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PRODUCTS AFFECTED

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

DEFINITIONS:

Barrier: Any issue that may be an obstacle to the member receiving or participating in a care management plan or self-management plan.

Care Coordinator (CC)/Case Manager Qualifications: Medica prefers MSHO/MSC+ Care Coordinators be a Registered Nurse, Public Health Nurse, Licensed Social Worker, County Social Worker evaluated under the Minnesota Merit System, Physician Assistant, Nurse Practitioner or Physician.

If a Care Coordinator (CC) does not meet the above criteria, they must:

1. be supervised by a Licensed Social Worker, Registered Nurse, Physician Assistant, Nurse Practitioner or Physician; and
2. meet the DHS requirements for the provision of case management by virtue of meeting the social work standards under the Minnesota Merit System, which require meeting the requirements in (a) or (b) and (c) below:
    a. a bachelor's degree from an accredited four-year college or university with a major in social work, psychology, sociology, or a closely related field; or
    b. a bachelor's degree from an accredited four-year college or university with a major in any field and at least one year of experience as a social worker/case manager/care coordinator in a public or private social services agency; and
    c. the knowledge, skills and abilities necessary to perform the job

For purposes of the above requirements, a closely-related field includes occupational therapy, physical therapy, speech-language pathology, audiology, recreational therapy, dietician, special education, rehabilitation counseling, nursing, human services or other field in health or human services that involves the job duties of a care coordinator/case manager, including assessment and service planning.

Once MnCHOICES is in place, all MSHO/MSC+ Care Coordinators except Physician Assistants, Nurse Practitioners and Physicians acting as Care Coordinators for members in nursing homes must be certified assessors providing both the assessment and ongoing case management functions for members, including

support planning services. A certified assessor is a person who completes training and obtains certification from DHS and performs long term care consultation assessments.

Care Coordination for MSHO Members: The assignment of an individual who coordinates the provision of all Medicare and Medicaid health and long-term care services for MSHO members and who assesses the need for and coordinates services to an MSHO member among different health and social service professionals and across settings of care.

Case Management for MSC+ Members: The assignment of an individual who assesses the need for and coordinates Medicaid health and long-term care services for an MSC+ member among different health and social service professionals and across settings of care. For purposes of this policy the term "Care Coordination" is interchangeable with the term "Case Management" for purposes of MSC+ members.

Care Management for all Enrollees: The overall method of providing on-going health care in which Medica manages the provision of primary health care services with additional appropriate services provided to a member. Care Management services may include, but are not limited to coordination of preventive, primary, acute, post-acute, rehabilitative, specialty, and pharmacy services. Medica promotes service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, culturally appropriate care, and fiscal and professional accountability.

Care Plan: The document developed in consultation with the member, the member's treating physician, health care or support professional, or other appropriate individuals, and where appropriate, the member's family, caregiver, or representative. The Care Plan, taking into account the extent of and need for any family or other supports for the member, identifies the necessary health and Home and Community-Based services to be furnished to the member. The Care Plan for Elderly Waiver members must meet the federal and state requirements related to person-centered planning. Medica does not require the use of a specific Care Plan. Any Care Plan that meets the DHS EW audit protocol requirements and all of the elements of the Community Support Plan (CSP) DHS e-doc form #2925 may be used. If a delegate plans to use a care plan other than those provided by Medica, prior approval is required by the Medica. Upon launch of the revised MnCHOICES application, the Community Support Plan will be referred to as the Assessment Summary and the Comprehensive Care Plan will be referred to as the Support Plan.

Certified Assessor: A person who completes training and obtains certification from DHS and performs Long Term Care Consultation assessments. For MSHO and MSC+, all Care Coordinators except physician assistants, nurse practitioners, and physicians acting as Care Coordinators for members in nursing homes must be Certified Assessors providing both the assessment and ongoing case management functions for Enrollees, including support planning services.

Change of Condition: A change in the health of the member that triggers an increase or decrease in the need for services. Changes in activities of daily living (ADLs), independent activities of daily living (IADLs), or other supports may indicate a change in condition. It is up to the professional judgment of the CC to determine if a change in member condition merits a reassessment. 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.

Engagement Coordinator (EC): A non-clinical employee of Medica that provides outreach efforts to MSC+ and SNBC members on their caseload that have refused Care Coordination or are unable to be reached with

the goal of successfully engaging members. Upon engagement and acceptance of ongoing care coordination, the EC will transfer the member to a CC who begin the Care Coordination process.

Essential Services: Services that must remain uninterrupted to ensure the life, health, and/or safety of the enrollee.

Informed Choice: A voluntary decision made by the member or the member's legal representative, after becoming familiar with the alternatives, and having been provided sufficient relevant written and oral information at an appropriate comprehension level and in a manner consistent with the member's or the member's legal representative's primary mode of communication.

Legal Guardian: An individual with authority to make decisions on behalf of another person, limited by court-issued documents which state the roles and responsibilities of the guardian. Whenever possible the guardian should support the choices of the person for whom s/he is a guardian. Unless specifically stated in the guardianship documents, the person under guardianship retains decision making authority.

Personal Health Information (PHI): Under HIPAA (Health Insurance Portability and Accountability Act), Protected Health Information is individually identifiable health information, held or maintained by a covered entity or its business associates acting for the covered entity, that is transmitted or maintained in any medium. This includes identifiable demographic and other information relating to the past, present or future physical or mental health or condition of an individual, or the provision or payment of health care to an individual that is created or received by a health care provider or health plan PHI includes oral information and information records in any form or medium. PHI does not include data that is de-identified or aggregated information.

Person-Centered Principles and Practices: Assurance that people have the opportunity for meaningful choice and self-determination, and that their civil and legal rights are affirmed and respected. This includes: (1) Treating each person with dignity, respect, and trust; (2) Building on his or her strengths and talents; (3) Helping him or her connect with his or her community and developing relationships; (4) Listening to and acting on his or her communication to you; (5) Making a sincere effort overall to understand him or her as a unique person realizing that quality of life is different for each individual; (6) Understanding and demonstrating how to balance preferences and health and safety; (7) Honoring the person's ability to express choice and preferences; (8) Promoting and establishing a shared vision between the person and his or her team.

Person-Centered Service Plan: The services and supports that are important to the individual to meet the needs identified through an assessment of functional need as well as what is important to the individual with regard to preferences for the delivery of such services and supports.

Self-Management Interventions: Interventions that are carried out by the member to take responsibility for all or part of their medical and/or social needs.

PURPOSE:

To clarify the role of Care Coordination/Care Management services that are designed to ensure access and integrate the delivery of all Medicare and Medicaid preventive, primary, acute, post-acute, rehabilitation, and long term care services, including State Plan Home Care Services, and Elderly Waiver (EW) services to MSHO/MSC+ Enrollees. Care Coordinators serve as member advocates; they are instrumental in identification

and coordination of person centered principles and practices to keep members in the least segregated settings, and promote appropriate utilization and self-management.

POLICY:
Every Medica MSHO/MSC+ member is assigned a Care Coordinator (CC)/Engagement Care Coordinator (EC). Medica will assign a CC based on the member's identified Primary Care Provider (PCP). CCs will perform the duties of Care Coordination and care management as described in DHS and Centers for Medicare & Medicaid Services (CMS) contracts as well as performs other duties assigned by Medica. The CC serves as the primary contact for member needs.

PROCEDURE:

1. CCs will perform Care Coordination duties in accordance with case and care management requirements as outlined in the DHS contract, CMS regulatory requirements, and Medica policies and procedures.

2. CCs will be informed of and comply with basic member protection requirements, including data privacy.

3. CCs will provide the name and telephone number of the CC to the member within ten (10) days of new assignment or change of CC.

4. CCs will conduct the initial Health Risk Assessment (HRA), using the appropriate HRA tool, within thirty (30) days of enrollment for MSHO members and MSC+ EW members or within sixty (60) days of enrollment for MSC+ Non-EW, Non-PCA members.
   a. Members have a right to make choices about assessments, contacts, and transition planning. If the member declines Care Coordination/Case Management services, CCs should reach out at least annually and upon notice of significant change in condition or a transition in care to readdress if the member is interested in Care Coordination services. Best practice is to engage with the member based on the member specific follow up plan that is created following the HRA. Medica requires the CC to attempt engagement with a member every 6 months, at a minimum.
   b. If the member is unable to be reached or refuses assessment and/or Care Coordination/Care Management services, documentation of attempted contact (for those unable to be reached) or the discussion with the member (for those who refuse) is required in the member's chart. Note: Members receiving EW services and/or PCA services must receive a re-assessment annually in order to maintain eligibility for these services in accordance with DHS guidelines.
   c. Use of alternate assessments and alternate forms of assessment contact type must be approved by Medica. Medica will accept tribal assessments by Tribal Assessors.

5. CCs will conduct reassessments, at least annually, within three hundred and sixty five (365) days of the previous assessment, and as necessary with a change in member condition.

6. CCs will use the HRA to identify health risks and chronic conditions, including but not limited to: (1) ADLs, (2) risk of hospitalizations, (3) need for primary and preventive care, (4) behavioral health needs, (5) rehabilitative services, and (6) protocols for follow up to assure that physician visits,

additional assessments or Care Coordination/Care Management interventions are provided when indicated.

7. CCs will enter the required information collected through the HRA into the Medicaid Management Information System (MMIS), for all members except those identified as institutional members. Following the launch of the revised MnCHOICES application and upon notice by the state, all assessments shall be maintained within the MnCHOICES application.

8. CCs will facilitate Advance Directive discussions annually with the member and/or authorized family members or legal guardians based on individual member needs and cultural considerations.

9. CCs will develop, monitor, and update the member's Care Plan based on the HRA and person-centered principles and practices within thirty (30) days of HRA completion.
    a. The Care Plan will include risks and needs identified through the HRA, prioritizing the goals, preferences, desired level of involvement, and self-management plans of members, authorized family members, legal guardians, and caregivers.
    b. The Care Plan will incorporate the individual member's unique strengths, assets, interests, wishes, expectations, hopes, strengths, resources, cultures, goals, and need for support.
    c. The Care Plan will identify if essential services are in place and if so what the backup plan is.
    d. The Care Plan will identify person-centered SMART goals, target dates, supports needed, notes monitoring progress/goal revision, and outcome or goal achievement dates.
    e. In addition to the prioritized goals listed above, those risk findings related to member identified medical or environmental safety should be considered among the highest priority.
    f. Only person-centered prioritized goals belong on the Care Plan. Members have a right to decline goals. When a member declines a goal, documentation on the HRA, Care Plan, or in the member's clinical notes should indicate why a goal is being declined. If safety concerns are involved, the Care Plan must include a Risk Plan.
    g. The Care Plan should attempt to increase quality of life, not simply maintain it. CCs will evaluate, identify, and coordinate available medical and non-medical supports and services to meet the member's needs identified in the HRA.
    h. The Care Plan shall employ an interdisciplinary and holistic approach by incorporating unique primary care, acute care, long-term care, behavioral health, and social service needs that the member identifies.
    i. The Care Plan should incorporate covered Medicare services, Medicaid services, and services available through the formal, informal, and quasi formal Home and Community Based Services (HCBS) as identified on the HRA. The Care Plan should also include services that were offered to the member, but declined.
    j. Discussion with the member and/or authorized family members, legal guardians, or other people of the member's choosing will occur prior to finalizing the Care Plan. The member must approve the Care Plan.
    k. The member maintains control of the Care Plan and information included. The member drives the planning process and formulating the plan, to the level he or she chooses. The member determines how Care Plan information is shared, who will receive it, and which sections of the Care Plan will be shared. The CC supports the member's decisions. At a minimum, for members receiving EW services (excluding Community Directed Community Supports (CDCS), Specialized Supplies and Equipment, and Personal Emergency Response

System), PCA services for EW members, or Housing Stabilization Services (HSS), CCs must attempt to obtain agreement from providers of the services and supports in the Care Plan and their agreement to deliver them as outlined. This must be updated with changes to the Care Plan that affect how EW services are provided. Changes may include:
    i. Change in hours/units
    ii. Change in provider
    iii. Addition of new provider

l. The member can request a change in the Care Plan at any time. Care Plans should be revised to address changes in the member's life and changes in the member's choices regarding services, supports, and providers. Any changes in services and supports require the CC to send a copy of the revised Care Plan to the member.

10. CCs will assist the member and/or authorized family members or legal guardians to maximize informed choices of services and control over services and supports based on information and experience, unrestricted by current resources or services.

11. CCs will schedule follow-up contacts and communication with the member and/or authorized family members or legal guardians based on member request, identified risk, needs, and frailty.

12. CCs will monitor the progress toward achieving the member's and/or authorized family members or legal guardian's prioritized goal outcomes in order to evaluate and adjust the timeliness and adequacy of services in the Care Plan.
    a. CCs will promote self-management activities, when applicable. If Self-Management Interventions are in place, the CC will clarify with the member and/or authorized family members or legal guardians that the interventions are acceptable and doable.
    b. Underlying barriers to meeting outcomes and complying with the Care Plan will be identified. Revision and enhancement of the Care Plan may be completed through written or verbal communication with the member and/or authorized family members or legal guardians.
    c. Assessment of a member's Care Plan outcome goal achievement progress may be completed during telephonic follow-up, during home visits, due to a change in member condition, and/or following a transition in care.
    d. Documentation of the goal outcomes will be completed at a minimum annually. It should include the date the goal has been achieved or revised and if it will be carried forward to the updated Care Plan.

13. CCs must verify the member has been offered a choice of supports and services, also that the member agrees with the Care Plan, and agrees with services and providers authorized by the CC.

14. CCs will educate the member and/or authorized family members or legal guardians about good health practices, the importance of wellness and preventative health care, and strategies to help avoid emergency room use and prevent hospital admissions/readmissions.
15. CCs will facilitate annual physician visits for primary and preventive care. CCs may assist the member and/or authorized family members or legal guardians in scheduling annual visits. CCs will provide a summary of assessment and care plan results to the primary care physician at least annually.

16. CCs will collaborate with the Interdisciplinary Care Team (ICT) based on the member's assessed physical, emotional, and service needs. ICT team members will be listed in the member's chart.

17. CCs will collaborate with Local Agency case managers, financial workers and other staff, as necessary, including use of the DHS form "Lead Agency Assessor/Case Manager/Worker LTC Communication Form," Form # 5181 as provided by the State.

18. CCs will collaborate with lead agencies, waiver workers, or county case managers on the authorization of medical assistance home care services to prevent duplication of services and to coordinate services in the most seamless way possible for the member using the DHS form "Managed Care Organization/County Agency and Tribal Nation Communication Form - Recommendation for State Plan Home Care Services, DHS-5841 as provided by the State. It is expected that a response will occur within 10 (ten) business days of submission for this form. This response time is required by both the CCs and with lead agencies, waiver workers, or county case managers.

19. CCs will collaborate with other providers for members identified as having special needs requiring additional intensive Case Management. Care Coordinators will collaborate with other Care Management and risk assessment functions conducted by appropriate professionals, including Long Term Care Consultation and other screenings to identify special needs. Medica CCs will share with other providers the results of its identification and assessment of that member's needs to prevent duplication of those activities.

20. Medica has been advised by DHS that CCs and waiver workers are permitted to share enrollee information without a release of information based upon an authorization provided at the time of the member's application for Medical Assistance. Medica expects that information will be the minimum amount necessary to perform the required activity.

21. On all fax transmissions, CCs will include a cover sheet that does not include Protected Health Information (PHI), and incorporates a confidentiality statement.

22. CCs will utilize secure email for all email communications containing PHI.

23. CCs will collaborate with Residential Services Living Providers when indicated.

24. Intensive Case Management may be provided within the Care System or County or externally by another provider. This may include:
    a. Case Management for serious and persistent mental illness
    b. Case Management for pre-petition screening
    c. Court ordered treatment, developmental disabilities, assessment of medical barriers to employment
    d. A State medical review team or social security disability determination
    e. Services offered through social service staff or county attorney staff for enrollees who are victims or perpetrators in criminal cases.

25. CCs will collaborate with social service staff and other community resources such as Area Agencies on Aging (AAA). Coordination with Local Agency social service staff is required when a member is in need of the following services:
    a. Pre-petition Screening;
    b. OBRA Level II Screening for Mental Health and Developmental Disability;
    c. Spousal Impoverishment Assessments;
    d. Adult Foster Care;
    e. Group Residential Housing Room and Board Payments;
    f. Substance Use Disorder (SUD) room and board services covered by the Consolidated Chemical Dependency Treatment Fund;
    g. Adult Protection
    h. Local Human Service Agencies for assessment and evaluation related to judicial proceedings.

26. CCs will collaborate with services and supports provided by the Veterans Administration (VA) for members eligible for VA services.

27. CCs will make referrals to specialists and sub-specialists including those with geriatric expertise when appropriate.

28. CCs will inform, educate, and assist the member and/or authorized family members or guardians with health plan related issues and with accessing needed resources and services beyond the limitations of the Medicaid and Medicare benefit sets. This may include identifying available benefits, services, and providers; assisting with resolving claims or cost sharing inquiries; and informing members of their rights to pursue grievances and appeals under the Medicaid and/or Medicare program.

29. CCs will provide information regarding services, including procedures for promoting rehabilitation of members following acute events, and for ensuring smooth transitions and coordination of information between acute, sub-acute, rehabilitation, Nursing Facilities, and Home and Community Based Services (HCBS) settings.

30. CCs will provide access to an adequate range of Elderly Waiver and Nursing Facility Services and appropriate choices among Nursing Facilities and/or Elderly Waiver services to meet the individual needs of members who are found to require a Nursing Facility Level of Care. These must include methods for supporting and coordinating services with informal support systems provided by families, friends and other community resources. These procedures must also include strategies for identifying Institutionalized members whose needs could be met as well or better in non-Institutional settings and methods for meeting those needs, and assisting such Institutionalized members in leaving the Nursing Facility. , as appropriate

31. CCs will collaborate with the Senior Linkage Line and other social service staff to ensure that the Pre Admission Screening (PAS) process is completed.
    a. CC is responsible to:
        i. Perform determinations of the need for Nursing Facility level of care;
        ii. Complete OBRA Level I Screening;
        iii. Provide documentation of the PAS result to the admitting nursing facility;

iv. Forward, if appropriate, to the county for OBRA Level II activity;
v. Enter PAS information into MMIS using the Long Term Care Screening document, if the consumer is not on a waiver program participant at the time of admission and
vi. Follow the process related to exiting individuals from the Elderly Waiver program if the admission exceeds 30 days.
vii. Provide relocation assistance to all of their enrolled members.

32. CCs will ensure that planned and unplanned transitions between settings of care are well managed and smooth with a consistent person supporting the member and/or authorized family members or guardians throughout the transition.

33. CCs will participate in Performance Improvement Projects (PIP) and Chronic Condition Improvement Plans (CCIP) as requested by Medica.

    CCs will assist and support members during transition periods between programs, care systems, agencies, counties, and health plans to ensure that timely, effective, and efficient communication occurs in order to maintain continuity of services and avoid unnecessary disruption that may negatively impact the member. CCs should use the DHS form "HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form" DHS 6037 as provided and directed by the State.

34. CCs will ensure that members are living in the most integrated setting that is the preferred option, unless the member is opposed to moving. (See DHS Person-Centered, Informed Choice, and Transition Protocol and My Move Plan Summary DHS 3936). The My Move Plan is required to be offered when an EW member is moving from his or her home. Information about the My Move Plan can be located here: https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-312487

35. Annually, CCs will share the process for filing a grievance, reporting dissatisfaction with services received from their CC, or how members can request a different CC.

36. In the event of large transfers of new members into Medica with the same enrollment date, and if Medica determines that meeting the DHS timelines for assessments cannot be met, Medica may submit a transition plan to DHS indicating the timeline in which they expect to be able to conduct the initial assessment. Medica will notify the Care Systems, Agencies, and Counties affected if an extension has been granted by DHS.

Cross References:
DHS Person-Centered, Informed Choice, and Transition Protocol and My Move Plan Summary DHS 3936
MSHO/MSC+ DHS Contract
DUAL Solution Model of Care

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