Policy Title:	**Unable to Reach/Refusing Member**
Department:	**Markets Growth & Retention**
Business Unit:	**Medicaid and Special Needs Plan**
Approved By:	**Director, Medicaid SNP Member Solutions & Innovation**
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PRODUCTS AFFECTED

- Minnesota Senior Health Options (MSHO) – Medica DUAL Solution®
- Minnesota Senior Care Plus (MSC+) – Medica Choice Care℠ MSC+
- Special Needs BasicCare (SNBC) – Medica AccessAbility Solution®
- Integrated Special Needs BasicCare (I-SNBC) – Medica AccessAbility Solution Enhanced®

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.

CMS: The Centers for Medicare & Medicaid Services

DHS: The Minnesota Department of Human Services

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 begins the Care Coordination process.

Refusal Member: A member that has been located either by mail or phone but declines an initial assessment or reassessment and/or Care Coordination.

Unable to Reach Member: A member that is unable to be reached via contact by phone or by mail and therefore is not available to complete a health risk assessment (HRA).[1] Commonly referred to as "missing member" (MM) or "unable to reach member" (UTR).

PURPOSE

[1] Throughout this policy, the terms "HRA" and assessment are used to refer to assessments completed both within and outside of MnCHOICES (e.g., MnCHOICES Assessment, MnCHOICES HRA, DHS 3428H, LTCC).

To clarify the role of the Care Coordinator/Engagement Coordinator when a member is unable to be reached or declines an assessment and/or Care Coordination

POLICY

Every Medica member is assigned a Care Coordinator (CC) or Engagement Coordinator (EC). CC/EC are required to account for outreach activities to members that are unable to be reached or declines assessment and/or Care Coordination.

All members will be contacted by CC/EC upon initial or transfer enrollment in the product as well as annually thereafter to offer a HRA and Care Coordination. See Assessment Schedule Policy for timeline requirements. The CC/EC must document all contact attempts in accordance with DHS, CMS and Medica requirements.

PROCEDURE

UNABLE TO REACH

1) If CC/EC is unable to contact a member after a minimum of three non-automated telephonic attempts and sending a letter, the member is considered an Unable to Reach Member.
    a. CC/EC must make and document a minimum of three non-automated phone call attempts and send the Medica Ongoing No Contact Letter to reach the member. It is best practice to make the call attempts on three different days at various times of the day.
    b. If the CC does not have a valid phone number or address for the member, suggested resources to locate member contact information include the following: County Financial Worker, Waiver Worker, Primary Care Provider (PCP), Primary Care Clinic, Pharmacy, Service Providers, Provide A Ride/Qryde, Medicaid Management Information System (MMIS), Restricted Recipient Program, MNITS, or other internet search options.
        i. Although an attempt to obtain alternative member contact information is not considered an outreach attempt, resources used to try and locate member contact information must be documented in the member's record.
    c. CC/EC is required to document all contact attempts in the member's record (three calls and the letter) and send the Member Engagement Questionnaire, Medica Leave-Behind Document, and Ongoing No Contact Letter to all Unable to Reach Members.
    d. Upon completion of required contact attempts (three calls and the letter), the CC/EC will enter relevant information about the Unable to Reach Member either in MMIS or in MnCHOICES.
        i. If working outside of MnCHOICES, Unable to Reach information must be entered in MMIS. See below for MMIS entry guidance.
        ii. If working in the MnCHOICES application, no MMIS entry is needed, but the CC/EC must create an HRA in MnCHOICES to identify the member as Unable to Reach. See below for MnCHOICES entry guidance.
        iii. The date of the unable to reach assessment that should be entered in MMIS or MnCHOICES is the date of the last attempt to contact the member (either the date of the third call attempt or the date of the Ongoing No Contact letter, whichever is later). Note: An Unable to Reach assessment is not considered a valid assessment if the CC/EC does not have a valid phone number for the member and the three telephonic contact attempts did not occur.
    e. Additional requirements for MSHO and I-SNBC members:

i. CC will complete the Medica Unable to Contact/Refusal Care Plan based on information known about the member. (optional for MSC+ and SNBC members). It is expected that the Care Plan will be updated as the CC is made aware of changes or on an annual basis at a minimum. The Unable to Contact/Refusal Care Plan should document the dates of the three call attempts and the date of the Ongoing No Contact Letter.
ii. CC must complete the Unable to Contact/Refusal Care Plan for all MSHO and I-SNBC Unable to Reach members, whether working in MnCHOICES or outside of MnCHOICES. If working in MnCHOICES, upload the Unable to Contact/Refusal Care Plan in MnCHOICES.
iii. if a member returns the Member Engagement Questionnaire the CC will document this in the member's record, update the member's Unable to Contact/Refusal Care Plan with provided information (e.g., PCP contact information, health concerns, mental health concerns, assistance needed, current supports, housing/food/transportation concerns, member goals), and follow up with the member consistent with their wishes.
iv. If the member indicates who their PCP is, or if the CC has identified the member's PCP from another source, the CC will communicate a summary of known member needs to the PCP which may indicate that they have been unable to contact the member to complete an HRA. This communication must also include the CC contact information.
    1. The PCP, when identified, as well as other individuals that the member identifies as part of the ICT (Interdisciplinary Care Team) should be documented in the Care Plan.
    2. If a PCP is not identified, and the member does not identify any other individuals they would like on the ICT, the ICT will consist of the member/responsible party and the CC.
v. Upon notification of a transition of care
    1. CC will attempt to follow up with the member and complete required transition of care activities. See Transition of Care Policy for additional information.
    2. CC will update the Care Plan with transition information.

f. If the member is on the Elderly Waiver or is receiving PCA/CFSS services and the waiver span has time remaining, authorize the services necessary until the waiver span or PCA/CFSS authorization is due to close. If a new assessment is not completed by the end of the waiver span or PCA/CFSS service authorization, a Denial, Termination, Reduction (DTR) for the waiver and/or all applicable services will be needed if the member is not able to be located to complete the required annual assessment by the end of the waiver span. See DTR Policy for additional information. Consultation with Medica Clinical Liaison may be warranted in these situations.
g. If the member is on the Elderly Waiver or is receiving PCA/CFSS services and the waiver span is due to close, a Denial, Termination, Reduction (DTR) for the waiver and/or all applicable services will be needed if the member is not able to be located to complete the required annual reassessment by the end of the waiver span. See DTR policy for additional information. Consultation with Medica Clinical Liaison may be warranted in these situations.

h. CC/EC is expected to make additional attempts to engage members during the year based on Enhanced Care Coordination (ECC) report, notification of changes in condition, or notification of transitions of care; at a minimum, outreach must occur annually to attempt to complete an assessment.
i. Reassessment timelines:
    i. Members with a fully completed assessment are due for reassessment within 365 days of the most recent fully completed assessment date **or**
    ii. Members that have not had a fully completed assessment and have not been enrolled in the product for over 365 days are due for reassessment within 365 days of member's enrollment date

REFUSAL

2) If CC/EC can contact the member, or someone authorized to speak on the member's behalf, and there is explicit communication that the member does not want to participate in an assessment after being offered the opportunity to do so the member is considered a Refusal Member.
    a. This communication must come from the member or an individual authorized to speak on behalf of the member, group home staff or other Case Managers cannot refuse the HRA on a member's behalf unless it is clear the member has given them authorization to do so on their behalf.
    b. CC/EC must document all discussions regarding the member's refusal to participate in an assessment in the member record.
    c. CC/EC is required to send a Member Engagement Questionnaire, Medica Leave-Behind Document, and Member Refusal Letter to all Refusal Members.
    d. Following the discussion with the member/authorized party during which they explicitly declined to participate in the assessment, the CC/EC will enter relevant information about the refusal either in MMIS or in MnCHOICES.
        i. If working outside of MnCHOICES, refusal information must be entered in MMIS. See below for MMIS entry guidance.
        ii. If working in the revised MnCHOICES application, no MMIS entry is needed, but the CC/EC must create an HRA in MnCHOICES to identify the member as a Refusal Member. See below for MnCHOICES entry guidance.
        iii. The date of refusal is the date of the refusal conversation with the member, or a person authorized to speak on the member's behalf when they indicated the member was declining to participate in the assessment process at that time.
    e. Additional requirements for MSHO and I-SNBC members:
        i. CC will complete the Medica Unable to Contact/Refusal Care Plan based on information known about the member. (optional for MSC+ and SNBC members). It is expected that the Care Plan will be updated as the CC is made aware of changes or on an annual basis at a minimum. The Unable to Contact/Refusal Care Plan should document the date of the conversation with the member/authorized party and should summarize the discussion that occurred with the member/authorized party.
        ii. CC must complete the Unable to Contact/Refusal Care Plan for all MSHO and I-SNBC Refusal Members, whether working in MnCHOICES or outside of MnCHOICES. If working in MnCHOICES, upload the Unable to Contact/Refusal Care Plan in MnCHOICES.

iii. If a member returns the Member Engagement Questionnaire, the CC will document this in the member's record, update the member's Unable to Contact/Refusal Care Plan with provided information (e.g., PCP contact information, health concerns, mental health concerns, assistance needed, current supports, housing/food/transportation concerns, member goals), and follow up with the member consistent with the member's wishes.
iv. If the member indicates who their PCP is, or if the CC has identified the member's PCP from another source, the CC will communicate a summary of known member needs to the PCP which may indicate that the member declined to participate in an HRA. This communication must also include the CC contact information.
    1. The PCP, when identified, as well as other individuals that the member identifies as part of the ICT should be documented in the care plan.
    2. If a PCP is not identified, and the member does not identify any other individuals they would like on the ICT, the ICT will consist of the member/responsible party and the CC.
v. Upon notification of a transition of care
    1. CC will attempt to follow up with the member and complete required transition of care activities. See Transition of Care Policy for additional information.
    2. CC will update the Care Plan with the transition information.

f. If the member is on the Elderly Waiver or is receiving PCA/CFSS services and the waiver span has time remaining, authorize the services necessary until the waiver span or PCA/CFSS authorization is due to close. If a new assessment is not completed by the end of the waiver span or PCA/CFSS service authorization, a Denial, Termination, Reduction (DTR) for the waiver and/or all applicable services will be needed if the member does not complete the required annual assessment by the end of the waiver span. See DTR Policy for additional information. Consultation with Medica Clinical Liaison may be warranted in these situations.
g. If the member is on the Elderly Waiver or is receiving PCA/CFSS services and the waiver span is due to close, a Denial, Termination, Reduction (DTR) for the waiver and/or all applicable services will be needed if the member does not complete the required annual reassessment by the end of the waiver span. See DTR policy for additional information. Consultation with Medica Clinical Liaison may be warranted in these situations.
h. CC/EC is expected to make additional attempts to engage members during the year based on Enhanced Care Coordination (ECC) report, notification of changes in condition, or notification of transitions of care; at a minimum, outreach must occur annually to attempt to complete an assessment.
i. Reassessment timelines:
    i. Members with a fully completed assessment are due for reassessment within 365 days of <u>the most recent fully completed assessment</u> date **or**
    ii. Members that have not had a fully completed assessment and have not been enrolled in the product for over 365 days are due for reassessment within 365 days of <u>member's enrollment date</u>

<u>UNABLE TO MEET TIMELINE:</u>

3) If CC can contact the member, but the member is not able to schedule an assessment within the required timeline per the Assessment Schedule Policy (scheduling conflicts, illness, weather hazards, etc.):
    a. CC will document all member discussions in the member's record.
    b. CC will enter a Refusal assessment in MMIS to meet required timelines per DHS guidance. Date of refusal is the date the CC spoke with member or responsible party, and they were not able to schedule HRA within the required timelines.
        i. This does not meet CMS guidance as a valid refusal assessment.
    c. If the member is on the Elderly Waiver or is receiving PCA/CFSS services and the waiver span has time remaining, authorize the services necessary until the waiver span or PCA/CFSS authorization is due to close. If a new assessment isn't completed by the end of the waiver span or PCA/CFSS service authorization, a Denial, Termination, Reduction (DTR) for the waiver and/or all applicable services will be needed if the member is not able to complete the required annual assessment by the end of the waiver span. See DTR Policy for additional information. Consultation with Medica Clinical Liaison may be warranted in these situations.
    d. If the member is on the Elderly Waiver or is receiving PCA/CFSS services and the waiver span is due to close, a Denial, Termination, Reduction (DTR) for the waiver and/or all applicable services will be needed if the member is not able to complete the required annual reassessment by the end of the waiver span. See DTR policy for additional information. Consultation with Medica Clinical Liaison may be warranted in these situations.
    e. Complete HRA on scheduled assessment date.
    f. Proceed with all assessment and standard paperwork. See Assessment Schedule Policy for additional information.
    g. If member cancels the assessment, or a full HRA is not completed:
        i. Follow unable to reach/refusal process as described above.

MMIS Entry (When working with Legacy Documents, NA when working in MnCHOICES)

Enter refusal or unable to reach in MMIS by the last business day of the enrollment month (for MSHO members), by the 60th day of enrollment (for MSC+, SNBC, and SNBC Enhanced members), or by the last business day of the reassessment month. Timelines are required for both initial assessments and annual reassessments. (MSHO and MSC+ nursing facility members and transferred members with an open elderly waiver (EW) span DO NOT get entered in MMIS). See DHS edoc #4669 and DHS edoc #5020A for detailed information related to MMIS entry.

MSHO/MSC+	• Complete screening document 3427H • Activity Type 07-Administrative Activity • Assessment Result 39 and Program Type 18 for members who have refused an assessment • Assessment Result 50 and Program Type 18 for unable to reach/member not found for the health risk assessment • Activity Type Date is the last day you attempted to reach the member verbally or via letter, or the date the member refused the HRA. • Do not enter refusal/UTR into MMIS for MSHO/MSC+ members in nursing facilities or transferred members with an open elderly waiver span. Members transferred to Medica with an open waiver span should remain eligible for EW until such time as CC

	is unable to complete the required reassessment required for EW. For these members, CC should complete MMIS entry to change the Care Coordinator using activity type 05, as directed in the Medica Assessment Schedule Policy.
SNBC/I-SNBC	• Complete screening document 3427H • Activity Type 07 • Assessment Result 39 and Program Type 28 for members who have refused an assessment. • Assessment Result 50 and Program Type 28 for unable to reach/member not found for the health risk assessment. • Activity Type Date is the last day you attempted to reach the member verbally or via letter, or the date the member refused the HRA.

MnCHOICES Entry (When working in MnCHOICES platform)

MSHO/MSC+ SNBC/I-SNBC	• Record the date of the last outreach attempt (call three or letter) for Unable to Reach members or the date of the conversation with the member/authorized representative for Refusal members. • Create an HRA • Complete the required fields in the ""Member Information"" and ""Assessment Information"" sections. • To indicate it's an Unable to Reach or Refusal member, choose the appropriate option in the Assessment Results dropdown. • Remember to Change the HRA status to ""Complete.""

At any time, if a member requests an assessment or is agreeable to an assessment when offered, the CC is to schedule time to meet with the member within 20 calendar days of the request.

Supplemental Documents CC is required to share with member annually:
Mail the following applicable documents to Unable to Reach/Refusal members:

- Ongoing No Contact Letter or Member Refusal Letter
- Medica Care Coordinator Leave-Behind Document
- Member Engagement Questionnaire
- CC/EC contact information
- Any other documents that may benefit the member such as "When and Where to Get Care," etc.

Supplemental Documents CC is required to share with the PCP annually:
Mail the following applicable documents to an Unable to Reach/Refusal member's PCP, when identified:

- PCP Letter- Unable to Reach or Refusing

Considerations

- If there is a safety concern with completing the assessment in the member's home, it is recommended the CC request another CC or staff member to accompany them to the home assessment or offer to see member in a public venue. Note – if the CC has further concern or questions, they may contact the Medica Clinical Liaison for consultation.
- Medica retains the ability, at any time, to reassign members who are unable to be reached or members who have refused the HRA and/or care coordination.

Unable to Reach/Unable to Locate Summary of Requirements	• Three non-automated phone attempts • If contact information is invalid, attempt to obtain updated information • Documentation of attempts to reach present in member record (on the Unable to Contact/Refusal Care Plan or in case notes). • Send On-Going No Contact Letter (including Medica CC Leave- Behind document, Member Engagement Questionnaire, and other supplemental documents as indicated) • MnCHOICES/MMIS entry (Date of last contact attempt should be used, either the third call attempt or the letter) • Review of Medica reports to identify PCP • If PCP identified, send PCP Unable to Reach/Refusing letter • Create UTR/Ref Care Plan (Required for MSHO/I-SNBC member, optional for MSC+ SNBC member) • Update Care Plan (return of Member Engagement Questionnaire, update re: PCP, transitions, etc.) at least annually.
Refuser Summary of Requirements	• The refusal must be obtained from the member, or someone authorized to speak on their behalf, and there must be explicit communication that the member does not want to participate in an assessment after being offered the opportunity to do so. Documentation of refusal discussion present in member record (on the Unable to Contact/Refusal Care Plan or in case notes). • Send Member Refusal Letter (including Medica CC Leave-Behind document, Member Engagement Questionnaire, other supplemental documents as indicated) • MnCHOICES/MMIS entry (Date of refusal) • IF PCP identified, send PCP Unable to Reach/Refusing Letter. • Documentation must be present if member refuses mailing of materials, ongoing contact, or PCP contact/inclusion in ICT • Create UTR/Ref Care Plan (Required for MSHO/I-SNBC member, optional for MSC+/SNBC member) • Update Care Plan (return of Member

	Engagement Questionnaire, update re: PCP, transitions, etc.) at least annually.

CROSS REFERENCES:
Assessment Schedule Policy (MSHO/MSC+ & SNBC/SNBC Enhanced)
Transition of Care Policy
DTR Policy
Part C Reporting Requirements
DHS edoc #4669
DHS edoc #5020A
MMIS online trainings available through DHS TrainLink
Unable to Reach & Refusal Members FAQ & Scenarios

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