Policy Title:	**Case Management Accountability SNBC/SNBC Special Needs Plan**
Department:	**Markets Growth & Retention**
Business Unit:	**State Public Programs**
Approved By:	**Director, Medicaid and SNP Product & Strategy**
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PRODUCTS AFFECTED

- Special Needs BasicCare (SNBC) – Medica AccessAbility Solution®
- Special Needs BasicCare (SNBC) Special Needs Plan– Medica AccessAbility Solution Enhanced®

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)/ Qualifications:

SNBC/SNBC (Special Needs Plan) SNP Care Coordinator - Medica prefers SNBC and SNBC SNP 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.

SNBC and SNBC SNP Care Coordinators must have experience working with people with disabilities, primary care, nursing, behavioral health, social services and/or community based services.

Care Coordination: The assessment, care planning, providing support, and coordination of needed services between members, involved health professionals, and care settings.

Care Management for all Members: 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 (including behavioral health), housing support, rehabilitation and other services to be furnished to the member. Medica does not require the use of a specific Care Plan. If a delegate plans to use a care plan other than those provided by Medica, prior approval is required by Medica. Upon launch of the revised MnCHOICES application, the Care Plan will be referred to as the Support Plan.

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 member'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/Case Management/Navigation Assistant services that are designed to ensure the coordination and delivery of Medicare, where applicable, and Medicaid preventive, primary, acute, post-acute, rehabilitation, specialty and pharmacy services, and long term care services, including State Plan Home Care Services for SNBC and SNBC SNP members. Care Coordinators serve as member advocates; they are instrumental in identification and coordination of activities that strive to keep members in the least restrictive settings, and promote appropriate utilization, and self-management.

POLICY:
Every Medica SNBC and SNBC SNP member is assigned a Care Coordinator (CC)/Engagement Coordinator (EC). Medica will assign a CC based on the member demographic location and identified special needs, willingness to participate in care coordination, and/or the primary care provider (PCP). The CC will coordinate the provision of services to members and promote and assure service

accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, culturally appropriate care, and fiscal and professional accountability. The CC serves as the primary contact for the member's needs.

PROCEDURE:

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

2. CCs will be informed of and comply with basic member protections 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 sixty (60) days of enrollment. The HRA may be conducted through telephonic or face-to-face contacts.
    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.
    c. Use of alternate assessments and alternate forms of assessment contact type must be approved by Medica.

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 Medicaid Management Information System (MMIS) for all 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, resources, cultures, goals and need for support. In addition, the Care Plan will employ an interdisciplinary and holistic approach by incorporating the unique primary care, acute care, long-term care, behavioral health, and social service needs of each member with appropriate coordination and communication across all relevant providers, lead agencies and other case managers. The Care Plan also must include identification of any risks to health and safety and plans for mitigating these risks, including Informed Choices made by members to manage their own risk.
    c. The Care Plan should incorporate covered Medicare services, when applicable, Medicaid services, and services available through the formal, informal, and quasi formal Home and Community Based Community Services (HCBS) as identified on the HRA. The Care Plan should include services that are provided by other waivers, if known. The Care Plan should also include services that were offered to the member, but declined.
    d. The Care Plan will identify if essential services are in place and if so what the backup plan is.
    e. The Care Plan will identify person-centered SMART goals, target dates, interventions/supports needed, note monitoring progress/goal revision, and outcome or goal achievement dates.
    f. Members have a right to decline goals. When a member declines a goal, if safety concerns are involved a Risk Plan/Emergency Plan/Self Preservation/Evacuation Plan needs to be created. These findings may be medical or environmental and should be among the highest priority when working with members. If this occurs, documentation on the HRA, Care Plan, or in the member's clinical notes should indicate why a goal is being declined.
    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 needs identified in the HRA.
    h. Discussion with the member and/or authorized members or legal guardians will occur prior to finalizing the Care Plan. This will include written documentation that informs them of the agreed upon State Plan supports that will be provided.
    i. 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.
    j. 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 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

11. CCs will provide self-management and educational materials to members with disability related conditions, as applicable.

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. CC's 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 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 will assist the member and/or authorized family members or legal guardians to maximize Informed Choices of services and control over services and supports.

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. CC's will promote self-management activities, when applicable.

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 visits.

16. CCs will provide a summary of assessment and care plan results to the primary care physician (PCP) annually.

17. 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.

18. CCs will have interventions and protocols for management of disability related conditions common among members with disabilities such as skin breakdown and urinary tract infections.

19. 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 settings.

20. CCs will make referrals to specialists and sub-specialists.

21. CCs will work in partnership with the member and/or authorized family members or alternative decision makers, and Primary Care Physicians (PCP) in consultation with any specialists caring for the member, to develop and provide services and to assure consent to the medical treatment or service.

22. CCs will coordinate care for American Indian members on their caseload.

23. CCs will coordinate with an Individual Education Plan (IEP), an Individual Family Service Plan (IFSP) or Individual Community Support Plan (ICSP) including services and supports.

24. CCs will coordinate with care coordination and services provided by children's mental health collaborative and family services collaborative and adult county mental health initiatives.

25. CCs will coordinate with transitional care for children between the ages of eighteen (18) and twenty-one (21) who require ongoing services as they transition to adult programs covered under the DHS Contract.

26. CCs will coordinate with county social service agencies, community agencies, nursing homes, residential and home care providers and case management systems involved in providing care for SNBC members using Health Insurance Portability and Accountability Act (HIPAA) compliant electronic communication vehicles.
    a. Referrals and/or coordination with County Social Service staff will be required when the member is in need of the following services:
        i. Pre-petition screening
        ii. Preadmission screening for Home and Community Based Services (HCBS)
        iii. County Case Management for HCBS,
        iv. Child protection
        v. Court ordered treatment
        vi. Case Management and service providers for people with developmental disabilities
        vii. Relocation service coordination
        viii. Adult protection
        ix. Assessment of medical barriers to employment
        x. State medical review team or social security disability determination,
        xi. Local Agency social service staff or county attorney staff for Members who are the victims or perpetrators in criminal cases.

27. CCs will coordinate with Local Agency human service agencies for assessment and evaluation related to judicial proceedings.

28. CC's 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.

29. 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 Recommendation for Authorization of State Plan Home Care Services,, DHS-5841 as provided by the state. It is expected that a response will occur within 10 business days of submission for this form. This response time is required by both the Care Coordinators and with lead agencies, waiver workers, or county case managers.

30. CCs will collaborate with other providers for members identified as having special needs requiring additional Intensive Case Management, other Care Management, and risk assessments including Long Term Care Consultation and other screenings to identify special needs such as: common medical conditions, functional problems, difficulty living independently, polypharmacy problems, health and long term care risks due to lack of social supports; behavioral and/or substance use disorders developmental disabilities; high risk health conditions; and language or comprehension barriers. Medica CCs shall share with other providers serving the member with special health care needs the results of its identification and assessment of that member's needs to prevent duplication of those activities.

31. Medica has been advised by DHS that CC and waiver workers are permitted to share enrollee information without a release of information based on 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.

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

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

34. CCs will collaborate with the Senior Linkage Line and other social service staff to ensure that the Pre Admission Screening (PAS) process is completed. CC is responsible to:
    i. Perform determinations of the need for a nursing facility level of care for facility admissions;
    ii. 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. Forward, if appropriate, to the county of financial responsibility for relocation assistance;
    vi. Enter PAS information into MMIS using the Long Term Care Screening document, if the member is not a waiver program participant at the time of admission.

35. 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. This includes completing documentation in the member's file, following specified timeframes, communication with members or responsible parties about changes to the member's health status and plan of care, collaboration with providers of services, providing education on how to prevent unplanned transitions, and coordinating services for members at high risk for having transitions.

36. CCs will make reasonable efforts to coordinate with services and supports provided by the Veteran's Administration (VA), if applicable.

37. CCs will help determine if members with HIV/AIDS and related conditions may have access to federally funded services under the Ryan White CARE Act, 42 U.S.C. § 300ff-21 to 300ff-29 and Public Law 101-381, Section 2.

38. CCs will assist in coordination of Substance Use Disorder (SUD) Treatment Services
    a. CD treatment services do not include detoxification (unless it is required for medical treatment).
    b. The MCO is responsible for the continuum of SUD services identified in Minnesota Statutes, §254B.05, excluding room and board.

39. CCs will notify members under the age of 21 of the availability of Child and Teen Checkup (C&TC) screenings annually. CC is to assist members in arranging appointments and/or finding new providers as requested by the member.

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

41. 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 will use the DHS form "HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form" DHS 6037 as provided and directed by the state.

42. CCs will assist members turning 65 years old in transitioning to MSC+ or MSHO per DHS requirements.

43. 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.

44. 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:
SNBC Contract

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