June Quarterly Care Coordination Meeting

June 4, 2024

9am-10:30am

Agenda

- Depression Overview and supportive resources – Medica Behavior Health (MBH) – MBH team
- MSHO Case Management with MBH – MBH Team
- DHS, Medica Updates, Spenddowns and EW Obligations– Becky
- 90-Day Grace Period – Becky
- Date of Death Report - Becky
- Regulatory Quality Updates – Lisa/Courtney
- Support Specialist Overview, Referral Request Forms (RRF) Updates - Angie
- MnCHOICES – Theresa
- Community First Services and Supports (CFSS) - Joy
- CC Reminders - Shelley

DHS Updates

- Announcement of CFSS launch 10/1/24
- Restarting Spenddown collection.
- New Manager of DHS Special Needs Purchasing Team-Chelsea Georgsen (replaced Gretchen Ulbee)

Medica Updates

- New Mailbox for email notifications re: reporting MedicaCCReports@medica.com
- New Support Specialist
- MSHO and ISNBC call campaign completed in Q1, member feedback received
- SNBC Contract requirement of a provider survey. Will be sending survey to dental providers soon.
- Next training for EW and HSS providers will be held July 16th.

Spenddowns and EW obligations – All products

Spenddowns

- Can apply to MSHO, SNBC and ISNBC members depending on their individual financial situation
- DHS manages Spenddown process, and member communications around Spenddowns
- The Spenddown amount is paid to DHS each month, members with 3m of nonpayment will be removed from Managed Care enrollment and be moved to FFS Medicaid.
- Care Coordinators are expected to play a role in educating members related to Spenddowns when questions arise
- Medica communicates to Care Coordinators when members have not paid their spenddown, based on reports received from DHS.
- DHS is working on further refining the reports sent to Medica, and the materials members receive around Spenddowns
- Members may be eligible for MA with a spenddown if they meet all of the following criteria: They have met all other MA eligibility criteria, Their net income exceeds the applicable MA income standard, and their incurred and ongoing medical expenses are equal to or greater than their spenddown.
- MSC+ members with spenddowns are not enrolled into MCO plans and can be disenrolled if they acquire a spenddown.
- MSHO, SNBC and ISNBC Members who acquire a spenddown while already enrolled can remain if they continue to pay their spenddown.
- DHS resources provided to members: DHS edoc 5525 (MSHO/MSC+) and DHS edoc 5373 (SNBC)

Elderly Waiver Obligations

- For our members, applies only to MSHO and MSC+ members and is dependent on their individual financial situation
- The Elderly waiver obligation amt is due to the provider, but only after the provider has submitted a claim to Medica and is told to collect a certain amt from the member to meet the EW obligation the member has.
- DHS provides Medica a report each month of members with an EW obligation which is loaded into our claims system
- EW enrollees with a waiver obligation who are enrolled in a managed care plan cannot use the designated provider option.

90-day grace period

MSHO and SNBC D-SNP (ISNBC):

- These are the members who have the true 90 day "future end date" span, sometimes referred to as the grace period. These members remain on your enrollment lists with a future term date and CCs are to try and figure out how a member's Medicaid coverage could be re-established, and the CC will follow these members for the 90 days, with many of these members having their Medicaid redetermined.
- During these 90 days, Medica continues to pay for services for members during the 90 days and all required care coordination contacts/requirements are to occur and the PMPM for care coordination continues. There is some mention of this in the Assessment Schedule policy.
- Example: MSHO May Enrollment report shows these Expiration (Term) dates. Member with term date of 7/31/24 has lost their MA eligibility and is in "future end date" span. Member with the Expiration date of 12/31/24 remains on Medicaid and this date will "refresh" in December of 2024 and will show a date of 12/31/25 at that time if member remains on MSHO.

SNBC members (Medicaid only):

- Members who have termed for what appears to be eligibility, these members do **not** need to be followed for 90 days, these members have termed from Medica. What we do ask is that the CC try to see if there is something that can be done to help the member regain their coverage because if they get their Medicaid paperwork processed by the county within 90 days, they will come back onto Medica with their eligibility backdated in most cases (will appear as a member who has returned, not a new member). **No claims are paid for services provided after the termination date. Claims will be paid if the members coverage is reinstated without a gap**.

MSHO/MSC+ with eligibility term and DHS expectations:

- DHS outlines the expectations of CCs in the 6037A and we also have information pertaining to this in the MSHO/MSC+ Assessment Schedule policy starting on page 5. This is not a new process, has been in place for many years prior to the PHE. After a member loses their MA eligibility, it is still an expectation that the CC works with the member/financial worker to find out what is happening and assist in getting the MA reestablished if able.
- If the member is on EW, and their MA is **not** reestablished, the CC needs to communicate with the county within 60 days although some counties would like to hear sooner. The reason why these members have a different process is due to the home care (PCA) and EW services that these members might have. MSHO/MSC+ typically leave the health plan due to eligibility which almost always gets re-established.

Date of Death (DOD)Report

The Department of Human Services (DHS) created a process several years ago where Care Coordinators (CCs) are asked to report member deaths to the Manager Care Organization (MCO) and the MCO is to report this to DHS. Please see the following reminders:

- **Only** report member deaths for members currently active on a Medica product [Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), Special Needs BasicCare (SNBC), Integrated Special Needs BasicCare (ISNBC).
- **Do not** report member deaths for members no longer active members (ie. members who have termed from Medica, showing as ineligible for managed care in Minnesota Information Transfer System (MN-ITS).
- DHS provides this information to the county financial workers, although this does NOT replace the current requirement in place for CCs to complete DHS 5181 forms to alert Financial Workers to member changes.

- **Tips for the date of death grid (also see "Field Descriptions" tab on report):**
  - Columns in yellow are required fields and **must** be completed before sending the report into Medica.
  - DHS asks that CC's report who they learned of the member death from in as much detail as you have (columns P and Q).
  - If you are not certain of the exact date of death, you are **NOT** to place the member on the grid.
  - If there is information you do not have, leave that column blank (do not put "N/A" or other notes in those fields)
  - All dates should be entered as MM/DD/YYYY
  - Column P, if you do not have the actual name to include here, leave blank

HRA Timeliness

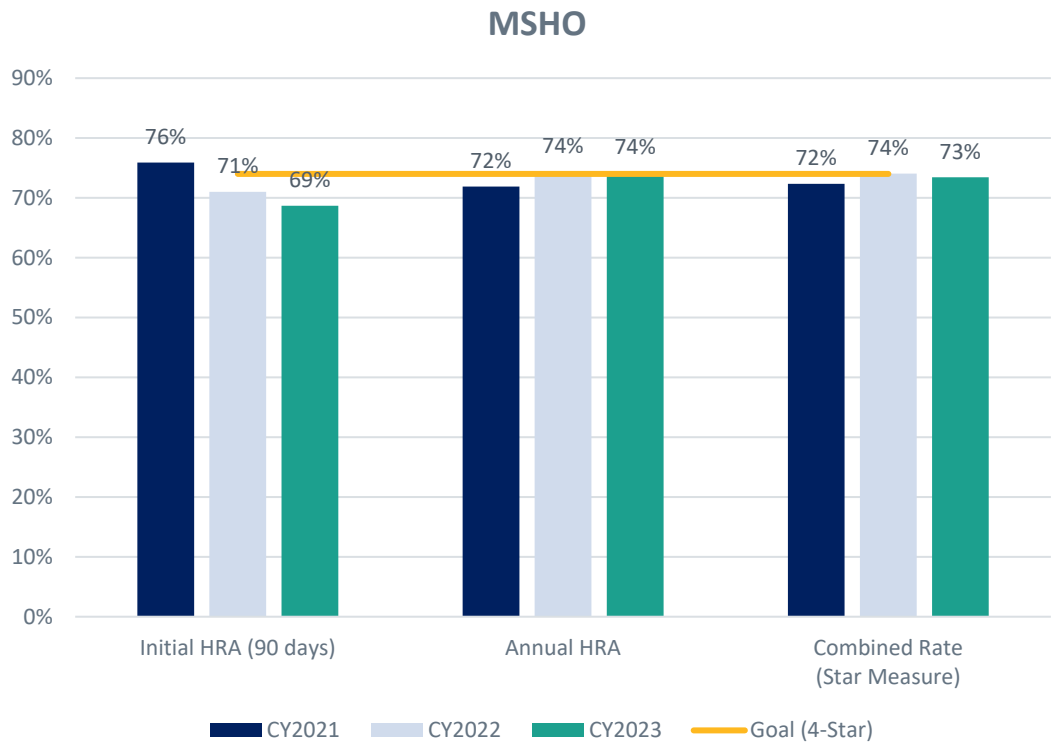
HRA Timeliness – Why Important

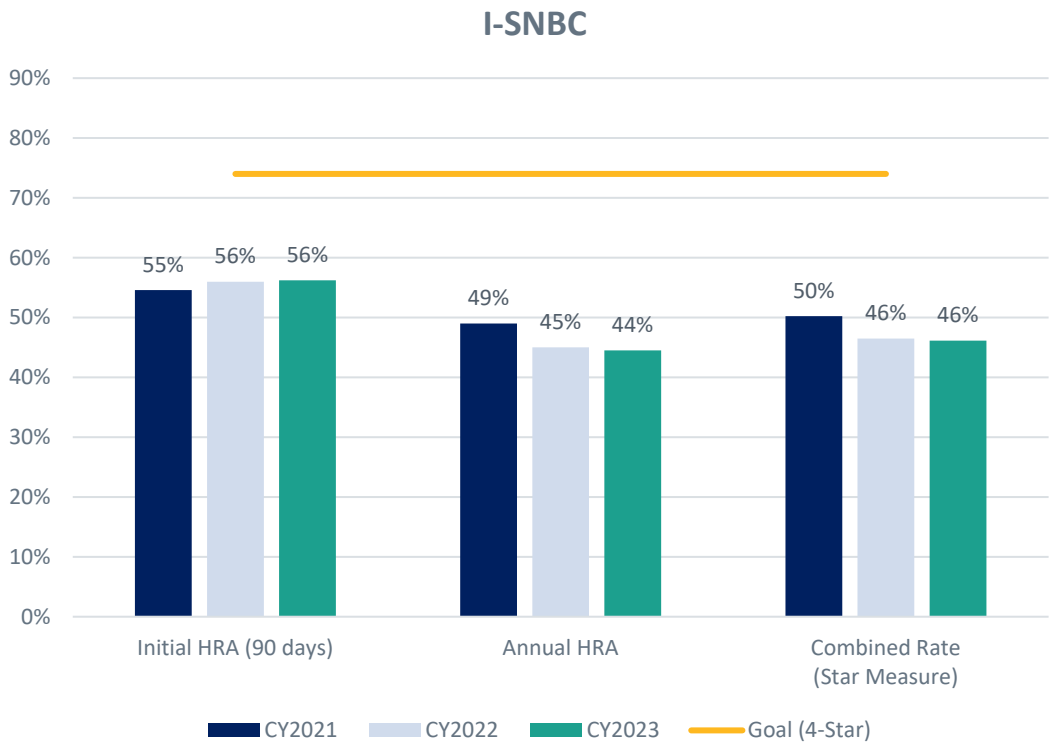
- Timely identification of member needs and preferences
- Regulatory compliance – DHS & CMS
  - DHS contract requirement & audit element
  - CMS Model of Care requirement & audit element (MSHO & I-SNBC)
- Medicare Star Ratings
  - Created by CMS to evaluate the quality performance of Medicare plans (includes MSHO & I-SNBC)
  - Plans rated on 5-point scale
  - Ratings help Medicare beneficiaries choose quality plans
  - High performing plans (Star Rating ≥4) receive a quality bonus that must be used to benefit members (e.g., to offer additional benefits)

Star Rating	Description
★★★★★	Excellent
★★★★	Above Average
★★★	Average
★★	Below Average
★	Poor

CY2023 HRA Timeliness

- MSHO: Decline in initial HRA timeliness since 2021
- I-SNBC: Decline in annual HRA timeliness since 2021
- Rates impacted by UTR/Refusal members

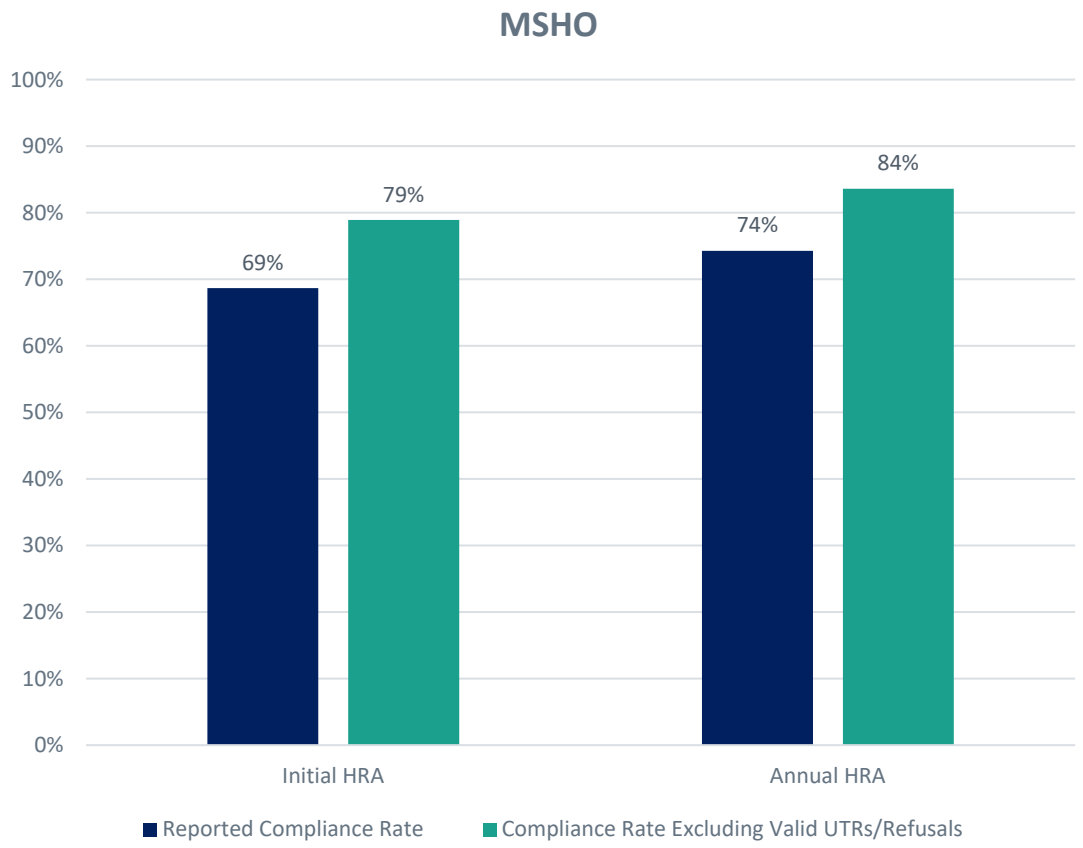


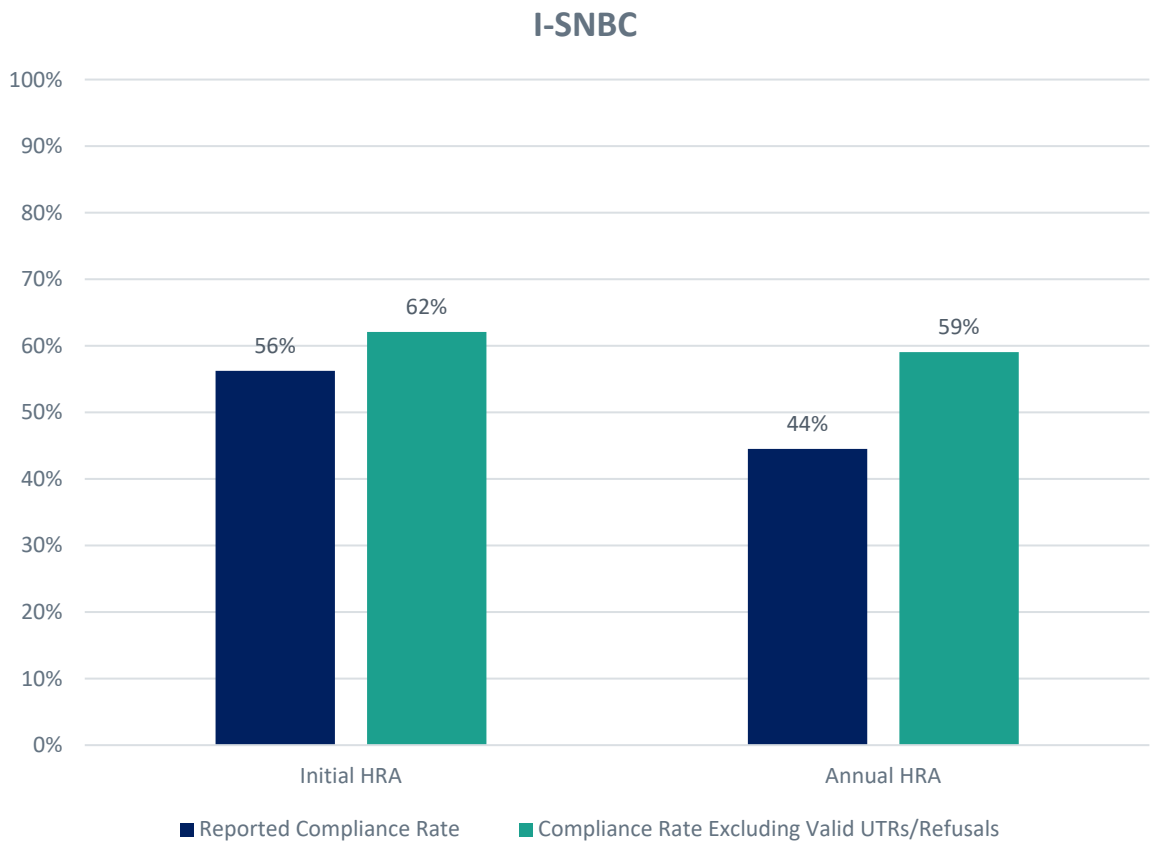


Note: Data shows initial HRAs completed within 90 days (CMS requirement). DHS requirement shorter – 30/60 days

CY2023 HRA Timeliness–UTR/Refusal Impact

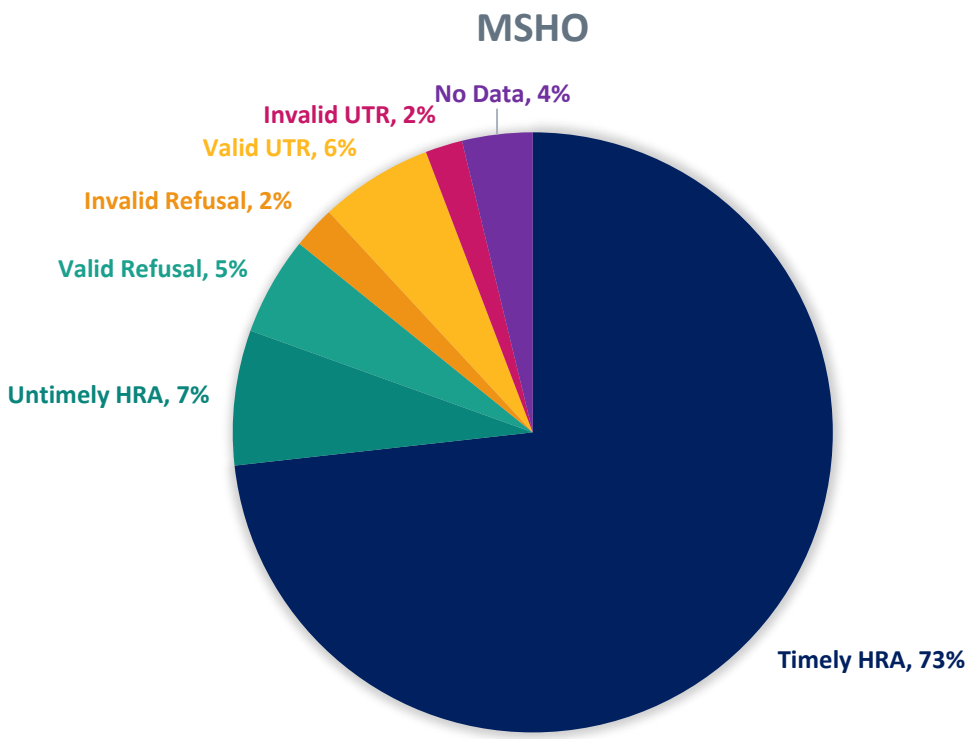
- CMS reported rate includes UTRs & Refusals in denominator (counted as non-compliant)
- Rates for both products impacted
- Valid UTRs/Refusals = met CMS requirements for documentation and timing (true unengagement rate higher)

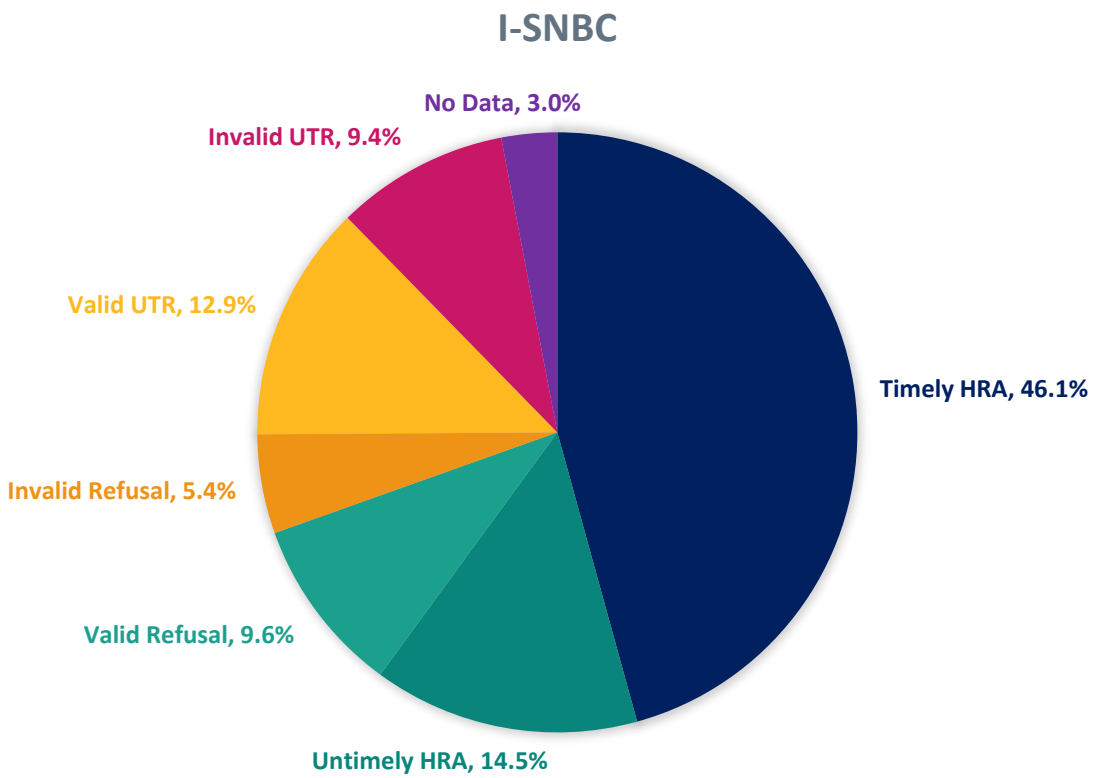




CY2023 HRA Timeliness Breakdown

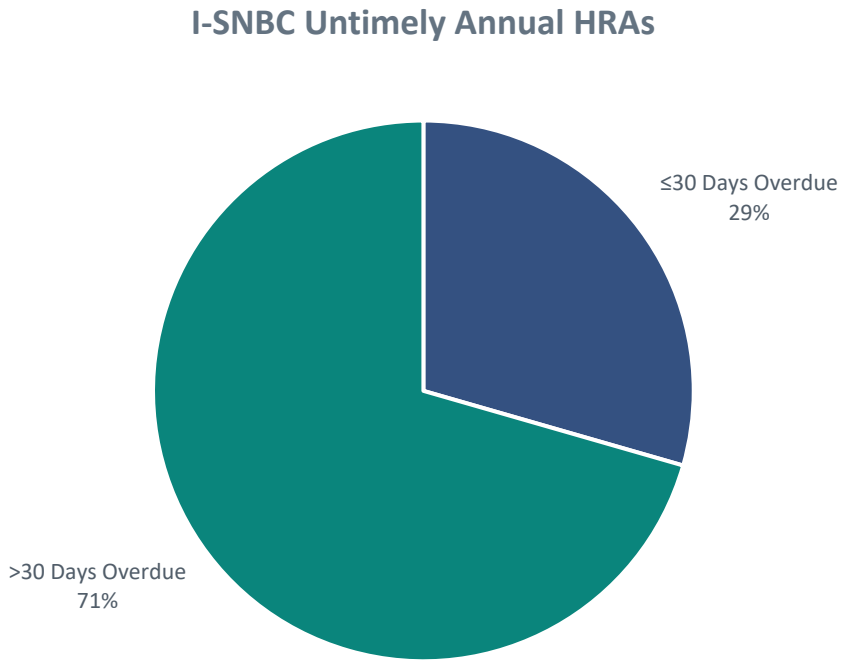
- MSHO: Members without a timely HRA = relatively even mix of untimely HRAs, Refusals, & UTRs
- I-SNBC: Largest group of members without a timely HRA = UTRs

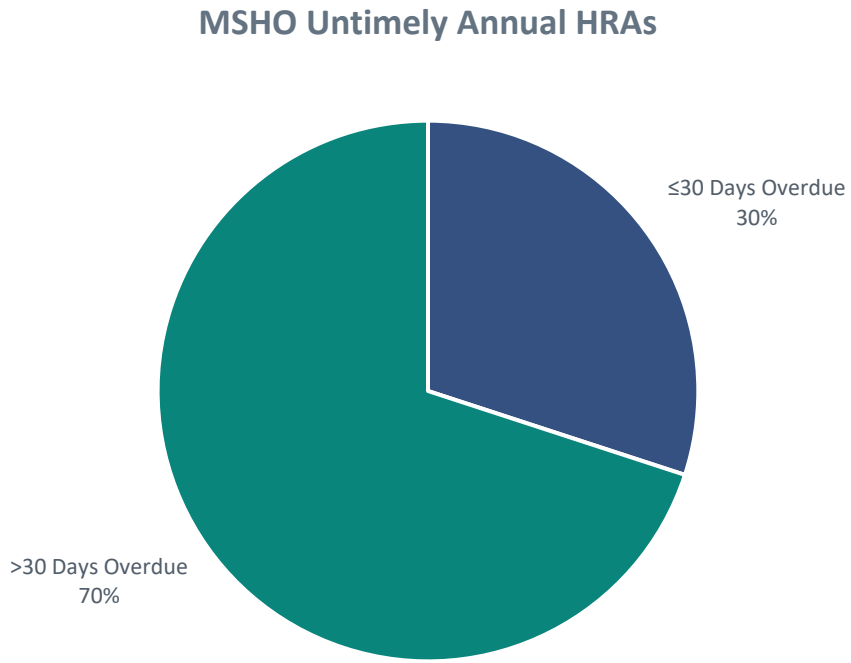




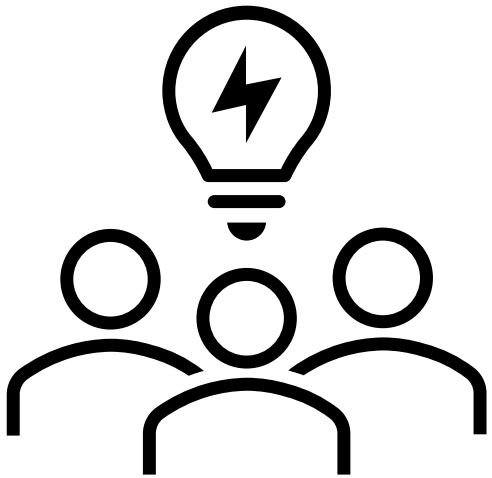
CY2023 Untimely HRAs

- Untimely **initial** HRAs all >30 days overdue
- Approximately 30% of untimely **annual** HRAs ≤ 30 days overdue



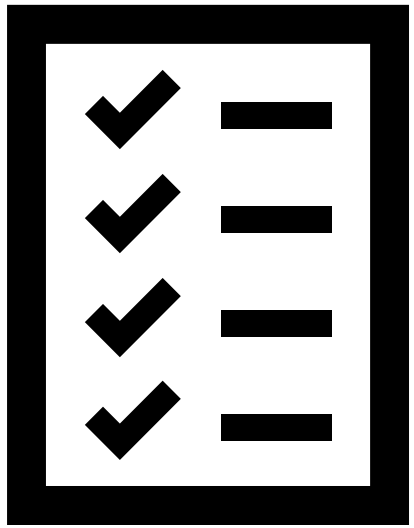


Opportunities



- Schedule assessments well in advance of deadline
- Strategies to increase engagement rate
  - Review internal processes for engaging members initially and at time of reassessment
  - Barriers/Challenges?
- Review UTR and refusal requirements/documentation

Coming Soon – New Corrections Report Format and Features



New Format

- Information on one tab, no longer needing to go to second tab to make updates

New Second Tab Features

- HRA Timeliness
- Face-to-Face Flag (CMS requirement)

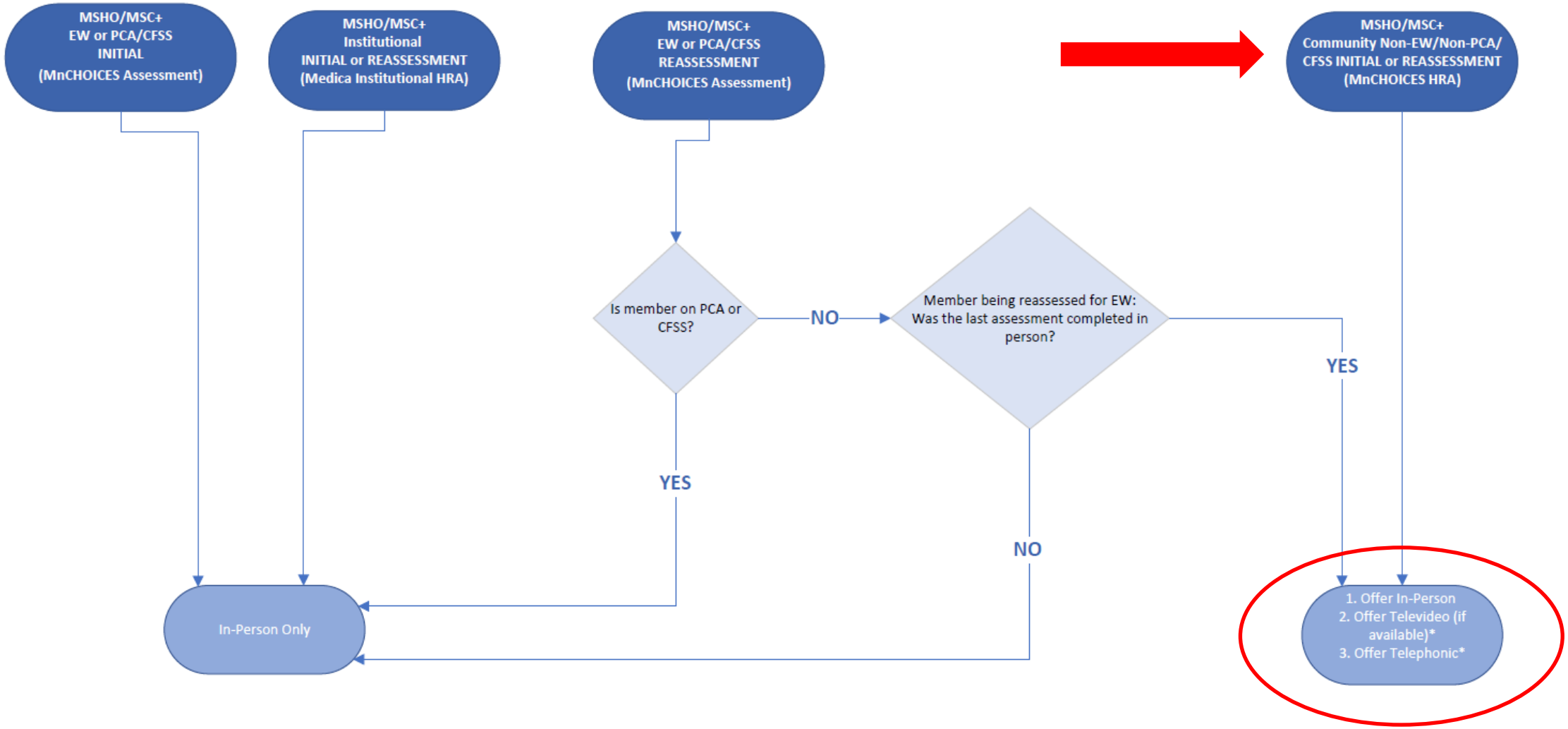
Next Steps:

- Send out for feedback before implementing
- Recorded training to be saved on the CC HUB and via newsletter or email

In-Person Assessment Guidance

Update - In-Person Assessment Guidelines

- Updated remote options for MSHO & MSC+ community non-EW/non-PCA/CFSS members to allow telephonic HRAs
- For all members, first step=offer in-person visit. Always document the assessment method, including if the member declined to meet face-to face



Support Specialist Team

Support Specialist Overview

Kristi Hocking – Support Specialist Supervisor

Mai Yang, Zach Tibodeau, Ellie Volk, Tim Ly, Kira Carlson

Contacts and Group Numbers

- Care Coordination Product Group Numbers for Special Needs Plans and MSC+
- Care Coordination Support Specialists Team Contact List
- Contact Numbers for Key Staff in Medica Care Coordination Products
- County, Care System and Agency Contact Numbers
- Contracted PCA and Home Care Services (HCS)

Referrals

- Claims Referral Guidelines
- Referral Request Form
- Chore Request Referral Form

* Update made to Claims Referral Guidelines

Supplies and Equipment covered under EW (items that do not have an assigned HCPC code) Items under $30 do not require a referral request form to be sent, but still need to meet supply and equipment policy	T2029	Include brief description of supply/equipment and cost on referral request form. Additional information regarding item and health/safety need can be entered in the "Comments" field on the Referral Request Form. **Items with an assigned Healthcare Common Procedure Coding System (HCPCS) code are not to be billed under T2029.**

RRF Review

Most common reasons RRF's are sent back:

1. Not enough information (i.e. "annual home modification", "brand name item", "chore services", "rental of ramp", "creams or other OTC items"), along with health/safety need .
2. Gaps in service. The start day of the new request leaves a period that is not covered
3. Units and hours given don't equal total units (i.e. 19 units, 5 hours of PCA, or 12.3 units of homemaking per week)
4. Member info missing or incomplete. We must verify the member's name, DOB, and ID number in our system to enter an authorization. If they don't match, we will send back asking for corrections.
5. HCPC code missing or incorrect (i.e. authorizing CDCS or foster care, but no code provided).
6. T2029 being used for an item that has a HCPC code.
7. Provider information is incomplete. Some providers have multiple locations, we use the address you give to select the correct provider. Also, some provider names are VERY similar. The address is another way to verify who are selecting and ensuring the authorization letter gets sent to the correct provider.

RRF Review Continue

Helpful hints:

1. Whenever an RRF is sent back to you, always include the RRF in your reply. The member's name is seldom listed in the body of the email. In one week, we send back an average of 50-70 RRF's unprocessed.
2. Please be timely in submitting RRF's and allow 10 business days for turn around time before reaching out to inquire on the status of an authorization.
3. Double check your work before submitting
    a. Ensure the correct member ID and DOB is entered.
    b. Ensure correct dates are entered.
    c. If the request is for Home Health Aid (HHA) or Personal Care Assistant (PCA), please be sure the provider is in network.
    d. If it is for home modifications, please add description of service in notes.
    e. Is the service staying the same or decreasing? If it is decreasing, have you submitted the Denial, Termination, or Reduction (DTR) form

4. We are getting a lot of "whoopsie" emails in the box. The CC sending back that they had made an error and the authorization needs correcting. We work from oldest request to the newest, so the correction that was sent in may take 10 more days to be processed.

MnCHOICES

MnCHOICES – Phase 4 coming soon!

Phase 3 continues through **June 28, 2024.** During this phase lead agencies are expected to:

- Continue to assign staff members to practice in the MTZ.
- Have 100% of users working in the production environment and completing HRAs, assessments and support plans in the production environment.
- Start all new assessments (including HRAs) in MnCHOICES revision.

Phase 4: This is the final transition period – "**ALL-IN PHASE"** scheduled to begin **July 1, 2024**.

- Medica's expectation is that 100% of our delegate staff members will start all new assessments (including HRAs) in the revised MnCHOICES. **(Do not start new assessments in Legacy Systems.)**
- Finish existing assessments and support plans in legacy systems by **Sept. 30, 2024**.

*Note: MnCHOICES 1.0 assessments and support plans not completed by Sept. 30, 2024, will **not** migrate to the revised MnCHOICES. DHS will deactivate MnCHOICES 1.0 after Sept. 30, 2024.

For full announcement: **Update on launch of MnCHOICES revision project**

MnCHOICES – Certified assessor recertification

Due to the delayed launch of the Revised MnCHOICES, many certified assessors may be coming up on the 3-year date for the recertification requirement. To continue working in MnCHOICES, this must be completed prior to the current certification expiring. We wanted to make sure this was on your radar and have a plan for tracking and managing your certified assessor dates and required trainings for recertification.

- 45 CLUs are required for recertification with at least 12 focusing on skills to improve the ability of an assessor to practice in a more person-centered way.

See the link below that houses the most current statewide list which includes the dates they are due for recertification as well as the resources from DHS for recertification.

MnCHOICES training

Statewide certified assessor list

Explanation about statewide list of certified assessors
Statewide list of certified assessors (XLS) (Updated Feb. 2, 2024)
Lapsed certified assessor audit protocol MnCAT

MnCAT Step 4 – Recertification: Instructions

Community First Services and Supports (CFSS)

Community First Services and Supports (CFSS)

- Announcement of CFSS launch 10/1/24
- Recipients transition from PCA to CFSS at annual reassessment
- CFSS for assessments and effective dates on or after 10.1.2024.
    - Example: September Assessments cannot access CFSS
- DHS reports developing specific training for case managers/care coordinators
- DHS CFSS has video trainings that offer a very good overview of the program and services.

Training:

- **DHS TrainLink**

Course Code	Course Name
CFSS_LA	COMMUNITY FIRST SERVICES AND SUPPORTS (CFSS) FOR LEAD AGENCIES

….More training opportunities to come

CC Reminders

CC Hub Navigation

https://bcove.video/3OFfXea

Documents added/updated on the CC Hub:

1. MBH Case Consultation Form
2. Referral Form for MBH MSHO Case Management
3. Claims Referral Guidelines have been updated
4. Reemo Benefit Guideline was updated to reflect email address CCs can use to contact the vendor.
5. TOC Training, recording and documents have been posted on the Training page.
6. New Date of Death Report Template is being added under tools and forms - Miscellaneous

***Future DTR Lunch and Learn**

***DME/T2029 Lunch and Learn, July 31st at noon**

***Next Quarterly CC Meeting, Tuesday, September 3rd at 9am.**

~Have a wonderful summer~


Medica®