MEDICA

January 2020

CARE COORDINATOR NEWSLETTER

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

Members on Elderly Waiver who have lost Medicaid eligibility

If you had a MSC+ member on the Elderly Waiver who lost their Medicaid eligibility as of 11/30/19, and per Mn-ITS, they remain ineligible for Medicaid, follow the DHS 6037 process by 1/31/2020.

If you have a MSHO member on the Elderly Waiver who lost their Medicaid eligibility as of 11/30/19 and are in a "future end date" where they remain with Medica for 90 days, if they remain ineligible for Medicaid per Mn-ITS, follow the DHS 6037 process by 1/31/2020.

Important Links:

- Medica Assessment Schedule Policy
- DHS 6037 form
- DHS 6037A scenarios
- DHS language related to the process for members who have lost eligibility and are not back with Medica found in the DHS 6037A

Transitions Needed Due to Loss of Medical Assistance (MA) Eligibility

Type of Change	10) Person is enrolled in MSHO/MSC+, on EW and loses Medical Assistance (MA) eligibility. In most cases, if MA eligibility is re-established within 90 days, the person continues on their Managed Care Organization (MCO) with no break in MCO enrollment.
Days 1-90 from loss of MA eligibility	The MCO tracks the status of the person and completes any necessary reassessments. The MCO cannot enter a LTC SDOC in MMIS when the person is not eligible for MA.

	The MCO sends DHS-6037 to the County of Residence (COR) **by day 60** if MA has not been re-established by this date. *This is for communication purposes only.* It is not a transfer of HCBS case management responsibility. The document should be filled out in its entirety with all attachments, including any assessments completed. This form alerts the COR that the person has lost MA eligibility and that the MCO will stop following the person at Day 90 if MA eligibility is not yet re-established by Day 90. **NOTE**: If a required reassessment is completed by the MCO after the DHS-6037 is sent to the COR and before Day 90, the MCO must also send the reassessment to the COR.
Day 90 and beyond from loss of MA eligibility	The COR tracks whether the person's MA eligibility was re-established by Day 90. If not, the COR contacts the person to determine the person's status. The COR assists the person to access services and supports as needed. **NOTE**: 1) If the COR was provided with a reassessment completed by the MCO during Days 1-90, the county may enter the MCO's reassessment in MMIS to establish EW eligibility. Please note that assessments must be entered within 70 days of the assessment date. 2) If the COR is not able to use a reassessment completed by the MCO, due to timelines, the COR completes any necessary assessments needed to reestablish eligibility for EW. The COR may need to communicate with the MCO to request the MCO close the EW span to the date the person lost MA eligibility, in order to enter a new assessment. The COR can open the person to AC if level of care criteria continues to be met but MA financial eligibility is no longer met or established. For a person who no longer meets either MA financial or level of care criteria, the COR can open the person to ECS.

MMIS Entry Timelines

On 11/25/19 we first sent out information related to MMIS entry timelines, including the importance of this as well as the dates in which MMIS entry for members on EW needs to be completed in order for there to be no unintended gaps in the members waiver or in the waiver payment made to Medica. We have received some good questions from some of you about on this topic, so we wanted to send this out again. We are asking that you review this with your staff doing assessments as well as the staff doing MMIS entry.

Please also review your internal processes to be sure that timely entry into MMIS is a priority, and the dates entry must be completed are well understood. Also, as mentioned in the 11/25/19 email, we are asking that you create whatever type of reminders you do in your system of the MMIS entry deadlines. We are sending

out the attachment from the 11/25/19 email again, see this for these dates as well as more information.

Per the DHS eDoc 4469, MMIS entry manual, the instructions are to enter screening documents as soon as possible, and for members on the Elderly Waiver, MMIS has to be up-to-date with the members rate cell prior to the Capitation (CAP) date in order for the waiver span to remain unbroken, and in order for the MCO to receive the proper capitation for members on EW. The proper payment by DHS allows the MCO to cover the waiver related provider claims.

Please give this serious attention. Thank you!

All Products

We have an exciting announcement about **new** Telephone Equipment Distribution (TED) Program devices and services. The TED Program helps Minnesotans with hearing loss or physical or speech disabilities access the phone.

New devices

The TED Program now offers new devices to those who qualify. The new devices make phone communication accessible. Examples of these devices include:

- Cell phone amplifiers
- Hearing aid streamers
- Bluetooth-enabled devices used for telecommunications, such as smart displays, smart speakers and Apple AirPods
- Apps that increase access to communication on smartphones and tablets
- Other assistive technology to use with the phone, such as electrolarynx speech devices

New Services

Phone and internet service discount applications

The TED Program now helps Minnesotans with hearing loss, physical or speech disabilities complete applications for discounted phone and internet services. These applications can be complex and may be denied when not completed correctly. Discount programs include:

- Lifeline (Federal program)

- Telephone Assistance Plan (State program)
- Internet services (Comcast)
- Midco

Information about assistive technology

The TED Program can talk to clients about other assistive technology that may benefit them. This includes providing resources for finding accessible apps.

More information

These new devices and services are available starting January 1, 2020. For more information, contact us!

Phone: 800-657-3663 voice or your preferred relay service
Videophone: 651-964-1514
Email: dhs.dhhsd@state.mn.us

CAHPS and HOS patient surveys, and the data they collect

Medica regularly collects data about Medica members' perceptions of their health plan, their medical care and their personal health status. Two important survey tools are the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and the Health Outcomes Survey (HOS).

What is CAHPS?
CAHPS is a survey administered annually by paper and phone to Medicaid and Medicare enrollees. Questions are grouped into the following categories:

- Getting Care Quickly
- Getting Needed Care
- Coordination of Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often
- Rating of All Health Care
- Rating of Health Plan
- Customer Service (health plan)
- Claims Processing (health plan)

While some CAHPS questions focus on health plan experience and services, others specifically address patients' experience with primary and specialty care:

- Appointments as soon as needed
- Specialist appointments when needed
- Getting care right away when needed
- Personal doctor listened carefully
- Personal doctor's explanations understandable

- Personal doctor informed about care from other doctors
- Ease of getting care, tests, treatment
- Personal doctor showed respect
- Personal doctor spent enough time with patient

CAHPS scores are a key component of health plan accreditation by the National Committee for Quality Assurance (NCQA). These scores are also used to calculate annual health plan rankings published by NCQA and Consumer Reports. Selected CAHPS results are also part of the Medicare Stars ratings assigned to Medicare cost and dual-eligible plans.

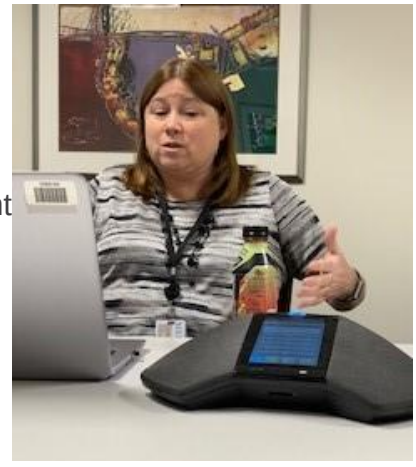
What is HOS?
HOS is a survey administered by the Centers for Medicare and Medicaid Services (CMS) to Medicare cost and dual-eligible enrollees. Respondents are surveyed twice in a two-year period to assess changes over time. HOS consists of questions about respondents' physical and mental health status and behaviors, activities of daily living, history of medical tests and treatment, and rating of physical and mental health. Several HOS measures are used to calculate Medicare Stars ratings:

- Improving or maintaining physical health
- Improving or maintaining mental health
- Monitoring physical activity
- Reducing the risk of falling

HOS information is also used for case-mix and risk adjustment and as a data source for clinical outcomes measures as part of the Healthcare Effectiveness Data and Information Set (HEDIS®).

How does Medica use CAHPS and HOS data?
Medica analyzes CAHPS and HOS results annually to identify trends and opportunities for improvement.

Diabetes Care Coordination Training



We were fortunate to have Jody Nelson, MD, medical director at Medica, provide a diabetes training for Care Coordinators early this month which was very well received. Dr. Nelson's passion for medicine and health care is evident through her engaging presentation. Dr. Nelson has graciously offered to provide further training throughout the year for our care coordination staff on various topics. So keep an eye out for future opportunities. Here is a photo from the training on January 14th. **Thank you, Dr. Nelson!**

Member Transfers

Medica has a responsibility to ensure that members experience limited disruptions including care coordinator changes. We recognize there are times when members do need to change care coordinators such as with a move to a new area or changing Primary Care providers. Medica recently made some changes to the Transfer Policy found on the Medica.com care coordinator site. Please review the policy to ensure you are following all the steps in sending or receiving a transfer. Some of the more notable changes are as follows:

- Clarification of members who are NOT to be transferred to other Medica entities. These include:
  - Members with a future end date cannot be transferred
  - Members currently hospitalized cannot be transferred
  - Members cases where any required activities/documents such as Residential Care tools, plan of care, and where assessments due that month are not completed cannot be transferred
- It is the sending entities responsibility to contact the receiving entity and confirm that they are able to receive the member. Phone numbers are found on the Contact list found on the Care Coordination site under Tools and Forms.
  - In the event that Medica is informing you of a member transfer, this step is not necessary as it has already been verified that the receiving entity is accepting this member transfer.
- Transfer requests received at Medica after the 24th of the month will not be processed for the following month.
- In order for Medica to receive all of the proper information when a member is moving from one delegate to another is to have the sending Care Coordination entity complete the Primary Care Clinic (PCC) Change Grid and submit it to Medica via ShareFile or secure email to SPPEnrollmentQ@medica.com.
- Once Medica has reviewed the information, you will receive information back from us if the transfer is approved. Once approved, the sending entity will send all transfer documents to the new entity. The sending entity will continue to provide care coordination for that member until the effective date of the transfer.

Please review the policy and reach out to the SPPEnrollmentQ@medica.com mailbox if you have any continued questions.

Medica Care Coordination Support

Email us at MedicaCCSupport@medica.com

Call us at 1-888-906-0971

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for an inside look at Medica's involvement in the community.

This email was sent by: **Medica**
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