December 2022

Medica | CARE COORDINATOR NEWSLETTER

End of the Year message to Medica Care Coordinators,

I would like to extend a heartfelt holiday greeting to all of the Medica Care Coordinators, including our new Care Coordination County delegates in our expanded SNBC service area.

We recognize members on Medicaid have unique and complicated needs. Through your work as Care Coordinators, you are not only assisting members to access medical, mental and dental health care, but also assisting members in accessing services to meet social determinants of health needs to include food insecurity and housing needs. We appreciate the work you have done to see more members in person, and appreciate your flexibility in how you support members as challenges with COVID have continued this year.

Wishing you a healthy and safe holiday season. Medica is grateful for you and your work with our members.

John Naylor

Medica President & CEO

All Products

Additional Benefits

The Additional Benefits grid was sent out to each delegate contact. This copy highlighted the new benefits for 2023 however several are continuing from 2022.

The grid (without the highlights) is also being added to the Care Coordination Hub for easy access for Care Coordinators under the benefit and clinical guideline section. Please familiarize yourself with the grid so that you can answer any questions your members may have. The grid is for Care Coordinator use only.

Department of Human Services (DHS) Updates

For those who have not received the Aging and Adult Services and Disability Services notice sent out on Dec. 1, 2022, please review.

Addressing liability when using assistive technology

Throughout 2022, DHS and its community partners will work together to make assistive technology (AT) available to more people with disabilities and older adults. In this message, we discuss how to deal with liability concerns when AT is used.

For more information, **go to full announcement**.

Individual community living supports (ICLS)

Please see the below clarification from DHS regarding the expectation that Case Managers/Care Coordinators will review, sign, and date the DHS 3751 (ICLS) Planning Form at reassessments (posted Dec. 13, 2022 on **Policy Quest**).

Question:

1. The Community Based Services Manual (CBSM) refers to the case manager completing the DHS-3751 to set up services. There is no reference to recreating this form upon a person's annual reassessment and new waiver span and we're wondering if this needs to be re-done upon waiver span renewal? The form itself does not have service span dates listed within it and only contains a date that the form is created.
2. The CBSM reports the case manager completes the DHS-3751 but we have had providers submitting their version of a service plan for the ICLS services, much like an individual writing a Consumer Directed Community Supports (CDCS) plan. Is it acceptable to approve a provider/client written version of a plan in place of the DHS-3751?

Answer:
Per the CBSM policy, “The case manager/care coordinator must complete the ICLS Planning Form, DHS-3751 to provide guidance and instruction to the ICLS provider about the needs of the person for each applicable service category.”

The case manager/care coordinator must:

- Identify the person's individual goals the ICLS service is intended to support
- Describe and provide detail about the type of services the person will receive within each ICLS service category
- Calculate the total amount of units and cost of ICLS services the person will receive each week.

As policy states, the DHS-3751 is a required form and must be completed by the case manager. This is how the case manager informs the provider what services and amounts of services are authorized. Providers should not be telling case managers what they will provide and how often. That is the responsibility of the case manager.

As person's needs may change with reassessment, and the DHS-3751 can be used to meet the provider signature requirements for the support plan, it is expected that this form be reviewed, signed and dated at reassessments.

Reminder: Temporary staffing program still is available for residential service providers with a COVID-19 outbreak

Residential service providers with an active COVID-19 outbreak still can request short-term emergency staffing if there is a critical shortage at the facility. Organizations that receive assistance will get help from temporary staff members for up to 21 days at no cost.

For additional information, **go to full announcement**.

Medica Behavior Health (MBH) Reminders

Medica transfer responsibility process requires that the Care Coordinator contact the receiving entity to verify that the request is appropriate and that the agency is able to take the member. MBH will have the opportunity to review & determine appropriateness and availability. MBH is getting transfers without having the opportunity to first talk with the sending CC to see if MBH will accept the member. Please refer to the transfer process/policy on the Care Coordination HUB.

Also, a reminder that members who are nearing 65 should not be transferred to Hennepin Health or Medica Behavioral Health (MBH).

Member Advisory Meetings

This fall, we were excited to be able to host two in-person Member Advisory Committee meetings. We held meetings with a group of Minnesota Senior Health Options (MSHO) members in Duluth on 10/13/22 and a group of Special

Needs Basic Care (SNBC) members in St. Paul on 11/30/22. The theme of the meetings was Affordable and Healthy Eating – we had speakers from Second Harvest, and we shared information about Healthy Savings and new supplemental benefits for 2023.

Members provided valuable feedback about Healthy Savings and their experience with Medica overall, which we will use to inform our product development and member experience. We provided a healthy meal kit and a grocery store gift card in appreciation for their participation. The advisory committees are pictured below. We will hold additional meetings throughout 2023, and welcome care coordinator referrals for topics and member participants. We will share upcoming meeting dates and times in this newsletter.

New Clinical Liaison

We are happy to announce that Theresa Wappes officially joined the State and Public Programs Clinical Liaison team on Monday November 14th. Theresa is a registered nurse who comes to us from the internal Medica Care System team where she has worked since 2012. During her time with the Medica Care System, she provided care coordination to members, worked as a Team Lead as well as a Care Coordination Team Supervisor.

Prior to joining the Medica Care System team, she was the Branch Manager and Assistant Director of Nursing for a home care agency in Duluth a and was an Adjunct Instructor at Fond du Lac Tribal and Community College in Cloquet,

teaching home health aide courses. Theresa brings a wealth of clinical expertise, along with organizational and leadership skills to the SPP team. In her role as a Clinical Liaison, Theresa will be working collaboratively with our current Clinical Liaison, Shelley Lano.

Support Specialist Reminder

Please make sure that provider address and fax numbers are accurate when submitting the Referral Request Form. This is necessary to ensure that letters and authorizations containing member Personal Health Information (PHI) are sent to the appropriate location.

Regulatory Quality Updates

MnChoices Auditing

We have recently began our joint Managed Care Organization (MCO) annual audit protocol review with Department of Human Services (DHS) for the 2023 audit season (which audits 2022 charts). We will be reviewing the Elderly Waiver (EW), Non-EW, and Special Needs Basis Care (SNBC) protocols. With the rollout extension of MnCHOICES, we are not anticipating a lot of changes in the audit protocol for the 2023 audit season given 2022 charts are not impacted by MnCHOICES (which audits 2022 charts). We will provide you with the updated audit protocols once they are finalized.

We are anticipating changes in the audit elements once MnCHOICES rolls out. This will impact the 2024 audit which will be reviewed in quarter 4 of 2023. This protocol will need to account for the current assessment and care planning process as well as the process once moved into MnCHOICES since both processes will occur in 2023. This will affect the 2024 audit season (which audits 2023 charts). In addition, we will need to determine the level of access auditors will have in MnCHOICES to review documents.

More to come as we venture down the MnCHOICES journey!

CMS approval for change in CC qualifications

We are happy to announce that Medica has updated its MSHO/MSC+ and SNBC Care Coordinator qualification requirements, effective immediately. These updates allow certain non-licensed staff to be Care Coordinators if they meet the social work standards under the Minnesota Merit System and are supervised by an appropriate professional. Please see below for the updated Care Coordinator qualification requirements and an updated documentation/approval process we are asking delegates to implement.

Note: These updates do not change any State licensure/scope of practice regulations for Social Workers or Nurses.

NEW Care Coordinator Qualification Checklists & Process for Notifying Medica

We have created the attached checklists to help you track Care Coordinator qualifications. There is one checklist for Minnesota Senior Health Options/Minnesota Senior Care (MSHO/MSC+) and one Checklist for SNBC/I-SNBC. Going forward, please follow the below process when hiring new Care Coordinators:

1. Complete the relevant checklist and maintain it in your records for **all** new Care Coordinator hires. All checklists should be available to Medica upon request.
2. If the new Care Coordinator does **not** meet Medica's preferred qualifications for either MSHO/MSC+ or SNBC, please send a completed checklist to the Medica Reg Quality mailbox at **MedicaSPPRegQuality@medica.com** for approval prior to hiring the Care Coordinator.
    - **Note:** The above process is similar to (and will replace) the approval process currently in place for SNBC Care Coordinator candidates who do not meet Medica's preferred qualifications.

MSHO/MSC+ Care Coordinator Qualification Requirements

Medica prefers MSHO/MSC+ 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 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.

Once MnCHOICES is in place, all MSHO/MSC+ Care Coordinators except

Physician Assistants, Nurse Practitioners and Physicians acting as Care Coordinators for members in nursing homes must be certified assessors providing both the assessment and ongoing case management functions for members, including support planning services. A certified assessor is a person who completes training and obtains certification from DHS and performs long term care consultation assessments.

SNBC/ISNBC Care Coordinator Qualification Requirements

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

Medica Care Coordination Policy Updates

We are in the process of updating all relevant policies to reflect the updated requirements but wanted to communicate the changes via email in the meantime.

Questions? Please email the SPP Reg Quality mailbox at **MedicaSPPRegQuality@Medica.com**.

Minnesota Senior Health Options (MSHO) + Minnesota Senior Care (MSC+)

Personal Care Assistance Assessments

Personal Care Assistance (PCA) Assessments for members on a waiver managed by the county and denial, terminations, and reductions (DTR)

Care Coordinators (CC) may have a member who is receiving PCA services and is on a waiver managed by the county, such as Community Access for Disability Inclusion (CADI). Upon new member enrollment, waiver status must be verified by reviewing MN-ITS and/or Medicaid Management Information System (MMIS). The CC can expect a member on a waiver managed by the county will be reassessed by the assessor or case manager for services, including PCA.

It is the CC's responsibility to be aware of members services through their disability waiver, and communicate with the waiver case manager any medical assistance home care must be provided by an in network provider, including PCA. If using an out of network PCA agency upon enrollment, the CC must work with the member and waiver case manager to transition to an in network agency within 120 days from enrollment. Please refer to the Home Care Policy posted on the Care Coordination Hub for more details.

It is also the responsibility of the CC to obtain the PCA Assessment that is completed by the waiver case manager or MnCHOICES assessor. The PCA assessment may be the Legacy Assessment or the MnCHOICES assessment. The CC should request the PCA Provider Summary portion of MnCHOICES assessment to understand the member's need for PCA.

The CC will review the PCA Assessment and reach out to the waiver case manager and/or assessor if there are any questions about the assessment. Information from the assessment is used for care planning purposes.

Medica is the responsible payer of PCA services. If the PCA assessment resulted in a denial, termination or reduction (DTR), the CC must submit a DTR to Medica. The DTR must include the PCA assessment used to determine the PCA units. This is either the Legacy Assessment or the PCA Provider Summary. A DTR submitted without one of these documents cannot be processed. Additionally, the rationale section of the DTR should include what resulted in the DTR from the previous assessment, such as member no longer dependent in mobility or no longer has wounds. It is helpful to also include the previous assessment, if possible.

Please contact **MedicaCCSupport@Medica.com** if you have questions.

Special Needs Basic Care (SNBC) + Integrated Special Needs Basic Care (ISNBC)

2023 SNBC Expansion

We like to take a moment to welcome our new counties, delegates, and agencies that will be providing Care Coordination in 2023 for our SNBC & ISNBC membership. We have added 24 new counties, 14 of which will be providing Care Coordination for both of these products. We are excited to have you join our team and look forward to working closely with you to support you in the new year.

We're here to help

Call or email, whichever works best for you.

Call us at 1-888-906-0971 (TTY:711)

Email us at **MedicaCCSupport@medica.com**.

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