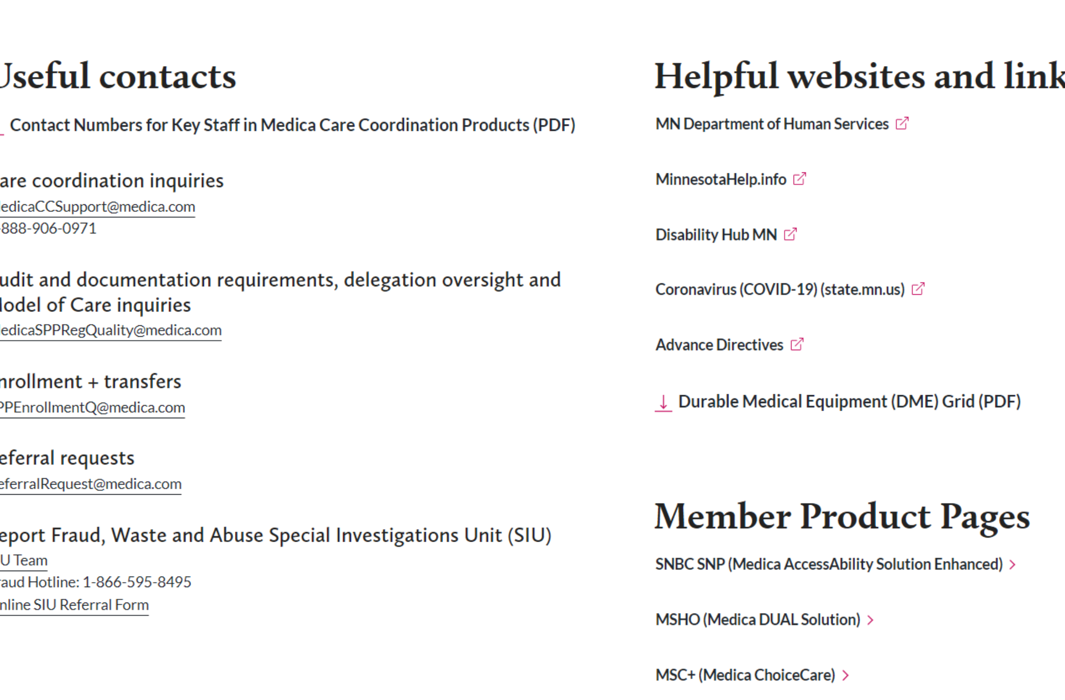
Care Coordination HUB Continued





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Care Coordinator Role

Initial Member Contact

- Care Coordinators must reach out to members within **10 business days** to introduce themselves, welcome them to Medica, answer questions and arrange for an assessment.
- Be sure to document the date you receive the enrollment list from Medica and the date of Care Coordinator contact.
- Contact can be made via the Medica Welcome Letter or a telephonic contact. The Care Coordinator must provide name and phone number at a minimum.

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Initial Assessment

- Within 30 days of enrollment (MSHO, MSC+ EW/PCA/CFSS) or 60 days (MSC+ non-EW/PCA/CFSS), the CC should complete one of the following:
    - MNChoice Assessment –or- DHS3428
    - MNChoice HRA-MCO –or- DHS3428H
    - Medica Transitional Member HRA
    - Unable to Reach/Refusal Assessment
    - Institutional Assessment
- Complementary Assessments
    - Residential Services Tool (Customized Living & Adult Foster Care)
    - DHS 3428Q

MNChoice Assessment/Health Risk Assessment

- All members must be offered an assessment.
- Refer to Telephonic Assessment Policy for “red flags” indicating the need for Face to Face for MSC+ members.
- 100% of the assessment must be completed.

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Medica Transitional Member HRA

The Transitional Member HRA can be used when the member is changing products (MSC+ to MSHO or vice versa) or changing Care Coordination entity.

It is not to be used if the member was previously Unable to Reach or Refusing.

If the member identifies any changes in health or needs, a new assessment may be needed.

<u>Transitional HRA process includes:</u>

Review most recent assessment, Care Plan, and signature page with the member.

Complete Transitional Member HRA form.

If the signature page is not received, there should be documentation of your attempt to retrieve one from the member.

Complete reassessment within 365 days from last FULL assessment, not from the transfer HRA date.

Transfer Member Health Risk Assessment
Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+)
Special Needs Basic Care (SNBC) & SNBC Enhanced

Completion of this form as described will meet requirements for a Health Risk Assessment (HRA) and a supplement to the existing care plan for the following members:

- MSHO/MSC+: Members who are newly enrolled community members with a HRA completed within the past 365 days, community members with a product change, transferred community members who have had a HRA/Long Term Care Consultation (LTCC)/MnCHOICES assessment within the past 365 days, or members with a product change who have had a LTCC/MnCHOICES assessment indicating opening of Elderly Waiver services (65th birthday assessment and must be full LTCC/MnCHOICES assessment).
- SNBC/SNBC Enhanced: Members with a product change who have had a HRA completed within the past 365 days.

This form should be completed within 30 days of transfer for all eligible MSHO/MSC+ members and within 60 days of transfer for all SNBC/SNBC Enhanced members. This form is to be attached to the most recent HRA/LTCC/MnCHOICES assessment and care plan. A new assessment and care plan must be completed if the Care Coordinator is unable to obtain a copy of the prior assessment and care plan to review and update. Throughout this form, the term "Assessment" may be used to refer to an HRA, LTCC or MnCHOICES assessment. **NOTE:** The next annual reassessment is due 365 days from the date of the last full HRA/LTCC/MnCHOICES assessment attached to this form. Please refer to the Assessment Schedule Policy for details.

I. PERSONAL INFORMATION

Name	PMI Number	Birth Date

Address (Street, City, ST, ZIP)	Phone

Physician	Phone	Clinic

Physician Address (Street, City, ST, ZIP)

II. ASSESSMENT/ CARE PLAN / PREVENTIVE CARE:

New product/Transfer enrollment date: Date of last Assessment:

Date of last Community Support Plan (CSP)/Collaborative Care Plan (CCP):

Reason for Transfer: Select one

Unable to Reach/Refusing

Unable to Reach:

- 3 phone attempts plus a letter are required.
- Document attempts to contact in member chart.
- Send On-going No Contact letter, include Member Engagement Questionnaire & Medica Care Coordinator Leave Behind Document.
- Create UTR/Refuser Care Plan. (MSHO ONLY)
- Attempt to identify Primary Care Physician and send Primary Care Physician letter. (MSHO)

Refusing:

- If ***member*** or ***authorized rep*** refuses an assessment, document the conversation with the member.
- Send Member Refusal letter, include Member Engagement Questionnaire & Medica Care Coordinator Leave Behind Document.
- Create UTR/Refuser Care Plan. (MSHO ONLY)
- Attempt to identify Primary Care Physician and send Primary Care Physician letter. (MSHO ONLY)

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Assessment Follow Up Work

- Within 30 calendar days of completing the Assessment:
  - Care Plan/Support Plan/Assessment Summary completed & sent to member
  - Member Signature Sheet signed & dated
  - OBRA Level 1 completed (DHS 3426)
  - Medica Care Coordinator Leave Behind Document left with member and Medication Disposal Form as indicated.
  - Complete Referral Request Form as needed to authorize services; submit to Support Specialist
  - Primary Care Physician (PCP) letter completed & sent to PCP
  - Member Post Visit letter completed & sent to member with Care Plan.
  - Care Plan sent to providers, when indicated (send again at day 60 if needed)
- If Transfer Member with unchanged needs
  - Update Care Plan to reflect changes or create new Care Plan.
  - Update MMIS
  - Update Financial Worker & Waiver Worker if applicable
  - Update Primary Care Physician
- If Unable to Reach/Refuser
  - Send Member Refusal or On-going No Contact letter, include Member Engagement Questionnaire & Medica Care Coordinator Leave Behind Document
  - Create UTR/Refuser Care Plan (MSHO Requirement).
  - Send Primary Care Physician letter (MSHO Requirement).

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Care Plan/Support Plan Tips

- Identified findings on the HRA must be carried over to the care plan. If the member declines needs for supports, this must be documented. We must know why the need is not carried over.
- Avoid using medical terminology or abbreviations.
- Keep Care Coordinator and PCP information up to date.
- Care plans goals should be written using SMART goals: specific, measurable, achievable, realistic, and time bound.
- Ongoing monitoring of progress and outcome of goals need to be documented on the Care Plan.
- Home and Community Based Service Agreement completed as part of the care plan.
- Remember to include informal supports on Service Agreement page.

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Reassessment

- Reassessment: Within 365 days of previous Assessment:
  - Annual reassessment completed
  - Completed within 30 days of assessment
    - Care Plan/Support Plan and Assessment Summary completed & sent to member
    - Close out previous Care Plan/Support Plan
    - Member Signature Sheet completed; signed & dated
    - Medica Care Coordinator Leave Behind Document provided to member and documented
    - Medication Disposal Form provided at Face to Face visits (MSHO requirement)
    - Complete Referral Request Form as needed to authorize services; submit to Support Specialist
    - Primary Care Physician (PCP) letter completed & sent
    - EW Provider Letter sent, if applicable (resend by day 60, if applicable)
    - Member Post Visit letter completed & s

If Unable to Reach/Refusal

- Assessment entered indicating Unable to reach or Refusal
- Member Refusal or On-going No Contact letter completed & sent, include Member Engagement Questionnaire and Leave Behind Document
- UTR/Ref Care Plan completed (MSHO requirement)
- Send Primary Care Provider Letter (MSHO requirement)

Changes in need after an assessment

- The lead agency may address some short-term changes after an assessment if a person already has an assessed need for supports through the following activities:
  - Realign resources within the person's current support plan, document changes and ensure the information is shared with the assessor at the person's annual reassessment.
  - Use a 45-day temporary increase for state plan PCA/CFSS services (refer to PCA Manual – 45-day temporary increase for PCA services.)
- If a person only uses state plan services (i.e., not waiver services), the lead agency must complete an in-person reassessment to address needs that require more than 45 days of increased PCA/CFSS services.
- If a person experiences a change in need that cannot be addressed using the above strategies, the lead agency may conduct an early reassessment or, for a person on EW, complete a *functional needs update.*
- The person, or others (on behalf of the person) may request an early reassessment.

MEMBERS ON OTHER WAIVERS

Members on other waivers (other than EW)

- Complete an HRA/MNChoice HRA
- Same Assessment Schedule
- Same Care Plan/Support Plan Requirements
- Communication and collaboration with waiver case manager (CM) is essential.
- Important to know that care coordinator is still involved, county/tribe is considered “lead agency” and assesses for continued waiver eligibility. County would also complete PCA assessment and Medica Care Coordinator would complete a referral request form as Medica is the payer of PCA services.

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MEMBERS LIVING IN AN INSTITUTIONAL SETTING

- Complete Institutional Assessment/Care Plan
- Partner Nursing Home checklist
- Relocation discussion annually
- PCP Communication
- Collaborate with facility staff
  - attending care conferences
  - consultation rounds
  - phone
- Nursing Facility Chart Coverage Guide
  - MSHO
  - MSC+

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CAREGIVER ASSESSMENT

- If the member has identified and unpaid caregiver, the CC is required to conduct a Caregiver Assessment.
- Determine if the Caregiver is in need of any additional support.
- Information obtained from the Caregiver is important in the development of the individualized care plan.
- Use form DHS 6914.

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Interdisciplinary Care Team (ICT)

- Gather ICT information during the HRA process
- Based on members assessed needs and concerns & who they choose to make up their ICT
- At a minimum the ICT must include the CC, the member, and the PCP (when known)
- Communicate to other members of the ICT regarding elements that are relevant to their work with the member
- ICT members must be documented on the Care Plan
- Communication must occur initially, annually, with changes in condition, and during member transitions
- Document collaboration attempts in the members case notes.

Care Coordinator Leave Behind Document

- Required to be provided annually
- CC name and contact information
- How your CC can help you
- How you can help your CC
- Grievance process
- Shared with member annual
- Available on the Medica CC website

Working With Your Medica Care Coordinator

PLEASE KEEP THIS IMPORTANT INFORMATION

Your Medica Care Coordinator's name is: ______________________

Your Medica Care Coordinator's phone number is: ______________________

Please share this contact information with your family. They can contact your Care Coordinator with updates on your health or if they have questions or concerns.

How your Care Coordinator can help you

Your Care Coordinator can help with your medical, social, and everyday needs. They'll also work with you to create a plan to help keep you healthy and safe in your home.

Your Medica Care Coordinator will:

- Call you to see how you are doing
- Offer to visit you in your home at least once a year and more often if your health changes
- Arrange services to help you in your home
- Give you information on resources available in your community
- Help you get transportation to your health care appointments
- Help you make health care and dental appointments
- Work with your health care team to assist with ongoing or new health conditions
- Help you if you have been or plan to be in the hospital
- Explain and help you understand benefits
- Give you info on your health conditions and topics such as nutrition, exercise, and fall prevention

How you can help your Care Coordinator

Call your Care Coordinator:

- When changes happen with your health
- When you have a scheduled procedure or surgery, including outpatient procedures at a hospital or clinic
- If you're hospitalized unexpectedly
- If you can't get to the doctor
- If you're having trouble with household tasks such as shopping, cleaning, or cooking
- If you need help to feel safe with bathing or dressing
- If you have a fall or are worried about falling
- If you move to a new home
- If you're having trouble getting housing, food, or transportation

Safe Disposal of Medication Handout

- CMS regulation requires plans to provide MSHO members with written and verbal information about the safe disposal of prescription drugs that are controlled substances when conducting an in-home Health Risk Assessment (HRA) with a member.
- Includes identifying at least two local takeback sites in the member's community
- Not required for members residing in an institutional setting where the institution has primary responsibility for disposal of residents' unused medications (e.g., nursing facility, Customized Living, AFC).
- The safe disposal handout does not need to be provided to members who complete an HRA over the phone. It also is not required for MSC+ members but may be a helpful resource to provide them as well.
- Available on Medica CC Hub.

Transition Management

- Goal is to have transitions between care settings be well managed and smooth with a consistent person supporting the member and/or authorized family members or guardians.
- Opportunity to engage with members and ensure that the care plan continues to meet the member's needs.
- Reduce incidents related to fragmented or unsafe care, by assisting in planning and preparations for transitions, coordinating follow-up care, and facilitating communication with all involved parties.
- Work closely with members, PCPs, facilities, and caregivers throughout the transition process
- Be sure to address the Return to Usual Care Setting Questions on the TOC log and update the Care Plan.

THANK YOU