Policy Title:	**Assessment Schedule MSHO/MSC+**
Department:	**Markets Growth & Retention**
Business Unit:	**Medicaid and Special Needs Plan**
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PRODUCTS AFFECTED

- Medica DUAL Solution® – Minnesota Senior Health Options (MSHO)
- Medica Choice Care℠ MSC+ - Minnesota Senior Care Plus (MSC+)

DEFINITIONS

Care Coordinator (CC): A person who assesses the member, creates a person-centered care plan/support plan, and then coordinates the provision of services and supports for those members among different health and social services professionals and across settings of care.

Change of Condition: Any change in the health of the member that triggers an increase or decrease in the need for services. Changes in activities of daily living (ADL's), independent activities of daily living (IADL's), or other supports may indicate the change in condition. The member's condition may have changed due to a major health event, an emerging need or risk, worsening health condition, or cases where the current services do not meet the client's needs. It is up to the professional judgment of the CC to determine if a change in member condition merits a reassessment.

CMS: Centers for Medicare and Medicaid Services under the U.S. Department of Health and Human Services

DHS: Minnesota Department of Human Services

Elderly Waiver (EW) Program: Medical Assistance (MA) program that funds home and community-based services for people 65 and older who require the level of care provided in a nursing facility, are eligible for long term care under Medical Assistance, and who choose to reside in the community.

Future End Date: Future end dates indicate members who have lost their Medicaid eligibility and Medica is covering services for 90 days. This information is located on the enrollment report sent to each care system, agency, and county lead. Future end dates only apply to MSHO members who meet criteria.

HRA and Assessment Tools for MSHO/MSC+
Medica owned tools can be found on the Medica Care Coordination Hub under Tools and Forms.
All Legacy tools can be found on the DHS Edocs site.

- DHS form 3426 OBRA Level I Criteria – Screening for Developmental Disabilities or Mental Illness (OBRA)- if using Legacy tools. This is built into the MnCHOICES assessments.
- DHS 3428 Minnesota Long Term Care Consultation Services Assessment Form (LTCC)/MnCHOICES Assessment- used for all MSHO/MSC+ EW members, and MSHO/MSC+ members with PCA services.
- DHS 3428D Supplemental Waiver PCA/CFSS Assessment – used for assessing for PCA/CFSS services using Legacy tools. This is used in addition to completing the LTCC (DHS 3428). This is built into the MnCHOICES Assessment.
- DHS 3428G Minnesota Service Change Form for EW and AC Participants/MnCHOICES Functional Needs Update- used for items/needs that have changed since the last assessment or reassessment completed resulting in need for changes in services or service plan. This does NOT represent a full reassessment.
- DHS 3428H Health Risk Assessment/MnCHOICES HRA– used for MSHO/MSC+ Non-EW members without PCA services and for MSHO/MSC+ members on other waivers (used for members on Community Access for Disability (CADI), Brain Injury (BI), or Developmental Disability (DD) waivers).
- Elderly Waiver Residential Services Tool/Rate Plan- used to determine proper payment to residential services providers.
- Medica Institutional Member Assessment- used for MSHO/MSC+ members identified as institutional or Rate Cell D, these members may reside in a nursing facility or ICF/DD home.
- Medica Transfer Member Health Risk Assessment & MnCHOICES Transitional HRA- used for MSHO/MSC+ community members that have transferred to Medica or transferred between MSHO and MSC+ and have had an LTCC/HRA/MnCHOICES assessment/MnCHOICES HRA within the past 365 days. Can only be used if CC is able to obtain a copy of the full assessment previously completed with the member. This does NOT represent a full assessment. At this time, you must complete both the Medica Transfer Member Health Risk Assessment & the MnCHOICES Transitional HRA for all transfers except:
    - The Transfer Member Health Risk Assessment is NOT to be used for members residing in an institutional living setting.
        - A MnCHOICES Transitional HRA would need to be completed for these members.
        - The CC would complete a review of the most recent institutional assessment and facility care plan. If there are no changes identified, the CC would document this and reassess within 365 days of the last assessment.

In-Person Assessment- An assessment conducted in-person with the member or member's legal representative. The in-person assessment could be conducted in the person's residence or other setting. For purposes of this definition "assessment" includes both legacy and MnCHOICES forms (e.g., MnCHOICES Assessment, MnCHOICES HRA, LTCC and DHS 3428H).

MMIS: Medicaid Management Information System. A complex, highly integrated claims payment, information management, and retrieval system implemented by the State of Minnesota Department

of Human Services to manage Medicaid enrollee data.

MnCHOICES: A single, comprehensive, web-based application that integrates assessment and support planning.

MSHO Rate Cell A: Community Non-Elderly Waiver Enrollees who, at capitation for MSHO, are coded in MMIS to be in a community living arrangement and are not enrolled in the Elderly Waiver for the first of the following month. These members are not 'nursing home certifiable" or not receiving at least one EW service.

MSHO Rate Cell B: Community Elderly Waiver Enrollees who, at capitation for MSHO are coded in MMIS to be in a community living arrangement and are enrolled in the Elderly Waiver for the first of the following month. These members are 'nursing home certifiable' and are receiving at least one EW service.

MSHO Rate Cell D: MSHO member who has been a resident of a nursing home for more than 30 days. Members considered to be "institutional" are shown on the full enrollment report to be in DHS designated living settings 41, 42, or 43.

MSC+ Non-EW: Community Non-Elderly Waiver Enrollees who, at capitation for MSC+, are coded in MMIS to be in a community living arrangement and are not enrolled in the Elderly Waiver for the first of the following month. These members are not "Nursing Home Certifiable" or not receiving at least one EW service.

MSC+ EW: Community Elderly Waiver Enrollees who, at capitation for MSC+ are coded in MMIS to be in a community living arrangement and are enrolled in the Elderly Waiver for the first of the following month. These members are "Nursing Home Certifiable" and are receiving at least one EW service.

MSC+ Institutional: MSC+ member who has been a resident of a nursing home for more than 30 days. Members considered to be "institutional" are shown on the full enrollment report to be in DHS designated living settings 41, 42 and 43.

Nursing Facility (NF) Level of Care: Standard to allow entry to nursing facilities and the home and community-based waivers for individuals demonstrating one or more of the following characteristics: a high need for assistance in four or more activities of daily living (ADL); a high need for assistance in one ADL that requires 24 hour staff availability; a need for daily clinical monitoring; significant difficulty with cognition or behavior; qualifying nursing facility stay of 90 days; or living alone and risk factors are present.

Remote Assessment- Assessment conducted by HIPAA secure interactive video or telephone in place of an in-person assessment. For purposes of this definition "assessment" includes both legacy and MnCHOICES forms (e.g., MnCHOICES Assessment, MnCHOICES HRA, LTCC and DHS 3428H). As outlined in this policy, for certain members, a Remote Assessment must be completed via HIPAA Secure interactive video; for others, a Remote Assessment may be completed via HIPAA Secure interactive video or telephone.

Screening Document Type "H": All Health Risk Assessments that were completed using the Legacy assessment tools for the following member types: Non-EW, Rate Cell A without PCA services, and members who have refused or are unable to be located will need to be entered in MMIS as a screening document type "H".

Screening Document Type "L": All assessments that were completed using the Legacy assessment tools OR the MnCHOICES Assessment for MSHO & MSC+ members on EW or who are receiving PCA services, the assessment should continue to be entered as a screening document "L". Assessments conducted using the LTCC assessment tool due to a member's request and/or need to determine eligibility for services can also be entered a screening document "L" even if the member is not opened to elderly waiver. This includes case management or document changes using activity type 05 and assessment result 98.

Transfer/Transitional Member: A member that has transferred/transitioned from County Fee-For-Service (FFS) or from another Managed Care Organization to Medica for Care Coordination; has changed from one Medica product to another (i.e.: MSC+ to MSHO or MSHO to MSC+) or has changed from one Medica Care Coordination Delegate to another Medica Care Coordination Delegate.

PURPOSE

To ensure all Medica members are assessed in a timely manner using the appropriate tools & mode of assessment in accordance with the DHS, CMS, and Medica requirements.

POLICY

Counties/Tribal Nations, Agencies, Care Systems, and internal Medica staff that provide services for Medica members must complete assessments and reassessments with members in accordance with the DHS, CMS, and Medica requirements. Assessment and reassessment timeliness will be audited items as part of the care plan audit.

HRA/ASSESSMENT REQUIRED

Care Coordinators must offer all MSHO and MSC+ members an in-person assessment[1] upon enrollment with Medica, and at least annually (within 365 calendar days) thereafter. If a member declines to complete an in-person assessment, a remote assessment may be allowed in certain circumstances, as detailed in Initial & Annual Assessment Guide at the end of this policy. The following member types are required to have in-person assessments and do not have a remote assessment option available:

- MSHO/MSC+ EW: All initial assessments must be in-person. EW services may not be started if the member does not complete an initial in-person LTCC or MnCHOICES Assessment. Reassessments may be completed remotely in certain circumstances. See [Initial & Annual Assessment Guide] at the end of this policy for detail.
- MSHO/MSC+ PCA/CFSS: Both initial and annual assessments must be in-person. PCA/CFSS services may not be started/continued if the member does not complete an in-person LTCC or MnCHOICES Assessment.
- MSHO/MSC+ Institutional: Both initial and annual assessments must be in-person.
- All members that request an in-person assessment.

[1] Throughout this policy, the term "assessment" may be used to refer to an LTCC, MnCHOICES Assessment or HRA (3428H or MnCHOICES HRA).

MSHO and MSC+ members residing in the community who are not receiving EW or PCA/CFSS services may be offered a remote assessment (initial or annual) if they decline to participate in an in-person assessment. For MSHO members, a remote assessment may be completed via a HIPAA secure interactive video (real time audio-visual interaction). For MSC+ members, a remote assessment may be completed via a HIPAA secure interactive video or via telephone. See Initial & Annual Assessment Guide at the end of this policy and the Remote Assessment Policy for additional detail on remote assessments. If a member declines/refuses a required in-person or remote (when allowed) assessment, proceed with the Refusal process.

If the CC determines a member's needs have changed, they will use their professional judgment to determine if the support plan can be updated, if a Functional Needs Update must be completed, or if a full reassessment is necessary. All Functional Needs Updates can be completed via remote interview with the member. If it is determined the member requires a full reassessment, the CC will refer to the Initial & Annual Assessment Guide to determine the mode of assessment (in-person or remote) that is required. Transfer/Transitional HRA's can be completed via remote interview with the member.

MEMBERS WHO LOSE ELIGIBILITY

Care Coordinators are required to support members in understanding why they have had a loss in Medicaid eligibility and assist them in re-establishing their eligibility, if possible. It is important to note the reason for the member's loss of eligibility. The reason for the loss of eligibility is found on the full enrollment report provided by Medica each month. The CC needs to determine if the enrollment report states "eligibility", "spenddown", or "other".

For all members who lose eligibility**"** but are due for an annual reassessment within 90 days of their Medical Assistance (MA) term, per DHS and CMS guidance, CCs are to complete the assessment by the due date. If the member is reinstated without a lapse in coverage, this assessment can then be entered into Medicaid Management Information System (MMIS)/MnCHOICES using the appropriate activity date.

For any member who had been on EW: <u>If the member is not reinstated within 60 days,</u> the CC is to complete and send the Managed care organization/County/Tribal agency communication form HCBS Waiver, AC and ECS Case Management Transfer and Communication Form (DHS 6037) to the county of residence for communication purposes. The county will determine if they need to enter a service agreement for continued payment of EW services the member is receiving.

If a member loses eligibility but is reinstated and there is no lapse in coverage with Medica a new assessment does not need to be completed provided the CC has maintained regular scheduled contact with the member, the assessment and Care Plan/Support Plan is current, and there has been no change of condition or a change in the supports identified or requested. A new assessment would need to be completed if there was a change in condition or change in the supports needed or requested during that time. Documentation in case notes should include notes on efforts made to the assist member with eligibility issues.

If a member on EW loses eligibility due to a managed care enrollment exclusion such as a nonpayment of their ***"spenddown"*** as determined by DHS or the financial worker, the CC is to complete and send the DHS 6037 form to the county of residence immediately, this allows the county to determine whether

they need to enter a service agreement for continued payment of EW services the member is receiving.

For MSHO members who lose their MA eligibility, most will remain on the program for 90 days. This future term date is called the future end date. During this time, all care coordination requirements remain in place to include any assessments due. Also, during this time, the CC is to be assisting the member and the county related to the members MA paperwork. CCs are to refer to their Full Enrollment report to identify if they have members with a future end date as they are to offer assistance with the Medicaid renewal process.

PROCEDURE:

1. The County/Tribal Nation, Agency, or Care System or internal Medica staff must contact new members via phone or approved letter within 10 business days of enrollment to inform the member of the CC and provide contact information. Best practice is to set up an initial assessment during the introductory call.

2. Initial Assessments
    a. **MSHO & MSC+ Community Members-** Initial assessment must be conducted within the first 30 calendar days of enrollment for all MSHO members and all MSC+ members receiving EW or PCA/CFSS. Non-EW, Non-PCA/CFSS MSC+ member assessments must be conducted within the first 60 calendar days of enrollment.

        If the member requests a deferment or if the assessment does not take place within 30/60 calendar days, the CC must document all attempts to offer/schedule the assessment and document why it was not completed timely. At a minimum there must be documentation of at least three phone call attempts to reach the member and a follow-up letter or documentation that the member explicitly declined to participate in the assessment.
            i. If the CC cannot schedule an assessment, an unable to find/refusal screening document type “H” should be entered in MMIS if using Legacy documents or an UTR/Ref HRA should be completed in MnCHOICES to record the date of the last outreach attempt or refusal conversation by the last business day of the enrollment month.
            ii. When the CC is able to complete an assessment, MMIS/MnCHOICES should be updated.

        Medica will honor any previous EW service authorizations. The CC will not terminate these services during the previously approved open waiver span.

        Medica will honor any previous PCA/CFSS authorizations. The CC will not complete a PCA/CFSS assessment due to a transition to Medica. The following scenarios will help guide the CC as to when to complete or not complete a new PCA/CFSS assessment.
            i. The CC will only complete a PCA/CFSS Assessment at the time of the initial HRA if the CC is unable to obtain the most recent PCA/CFSS Assessment or authorization, there is a change in condition or supports, the member requests a new PCA/CFSS Assessment, or the PCA/CFSS authorization will end within 30 calendar days of the HRA date.
            ii. A PCA/CFSS reassessment will not be completed if member has a current

authorization for PCA/CFSS services and can obtain the current authorization and PCA/CFSS assessment from the PCA/CFSS provider or the member.

iii. The CC will not complete the PCA/CFSS assessment if the CC does not have the previous LTCC/ /MnCHOICES Assessment and needs to complete a new LTCC/MnCHOICES Assessment. It is likely that the CC will need to conduct another LTCC/MnCHOICES Assessment and PCA/CFSS Assessment before the end of the PCA/CFSS authorization.

iv. If a member is on a waiver managed by the county, the county is responsible for the PCA/CFSS assessment. The CC will review and authorize PCA/CFSS services and communicate with the waiver case manager and may use DHS 5841.

b. **MSHO & MSC+ Institutional—**Initial assessment must be conducted within 30 calendar days of enrollment for MSHO members and within 60 calendar days of enrollment for MSC+ members.

If the member requests a deferment or if the visit does not take place timely, the CC must document all attempts to offer/schedule the assessment and document, why it was not completed timely. At a minimum there must be documentation of at least three phone call attempts to reach the member and a follow-up letter or documentation that the member explicitly declined to participate in the assessment .

i. If the CC cannot schedule an assessment, the CC should record the contact attempts or refusal conversation in the members file by the last business day of the enrollment month.

ii. When the CC is able to complete the assessment, the member's file should be updated.

3. The CC will complete the appropriate MMIS/MnCHOICES entry following all assessments.

4. The CC will determine appropriate Rate Cell/EW eligibility/NF level of care status based on outcome of the assessment. If the CC initially completed the DHS 3428H/MnCHOICES HRA and it appears the member may be appropriate for Elderly Waiver, the CC will need to complete the LTCC/MnCHOICES Assessment to determine rate cell and open the Elderly Waiver. Members who request PCA/CFSS or initial Elderly Waiver services must have an in-person LTCC/MnCHOICES Assessment completed to determine eligibility.
    a. To be eligible for EW the Enrollee must receive Care Coordination and have authorized and delivered at least one additional formal waiver service as documented in the EW care plan/support plan.
    b. Enrollees are eligible for EW for a maximum of sixty (60) days without the authorization of an additional waiver service, beyond case management.
        i. 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 to authorize waiver services may be allowed.
        ii. If services are not authorized during this time frame, the participant must exit the waiver until determined eligible and additional waiver services can be authorized. Refer to the DTR policy.

5. Upon completion of the required assessment, the CC will set up a follow-up contact schedule with the member.
    a. Follow up frequency and purpose will be noted on the care plan/support plan. Follow up frequency for each member is based on the professional judgement of the CC and is drawn from the member's assessment and identified needs, concerns and wishes as well as Rate Cell/EW eligibility/NF level of care status.
    b. CCs should consider the member's care level on Medica's Enhanced Care Coordination/Impact Report when setting the contact schedule. These are the minimum required contacts:
        i. MSHO/MSC+ Community Members (that are <u>not</u> on another waiver i.e.: DD, BI, CADI):
            1. Refer to Initial & Annual Assessment Guide at the end of policy
            2. Minimum contact every 6 months (additional contacts per CC judgement and identified member needs)
            3. Contacts related to member transitions

        ii. MSHO/MSC+ Institutional Members or Members residing in an ICF-DD:
            1. Refer to Initial & Annual Assessment Guide at the end of the policy
            2. Participation in care conferences
            3. Minimum contact every 6 months (additional contacts per CC judgement and identified member needs)
            4. Contacts related to member transitions

        iii. MSHO/MSC+ Members who have been determined eligible for another waiver (DD, BI, CADI):
            1. Refer to Initial & Annual Assessment Guide at the end of policy
            2. Minimum contact every 6 months (additional contacts per CC judgement and identified member needs)
            3. Contacts related to member transitions
            4. Annual and PRN contact with county case manager

6. If the member resides in a residential setting and recently had a change of condition or change of living setting, the CC will complete the RS Tool/Rate Tool as well. A new assessment must take place with 20 days of request.

7. If the member has PCA/CFSS services and recently had a change of condition, the CC will complete the PCA /CFSS assessment & DHS 3428 or a MnCHOICES Assessment during an in-person visit.

8. If an EW member, that is not receiving PCA/CFSS services, has a change in needs after an assessment is completed, the CC should attempt to realign resources within the person's current support plan, document changes & ensure the information is shared with the ICT (Interdisciplinary Care Team). The CC may complete a MnCHOICES Functional Needs Update for members receiving EW if there is a change in the members needs anytime during the service agreement year. The MnCHOICES Functional Needs Update does NOT represent a full reassessment. Situations in which the CC may use a functional needs update included the need

to make a change based on:

a. Emerging need or risk (e.g., changes in need that requires a change in the monthly case mix budget for EW, establishing eligibility for 24 hour customized living for EW
b. Major health event or worsening health condition if the person's current services and/or supports do not meet their needs.
c. Change in case mix that needs to be document.

9. Annual reassessments must be completed within 365 calendar days of the previous assessment. If the member requests a deferment refer to the unable to reach refusal process listed under initial assessment instructions.

10. Refer to grids at the end of this policy for additional information regarding enrollment scenarios, required mode of assessment, and care coordination actions to be completed.

MMIS ENTRY PROCESS

Activity Type 01: Telephone Screen

- For use with initial assessments and reassessments conducted by telephone for MSC+ members. Assessment Result 35. Program Type 18.
- For use with nursing facility admission. MCO staff complete the Pre-Admission Screening (PAS) process using DHS 3427T

Activity type 02: Face to Face Assessment

- MSHO Rate Cell A: For use with initial assessments and reassessments conducted through an in-person visit. Assessment result is 35. Program Type 18
- MSHO Rate Cell B: For use with only initial opening to EW
- MSC+ Non EW: For use if not using Activity Type 01, Use for initial and reassessments, assessment result is 35. Program Type 18.
- MSC+ EW: For use only for initial opening to EW

Activity Type 05: Document Change

- For use when showing a change in Care Coordinator, Care Coordination Delegate, or Managed Care Organization (MCO)
    - A member that has been internally transferred and assigned to a new Care Coordinator assigned within the same Care System, County, or Agency or to a new Medica Delegate without a change in product.
    - A member that has been transferred and assigned to Medica as the new MCO
- Activity Date can be the same as the assessment result date
- Assessment Result should be 98
- Health Plan: MED
- Assessment team: 02
- Program Type 18

Note: Activity Type 05 cannot be used to open a waiver span

Activity Type 06: Reassessment

- For use only for MSHO Rate Cell B and MSC+ EW members to continue waiver eligibility.

Note: Activity Type 06 cannot be used for MSHO rate cell A reassessments or for MSC+ non-EW reassessments.

Activity Type 07: Case Management/Administrative Activity

- For use when a HRA was not successful due to the member declining to complete. Assessment

result 39. Program Type 18.

- For use when a HRA was not successful due to the member not being located. Assessment result 50. Program Type 18.
- For use when a review of the last HRA occurred with the member due to a change in products (MSHO to MSC+ or MSC+ to MSHO). Activity date: date CC completes review. Assessment result 51. The Effective Date field must match the Effective Date of the last Assessment Result 35 and not be more than 366 days from the current date. Program Type 18.
- To exit EW members due to SNF admission, Death, or no longer using EW services.
- Updating MMIS for members who are already on EW but choosing to start CDCS.

Activity Type 09: Eligibility Update

- Only used when additional eligibility determination(s) unrelated to the assessment have not been completed by the county within the 60 day window.
- See MMIS manual for more details.
- Allows the earliest effective date of eligibility to be the date of the face-to-face assessment, if the eligibility update occurs within 90 days of the face-to-face assessment and all other eligibility requirements are met

Activity Type 10: Annual Reassessment is Not Due & Member has Change in Needs which result in a change in services, requiring additional resources

- Used if the member's case mix classification has changed, if the change results in eligibility for 24 CL rate limits, or additional funding under CDCS.

Note: Activity type 10 cannot be used when updating the person's service plan with existing resources or when an annual reassessment is due within 30 days, in this case, perform a reassessment.

Scenario	Action
Newly enrolled in Managed Care Organization (No previous Care Coordinator, No previous Fee For Service (FFS)) **OR** **Transfer (FFS, External, Internal)**- No current assessment (Member not assessed within the last 365 calendar days), **OR** unable to obtain required transfer documents for review, **OR** inconsistent documentation as listed below: ▪ Health Risk Assessment not aligned with member needs ▪ Collaborative Care Plan/Support Plan/CSP/CSSP goals and interventions not consistent with HRA review.	▪ **Send member Welcome letter OR contact member,** introduce self and provide updated CC contact information. If contact is other than a Welcome letter, this must be documented in member's file in case notes. ▪ **Complete new assessment and paperwork per CC assessment and follow-up activities grid below.** ▪ **Update MMIS-** Complete MMIS entry process outlined above for all Legacy documents completed, this may include Assessment Type 1 or Assessment Type 2. Complete MMIS entry outline above for all MnCHOICES Assessments, this may include Assessment Type 1 or Assessment Type 2. MMIS entry is not required for MnCHOICES MCO HRA assessments.
Transfer from FFS - Able to obtain current assessment, member signature sheet or DHS 6791, and Collaborative Care Plan/Support Plan or CSP & CSSP for the transferred member **OR**	▪ **Send member Welcome letter OR contact member,** introduce self and provide updated CC contact information. If contact is other than a Medica Change of CC letter, this must be documented in member's file in case notes. ▪ **Review received paperwork** including, but not limited to DHS-6037-ENG Home and Community-Based Services Case Management Transfer Form**,** copy of current assessment, care plan/support plan, member signature sheet/support plan signature sheet/ DHS 6791, and PCA/CFSS assessment/RS Tool/Rate Tool, if applicable. ▪ **Transfer Health Risk Assessment (HRA)/MnCHOICES Transitional Assessment -** CC will review the

Scenario	Action
External Transfer- Able to obtain current assessment, member signature sheet or DHS 6791, and Collaborative Care Plan/Support Plan or CSP & CSSP for the transferred member ▪ Transfer to Medica from another Managed Care Organization (MCO) ▪ Transfer within Medica from Medica Care System/County/Agency to another Medica Care System/County/Agency **OR** **Change in Product (<u>even if CC did not change</u>)-** Able to obtain current assessment, member signature sheet or DHS 6791, and Collaborative Care Plan/Support Plan or CSP & CSSP for the transferred member ▪ MSC+ to MSHO ▪ MSHO to MSC+ ▪ SNBC/ISNBC to MSHO/MSC+ Community Members	previous assessment **with member** and complete the Medica Transfer HRA Form within 30 calendar days of transfer/enrollment**.** CC will document that review occurred on the Medica Transfer HRA Form, including the date and if there are any updates or changes needed. If working in MnCHOICES, CC must also create a Transitional HRA to document the date of the review of the prior assessment and care/support plan with the member. ▪ If completing a new assessment and support plan because the prior assessment and care/support plan are not available for review or the member had a change of condition, do not create a Transitional HRA in MnCHOICES. Instead, follow process for completing a new MnCHOICES Assessment or HRA and Support Plan. ▪ For institutional members, the CC will document that a review of the current Institutional Assessment occurred in the member's case notes. MnCHOICES Transitional HRA ▪ **Care Plan/Support Plan-** CC will review previous care plan/CSP/CSSP/Support Plan **with member** CC will document that review occurred on the Medica Transfer HRA Form, including the date and if there are any updates or changes needed. If updates to the care/support plan are needed, CC will update the health related goals section of Medica Transfer HRA Form, create a new care plan (if using legacy documents) or revise the current MnCHOICES Support Plan, as necessary. ▪ **Member Signature Sheet/Support Plan Signature Sheet or DHS 6791**- must be included in the transfer paperwork received or CC should review elements with member and obtain new signature sheet. ▪ **Update MMIS-** If using Legacy documents, complete Document Change in MMIS, see MMIS Entry Process above. No MMIS entry needed if completing transitional health risk assessment activity in MnCHOICES. For the transfer members with a change in CC there would need to be a 05 document change to update the new CC in MMIS. ▪ **Update Financial Worker, Primary Care Physician, and Waiver Worker:** CC will document date notification of change in CC or that change in product occurred on Transfer HRA.

Scenario	Action
Internal Transfer- New Care Coordinator assigned within your Care System, County, or Agency- Able to obtain current assessment, member signature sheet or DHS 6791, and Collaborative Care Plan/Support Plan or CSP & CSSP for the transferred member	▪ **Send member Medica Change of CC letter OR contact member,** introduce self and provide updated CC contact information. If contact is other than a Medica Change of CC letter, this must be documented in member's file in case notes. ▪ **Review received paperwork** including, but not limited to DHS-6037-ENG Home and Community-Based Services Case Management Transfer Form**,** copy of current assessment, care plan/support plan, member signature sheet/support plan signature sheet/ DHS 6791, and PCA/CFSS assessment/RS Tool/Rate Tool, if applicable. ▪ Transfer/Transitional HRA is NOT required when internal transfer occurs. CC will review member documents to ensure all documents are current, present, and representative of member's needs. This will be documented in the members case notes. ▪ **Update MMIS-** Complete Document Change in MMIS, see MMIS Entry Process above. CC will need to assign the member to themselves in MnCHOICES prior to accessing or creating assessment. ▪ **Update Financial Worker, Primary Care Physician, and Waiver Worker-** CC will document date notification of change in CC or that change in product occurred in member file.
Change in Product- Institutional Member (even if CC did not change) ▪ SNBC/ISNBC to MSHO/MSC+ Institutional Member	▪ **Send member Welcome letter OR contact member,** introduce self and provide updated CC contact information. If contact is other than a Welcome letter, this must be documented in members file in case notes. ▪ **Complete new assessment and paperwork per CC assessment and follow-up activities grid below.** ▪ **Update MMIS-** Complete Document Change in MMIS, see MMIS Entry Process above. ▪ **Update Financial Worker, Primary Care Physician, and Waiver Worker:** CC will document date notification of change in CC or that change in product occurred in member file.
Change in Product - With PCA/CFSS (even if CC did not change)- ▪ SNBC/ISNBC to MSHO/MSC+	▪ **Send member Welcome letter OR contact member,** introduce self and provide updated CC contact information, if applicable. If contact is other than a Welcome letter, this must be documented in members file in case notes. ▪ **Review received paperwork** including, but not limited to DHS-6037 Home and Community Based Services Case Management Transfer Form. ▪ **Complete new LTCC/MnCHOICES Assessment** and paperwork per CC assessment and follow-up activities grid below

Scenario	Action
	▪ **PCA/CFSS Authorization-** Obtain the most recent PCA/CFSS Assessment (PCA Legacy Assessment or MnCHOICES Assessment) from the PCA/CFSS Provider, member or the county. Contact the PCA/CFSS agency by phone or by using the Flexible Verification Form to receive the number of units remaining in the authorization using the MSHO/MSC+ enrollment date and the end date on the current authorization. If the PCA/CFSS provider is an out of network provider, the CC will assist the member in transitioning to an in network provider as soon as possible. The authorization for an out of network provider cannot extend beyond 120 days. ▪ **PCA/CFSS Assessment-** the CC will <u>NOT</u> complete a new PCA/CFSS Assessment at the time of the initial HRA. The CC will only complete a new PCA/CFSS assessment at the time of this HRA if: o The CC is unable to obtain the most recent PCA/CFSS Assessment or authorization o There is a change in condition or a change in member supports o Member requests a new PCA/CFSS Assessment o The PCA/CFSS Authorization will end within 30 days of the HRA date ▪ **Missing Member or Refusing Member**-The CC will complete the referral for PCA/CFSS services through the initial authorization period. The member will require a LTCC/MnCHOICES Assessment and PCA/CFSS Assessment completed before the end of the authorization. If the CC is unable to complete an LTCC/MnCHOICES Assessment and PCA/CFSS assessment during the required time period, the member will be considered Unable to Reach/Refusing and the CC will need to enter a screening document type "H" and complete a DTR for the PCA/CFSS services. ▪ **Waiver managed by the county**: If the member is on a waiver managed by the county (ex: CADI), the CC will obtain the most recent PCA/CFSS Assessment or MnCHOICES assessment from the county waiver Case Manager and utilize the DHS 5841 to communicate the authorization. ▪ **Note:** Because in most cases the LTCC/MnCHOICES Assessment and PCA/CFSS Assessment will not be aligned, it will require the CC to do an additional visit to complete another LTCC/MnCHOICES Assessment and a PCA/CFSS Assessment prior to the end of the initial PCA/CFSS authorization. This will align the assessments going forward.
Change of Condition or Change in Living Setting	▪ Complete new LTCC /MnCHOICES Assessment and paperwork per CC assessment and follow-up activities grid below. ▪ If the member has PCA/CFSS and recently had a change of condition, the CC will complete a new PCA/CFSS assessment with an in-person assessment if using Legacy Tools or would complete a new MnCHOICES Assessment.

INITIAL AND ANNUAL MODE OF ASSESSMENT GUIDE

Product/Member Type	Initial Assessment	Annual Assessment	Notes
MSHO/MSC+ EW (no PCA/CFSS)	In-person	1. Offer/attempt to schedule in-person 2. If member declines to complete an in-person assessment, may complete remotely via HIPAA secure interactive video or telephone if: a. Prior LTCC/MnCHOICES assessment was in-person b. Member/legal representative is provided information to make an informed choice between a remote and in-person assessment c. Member/legal representative provides informed consent for a remote reassessment d. Document that offered the member/legal representative informed choice regarding method of assessment and member/legal representative's decision to complete a remote reassessment. 3. Note: All MSHO/MSC+ members receiving EW services must have at least one in-person visit per 12-month period. Consequently, if a member completes a remote assessment in accordance with above requirements, the CC must complete a separate in-person visit during the same 12-month period.	If a reassessment is completed remotely, CCs must track and document compliance with the remote reassessment requirements and with the annual in-person visit requirement Initial assessments must be completed In-person. EW services cannot be started until an in-person assessment has been completed.
MSHO/MSC+ PCA/CFSS	In-person	In-person	PCA/CFSS services cannot be started until an in-person assessment has been

			completed. Remote assessments are not allowed.
MSHO Community – Non-EW & Non-PCA/CFSS	1. Offer/attempt to schedule in-person 2. If member declines to complete an in-person assessment, may complete assessment remotely via HIPAA secure interactive video 3. CC must document the assessment method, including the member's refusal to complete the assessment in-person, as applicable	1. Offer/attempt to schedule in-person 2. If member declines to complete an in-person assessment, may complete assessment remotely via HIPAA secure interactive video 3. CC must document the assessment method, including the member's refusal to complete the assessment in-person, as applicable	
MSC+ Community – Non-EW & Non-PCA/CFSS	1. Offer/attempt to schedule in-person 2. If member declines to complete an in-person assessment, may complete assessment remotely via HIPAA secure interactive video or telephone 3. CC must document the assessment method, including the member's refusal to complete the assessment in-person, as applicable	1. Offer/attempt to schedule in-person 2. If member declines to complete an in-person assessment, may complete remotely via IHPAA secure interactive video or telephone 3. CC must document the assessment method, including the member's refusal to complete the assessment in-person, as applicable	
MSHO/MSC+ Institutional	In-person	In-person	

CARE COORDINATION ASSESSMENT & FOLLOW UP ACTIVITIES

CARE COORDINATION TASKS TO BE COMPLETED	**MSHO/MSC+EW**	**MSHO/MSC+ NON EW**	**MSHO/MSC+ INSTITUTIONAL**	**MSHO/MSC+ NON EW WAIVER (BI, CADI, DD)**
ASSESSMENT COMPLETION & MMIS/MnCHOICES ENTRY	Initial, LTCC/MnCHOICES Assessment including OBRA Level 1 (if using Legacy Tools), PCA/CFSS & RS Tool	MSHO/MSC+ with PCA/CFSS: Initial, LTCC/MnCHOICES Assessment including OBRA Level 1 (if using Legacy Tools),	MSHO: Initial, Medica Institutional	MSHO: Initial, 3428H/MnCHOICES HRA including OBRA Level 1 (If using Legacy Tools), within

CARE COORDINATION TASKS TO BE COMPLETED	MSHO/MSC+EW	MSHO/MSC+ NON EW	MSHO/MSC+ INSTITUTIONAL	MSHO/MSC+ NON EW WAIVER (BI, CADI, DD)
	(if applicable) within 30 calendar days of enrollment For initial assessment Transfer/Transitional HRA process may be used if required documentation present <u>For both MSHO/MSC+:</u> LTCC/MnCHOICES Assessment annually (within 365 calendar days of prior assessment) If using LTCC, screening document type "L" in MMIS before DHS cutoff date	PCA/CFSS within 30 calendar days of enrollment For initial assessment Transfer/Transitional HRA process may be used if required documentation present MSC+ <u>without</u> PCA/CFSS: Initial, 3428H/MnCHOICES HRA including OBRA Level 1 within 60 calendar days of enrollment <u>For both MSHO/MSC+</u>: LTCC/MnCHOICES Assessment/HRA/MnCHOICES HRA annually (within 365 calendar days of prior assessment) If receiving PCA/CFSS, PCA /CFSS Assessment must be completed with LTCC/MnCHOICES assessment annually to authorize PCA/CFSS services If using LTCC, screening document type "L" in MMIS before DHS cutoff date	Assessment within 30 calendar days of enrollment MSC+: Initial, Medica Institutional Assessment within 60 calendar days of enrollment Transfer/Transitional HRA process is not used for these members. <u>For both MSHO/MSC+:</u> Medica Institutional assessment annually (within 365 calendar days of prior assessment) Not entered in MMIS	30 calendar days of enrollment MSC+: Initial, 3428H/MnCHOICES HRA including OBRA Level 1 (if using Legacy Tools) within 60 calendar days of enrollment For initial assessment Transfer/Transitional HRA process may be used if required documentation present <u>For both MSHO/MSC+:</u> 3428H/MnCHOICES HRA annually (within 365 calendar days of prior assessment) If using 3428H, screening document type "H" before DHS cutoff date PCA/CFSS: The waiver case manager is responsible for the PCA/CFSS assessment.

CARE COORDINATION TASKS TO BE COMPLETED	MSHO/MSC+EW	MSHO/MSC+ NON EW	MSHO/MSC+ INSTITUTIONAL	MSHO/MSC+ NON EW WAIVER (BI, CADI, DD)
		If using 3428H, screening document type "H" in MMIS before DHS cutoff date		The CC reviews and authorizes the PCA/CFSS services
CARE PLAN/SUPPORT PLAN	Collaborative Care Plan/Support Plan sent to member within 30 calendar days of assessment Signed Member Signature Sheet/Support Plan Signature Sheet (note: Services cannot be withheld from someone who does not sign the care/support plan, continue to attempt to obtain signatures)	Collaborative Care Plan/Support Plan sent to member within 30 calendar days of assessment Signed Member Signature Sheet/Support Plan Signature Sheet (must make and document a minimum of two attempts to obtain signature)	Review and attach copy of nursing facility care plan Complete Institutional Assessment Care Plan Section No Member Signature Sheet requirement	Collaborative Care Plan/Support Plan sent within 30 calendar days of assessment Signed Member Signature Sheet/Support Plan Signature Sheet (must make and document a minimum of two attempts to obtain signature)
MEMBER DOCUMENTS MADE AVAILABLE AFTER ASSESSMENT	• Collaborative Care Plan/MnCHOICES Support Plan (Sent to member/legal representative & providers with permission of member/legal representative within 30 days of assessment) • MnCHOICES Assessment Results (upon request)	• Collaborative Care Plan/Support Plan (Sent to member/legal representative & providers with permission of member/legal representative within 30 days of assessment) • MnCHOICES Supplemental Summary Chart (if applicable sent to member/legal representative, CFSS/PCA	• Nursing Facility Chart Coverage Guide provided to Nursing Facility for member chart • Medica Leave Behind Document • Medica Institutional Post Visit Member Letter sent to member and nursing facility	• Collaborative Care Plan/Support Plan (Sent to member/legal representative & providers with permission of member/legal representative within 30 days of assessment)

CARE COORDINATION TASKS TO BE COMPLETED	MSHO/MSC+EW	MSHO/MSC+ NON EW	MSHO/MSC+ INSTITUTIONAL	MSHO/MSC+ NON EW WAIVER (BI, CADI, DD)
	• MnCHOICES Assessment Report (upon request) • MnCHOICES Assessment Summary (Within 30 days of assessment) • MnCHOICES Functional Assessment (upon request) • MnCHOICES Supplemental Summary Chart (if applicable sent to member/legal representative, CFSS/PCA Providers within 10 days of assessment) • About Me- My Care Team (upon request) • Care coordination next steps indicator report (upon request) • Medica Leave Behind Document • Medication Disposal Flyer (For MSHO in-person visits) • Medica Post Visit Member Letter	Providers within 10 days of assessment) • MnCHOICES Health Risk Assessment- MCO (upon request) • About Me- My Care Team (upon request) • Care coordination next steps indicator report (upon request) • Medica Leave Behind Document • Medication Disposal Flyer (For MSHO in-person visits) • Medica Post Visit Member Letter		• About Me- My Care Team (upon request) • Care coordination next steps indicator report (upon request) • Medica Leave Behind Document • Medication Disposal Flyer (For MSHO in-person visits) • Medica Post Visit Member Letter

CARE COORDINATION TASKS TO BE COMPLETED	MSHO/MSC+EW	MSHO/MSC+ NON EW	MSHO/MSC+ INSTITUTIONAL	MSHO/MSC+ NON EW WAIVER (BI, CADI, DD)
FOLLOW-UP	• Annual assessment within 365 calendar days of previous assessment • PCP contact annually, with changes in condition, changes in product, changes in CC, and with transitions • Minimum contact every 6 months (additional contacts per CC judgement and identified member needs) • Follow-up with each notice of transition • Send Care Plan/Support Plan documents to EW/HSS/Non-EW providers per member discussion within 30/60 calendar days	• Annual assessment within 365 calendar days of previous assessment • PCP contact annually, with changes in condition, changes in product, changes in CC, and with transitions • Minimum contact every 6 months (additional contacts per CC judgement and identified member needs) • Follow-up with each notice of transition • Send Care Plan documents to HSS providers within 30/60 days	• Annual assessment within 365 calendar days of previous assessment • PCP contact annually, with changes in condition, changes in product, changes in CC, and with transitions • Minimum contact every 6 months (additional contacts per CC judgement and identified member needs) • Follow-up with each notice of transition • Participation in Care Conferences • If applicable: Transfer to Medica Care System after 100 days in NF	• Annual assessment within 365 calendar days of previous assessment • PCP contact annually, with changes in condition, changes in product, changes in CC, and with transitions • Minimum contact every 6 months (additional contacts per CC judgement and identified member needs) • Follow-up with each notice of transition • Annual contact with waiver case manager

CROSS REFERENCES

DHS MSHO/MSC+ Contract
Instructions for Completing and Entering the LTCC Screening Document and Health Risk Assessment into MMIS for the MSC+ and MSHO Programs DHS 4669
MnCHOICES revision assessment and support plan documents and reports

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