MEDICA.

March 2020

CARE COORDINATOR NEWSLETTER

Please disregard the last Care Coordinator Newsletter sent on March 26 at 3:45PM, as it contained outdated information related to COVID-19.

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

Reminder: Members on Elderly Waiver who have lost Medicaid eligibility

We have learned that this continues to be an issue so, we are wanting to provide this reminder once again this month.

If you had a MSC+ member on the Elderly Waiver who lost their Medicaid eligibility as of 2/29/2020, and per Mn-ITS, they remain ineligible for Medicaid, follow the DHS 6037 process by 4/30/2020.

If you have a MSHO member on the Elderly Waiver who lost their Medicaid eligibility as of 2/29/2020 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 4/30/2020.

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.

All Products

Dental gaps closure coordinated effort for 2020

To help Medica members receive dental care in 2020 Medica is implementing a comprehensive dental gaps communications program for members and stakeholders. This initiative is for Minnesota Health Care Programs (MHCP) members served by Medica including Medica DUAL Solution® (MSHO), Medica Choice Care℠ MSC+ (MSC+), Medica AccessAbility Solution® Enhanced (SNBC SNP) and Medica AccessAbility Solution® (SNBC) members.

The multichannel effort includes member letters, member calls, social media, and communications to care

coordinators and stakeholders. Member letters will be sent in waves; the first is planned for April, another for June, and one more for August. We will share with you which members received communications and a template of each communication for use as a reference as the waves go out.

Something unique about the member communications is that we are referring members to our 24/7 NurseLine service, HealthAdvocate™. This is aimed to help do two things, provide members the opportunity to call at any time to receive help and act as an assist for CCs who have busy caseloads. If a member calls you for help we want to be sure you remember that you have direct access to the Delta Dental of Minnesota Dental Care Coordinators at **1-866-303-8138** (toll free); TTY: **711**, 8 a.m. – 5 p.m., Monday – Friday. **Please note that this phone number is for Care Coordinator use only**.

You are already familiar with the quarterly dental gaps list that Medica has provided for the last couple of years and that will continue to happen throughout 2020. There will be additional details included with some of those quarterly lists to let you know which member touchpoints Medica is developing. We are also evaluating the use of targeted incentives and will share more on that in the coming months.

Your work with your members, continues to be the most essential intervention Medica has to ensure that members receive an annual dental visit. This initiative aims to support the efforts of Care Coordinators through providing additional communications and assistance to members who need help accessing dental care.

Model of Care (MOC) audit follow-up and care coordination process changes

In the March Quarterly Care Coordinator Meeting, you learned about Medica's participation in a week long, comprehensive Mock Model of Care Audit. This practice audit is to best prepare us for a likely Centers for Medicare and Medicaid Services (CMS) Program Audit sometime in 2020. Thanks again to those of you who were called upon to submit cases for this audit. From the case reviews that were conducted, the auditors made several recommendations that Medica needs you to review and implement immediately for MSHO and SNBC Enhanced members only. Delegates may also implement change as best practice for MSC+ and SNBC. These changes are required **only** for MSHO and SNBC Enhanced members.

1) The CMS expectation is that ALL members have a care plan, including Unable to Reach (UTR)/Refuser members. Medica created the UTR/Refuser Care Plan to help to satisfy this expectation. It is important that when creating the UTR/Refuser Care Plan that you include the information that you know about the member. For example:

- If a member completes and returns the Self-Report Health Risk Assessment (HRA).
- Medical or provider information found in the electronic medical record (EMR) or Summary of Care.
- When a Transition of Care (TOC) occurs, the UTR/Refuser care plan (CP) should be updated to include at least a minimum of an explanation of the hospitalization.

In addition, CMS places strong emphasis on the Interdisciplinary Care Team for the member. If you are aware of who some of those members are, make sure to include their names in the UTR Refuser Care Plan.

Update the CP throughout the year as you learn more information about the member.

2) Transitions of Care *always* warrant an update to the Care Plan for all members. Hospitalizations, Skilled Nursing Facility (SNF) or Transitional Care Unit (TCU) stays are a significant event for the member. Even if there is no change in services needed, at a minimum, the CP should include information about the event.

3) CMS will look to ensure that the follow up plan documented in the Care Plan is specific to that members needs over time. This follow up plan is based on the identified needs in the HRA and your clinical judgement. When there are significant clinical issues or significant need for services, the follow up plan is to reflect the actual work and follow-up that is done by the CC with the member and the frequency of contact consistent with those needs. In the charts reviewed, some were definitely individualized to the member in frequency of contact, and others were marked as “every 6 months” when clearly more contact was clinically necessary and in most cases was being provided. The frequency of contact on the CP can change over the course of the year, and those changes reflected on the CP.

Having the opportunity to have an external entity with expertise in the CMS Audit processes review our Model of Care and the processes within it has been invaluable to Medica. As we continue to learn, you can expect feedback and changed expectations like the three items above, as well as some changes in policies and procedure details.

Please review this information in your next team meeting or use whatever mechanism you have within your agency to make sure your Care Coordinators are trained in the details provided above.

Thank you for all of your work and all that you do for Medica members.

Medica Care Coordination Support

Email us at MedicaCCSupport@medica.com

Call us at 1-888-906-0971