Medica | CARE COORDINATOR NEWSLETTER

All Products

Auditors Corner: Assessment & Care Plan Timeliness

Care Coordinators (CCs) must complete assessments and care plans with all members in accordance with Department of Human Services (DHS) and Centers for Medicare & Medicaid Services (CMS)-required timelines.

Member

Requirement	Member Type	Contact Options & Documentation	Special Considerations
Initial contact within 10 days of enrollment notification OR change of Care Coordinator (CC)	All members	• Welcome Letter • Change of Care Coordinator Letter • Case Note stating that CC name and contact information was provided	Both letters provide CC name and contact information. **Note:** Medica auditors need to verify this contact is occurring with each enrollment or change in Care Coordinator.
Within 30 days of an initial assessment or reassessment	All members, except Minnesota Senior Health Options (MSHO)/ Minnesota Senior Care Plus (MSC +) Institutional (at this time) *This will also be an expectation for MSHO/MSC+ after 1/1/2024*	• Post Visit Letter • Case Note stating what documents were sent to the member • *Effective 1/1/2024 MSHO/MSC+ Institutional Post Visit Letter*	If you are including the Medica Leave Behind Document or the Medication Disposal Flyer, you will need to document this in your case notes or on the Care Plan. This Post Visit Letter must be sent with the care plan as it includes the required language block. **Note:** Medica auditors need to verify this contact is occurring after each assessment.
If, after 3 attempts, you are unable to contact a member to coordinate initial assessment or reassessment	All members that are identified as unable to reach (UTR)/unable to contact	• Ongoing No Contact Letter • Case Notes stating date of each contact attempt	The letter Indicates that you have provided the *Member Engagement Questionnaire (referred to as mailed or self-report Health Risk Assessment (HRA) prior to 1/1/24)* and Medica Leave Behind Document as well as CC name

		• UTR/Refusal Care Plan (MSHO & SNBC Enhanced)	& contact information. **Note:** Medica auditors need to verify this contact is occurring if you are unable to contact the member.
If a member or member representative refuse an initial assessment or reassessment	All members that have refused a Health Risk Assessment	• Member Refusal Letter • Case Note stating discussion with member or member representative that led to refusal of assessment. • UTR/Refusal Care Plan (MSHO & SNBC Enhanced)	The letter Indicates that you have provided the *Member Engagement Questionnaire (referred to as mailed or self-report HRA prior to 1/1/24)* and Medica Leave Behind Document as well as CC name & contact information. **Note:** Medica auditors need to verify this contact is occurring after each refusal.

Primary Care Physician

Requirement	Member Type	Contact Options & Documentation	Special Considerations
Communication of care plan elements with Primary Care Physician (PCP) must occur annually, with change in condition, with change in product, with change in CC, or following a transition For MSHO & SNBC Enhanced UTR/Ref Members, it is required that the CC attempt to identify the PCP. These attempts may include information being obtained from: member, claims review, other specified sources (PCP attribution list). Once PCP identified PCP communication must occur.	All members	• PCP Letter • PCP Fax Notification • Case Notes stating name of PCP, method of PCP contact, & documentation of discussion	PCP letters are an opportunity to address findings from the most recent HRA, identify services the member is receiving, identify the PCP as an integral part of the Interdisciplinary Care Team & provide CC contact information. Note: Medica auditors need to verify this contact is occurring as indicated in requirements. MSHO & SNBC Enhanced PCP letters also include Model of Care Training Requirements for Physicians PCP Fax Notification allows CCs to complete PCP communication of admissions & discharges during a transition

Care Plan Sharing with Providers- Member's Choice

Requirement	Member Type	Contact Options & Documentation	Special Considerations
If the member chooses, a summary of the Care Plan must be sent within 30 days of completion of	Elderly Waiver (EW) members & members receiving Housing	• Care Plan Summary Letter	The CC Hub has Home and Community Based Services (HCBS) Providers Included in the Care Plan Sharing

the Care Plan. If not returned signed it must be sent again within 60 days of completion of the Care Plan.	Stabilization Services		Requirement and a FAQ. Specific instructions are also included on #51 of the MSHO & MSC+ Care Plan Instructions. **Note:** Medica auditors need to verify this contact is occurring, when chosen, after each assessment.

County Worker

Requirement	Member Type	Contact Options & Documentation	Special Considerations
The Care Coordinator/Case Manager will maintain communication with county social services or public health agencies throughout the year as needed. (Such as with financial workers & case managers). This may include, but is not limited to, referrals and/or coordination with county service staff for members in need of the following services: —Pre-petition screening for civil commitment —Preadmission screening for HCBS waivers. —County case management for HCBS waivers. —Child Protection —Court ordered treatment —Housing funding resources —Assessment of medical barriers to employment —Adult Protection —Relocation Service Coordination —State medical review team or social security determination —Working with Local Agency social service staff or county attorney staff for members who are the victims or perpetrators in criminal cases.	All members	• 5181 • 5841 • Case Note stating communication that occurred with specific county worker.	Communication, coordination, or referral may be via letter, fax, email, face to face contact, or phone call. If members are on another waiver, Medica expects annual collaboration with the waiver worker to assure member needs are being met and there is not duplication of services. **Note:** Medica auditors need to verify this contact is occurring annually.

Behavioral Health

Requirement	Member Type	Contact Options & Documentation	Special Considerations
When behavioral health concerns are identified, referrals will be made to qualified behavioral health professionals. Updates and changes to the	All members	• Case Note stating communication that occurred re: behavioral health concern & referral	Communication, coordination, or referral may be via letter, fax, email, face to face contact, or phone call. **Note:** Medica auditors need to verify this contact is occurring

member's condition and needs as appropriate	• If you identify a behavioral health need, but do not complete a referral, documentation as to why a referral was not completed must be present	if behavioral health concerns are identified.

If you have questions about this audit element, please reach out to your auditor or email **MedicaSPPRegQuality@Medica.com**.

Chore Service Reminder

When Care Coordinators are submitting a referral to their support specialist for chore services, please put "Chore Services" in the subject line and send it high priority. We need to review them before services are started, and don't want to delay services. Please also include details of the chore service you are requesting.

Department of Human Services (DHS) Update: Case manager and care coordinator toolkit

Reminder **eList announcement** sent out June 13, 2023:

The Aging and Adult Services and Disability Services divisions launched the Case manager and care coordinator toolkit in November 2022. The toolkit includes DHS resources, training opportunities, policy changes and/or updates and other resources related to the duties of a case manager and care coordinator. Please bookmark this helpful resource: **Case manager and care coordinator toolkit**.

DHS wants your feedback. Fill out this form to request added content for the toolkit: **Case management/care coordinator toolkit feedback**.

DHS Update: Policy change about temporary admissions to certain facilities for 121 or fewer days

DHS policy change regarding temporary admissions retroactive to May 1, 2022. People who were admitted to certain facilities for 121 or fewer days and were receiving HCBS may return to the community with HCBS waiver services without needing an assessment. Please review the full **eList announcement**.

DHS Update: Temporary waiver exits and restarts: MMIS actions - Post-COVID-19 policy starting 7/1/23

The end of continuous coverage for people incarcerated or admitted to a residential treatment setting before July 1, 2023. Please review the **complete information**.

DHS Update: Medicaid redeterminations/renewal process

Medicaid redetermination/renewals continue, and Care Coordinators are the face of "Medica" for our members. You will play an important role in helping your members understand the Medicaid redetermination/renewal process.

For some members, it has been several years since they have gone through the annual Medicaid renewal process and for other members, they are newer to Medicaid coverage and have never gone through the renewal process at all. Considering the vulnerable population, you work with, all members will require some level of assistance which is why your calls to them are so important.

Adult Day Services (ADS) Alternative and Remote

DHS authorized licensed Adult Day Service providers to deliver alternative ways during COVID-19 peacetime emergency. **Alternative adult day services ended June 30, 2023.** A **Remote** ADS delivery option is available July 1, 2023, for licensed adult day service providers who are enrolled with DHS to offer Remote services. DHS defines Remote ADS as an individualized and coordinated set of services provided via live, two-way communication by an adult day services center. Live, two-way communication is real-time audio or audio and video transmission of information between a member receiving services and an actively involved adult day services staff member.

Providers must meet remote requirements and specifically be enrolled with DHS to provide Remote ADS. To verify a provider meets the Remote requirements, use the **DHS licensing information lookup.** Under "Licensing Type" choose the drop-down "Adult Day Services" and check the "Remote Services" box and then submit. Providers enrolled to offer remote ADS will be listed here. You can also use this lookup tool to query all active ADS providers, then chose the link for the provider you are researching, and their DHS license will include more details. Under "Licensed to provide," **Remote Services** will be listed.

There are additional care planning requirements when including remote ADS on a member's service plan. DHS released an on-demand, online training for lead agency staff and providers to better understand the new remote adult day services option. To find the course, visit **TrainLink** and search for course code "AASD-RADS" or course title "Remote Adult Day Services: Training for Lead Agencies and Providers." Please review this training prior to authorizing Remote ADS.

Medica will no longer enter authorizations for Alternative Adult Day services. To authorize Remote ADS, the CC must verify the provider is enrolled with DHS to provide Remote ADS and care plan for the service per DHS requirements. Indicate on the Referral Request Form the number of units and days per week of the ADS service. Example 4 days per week in person and one day a week remote. Please note, members authorized for Remote must receive in person ADS at least quarterly.

The ADS Benefit Guideline will be updated to reflect the remote delivery option and we will let you know when it is posted.

For more information, please review the following DHS Announcements and Resources:

- **AASD and DSD Announcement**
- **MHCP provider news and updates**

MnCHOICES Phase 1

Phase 1 of the revised MnCHOICES application launch has begun and is effective July 10 to Sept. 29, 2023.

Per DHS guidance, delegates should:

- Be working with Medica to set up all user accounts and permissions in the revised MnCHOICES system.
- Assure that staff continue to practice in MTZ.
- Have up to 10% of users (minimum of one or two users per agency) complete health risk assessments (HRAs), assessments and support plans in the production environment.
- Allow remaining staff members to continue using legacy systems.

The next revised MnCHOICES application launch webinar in schedule for 8/9/23 10am-12noon. We encourage all mentors to attend.

Newsletter notification

We are making a change to our current process. Instead of emailing the actual CC newsletter, we will just be emailing our delegate leadership a notice monthly once the newsletter has been posted to CC Hub. It is important to share this notice with staff. It is the responsibility of our delegates to review the newsletter each month for important updates and communications. The newsletter typically will post on or before the 28th of each month.

Office Hours

We have discontinued our delegate office hours. If there is interest in the future, we can reevaluate how these will serve as a benefit our delegates.

Our last office hours for MSHO/MSC+ were 6/14/23 and for SNBC/SNBC Enhanced 6/28/23.

Welcome Support Specialist Demarie

We have a new member on the Support Specialist Team for the delegates. We would like to introduce Demarie Davis. She started with us on 5/30/2023. Demarie has worked with each of the team members and has covered for vacations. She has been assigned a few delegates, and as she is ready, we will assign her a couple more. We will get the assignment grid updated shortly. In the meantime, we have emailed the delegates she will be working with.

Upcoming August Meetings/Trainings

DME Training – August 9th, 2023, 12-1pm
IDT consults – August 16th, 2023, 9-12pm
Trauma Informed Training #1 – August 28, 2023, 11am-1pm
Trauma Informed Training #2 – August 30, 2023, 11am-1pm

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

Environmental Accessibility Adaptations (EAA)

Environmental Accessibility Adaptations (EAA) are physical adaptations to a person's **primary home** or **primary vehicle** to ensure the person's health and safety or enable them to function with greater independence.

We realize that Environmental Accessibility Adaptations (EAA) may be new to you, or you have not had a member in need of this service in a while. Please note below where to find information and an update on vehicle assessments.

You can find **Environmental Accessibility Adaptations (EAA) training** on the Medica CC site. Education provided in section **Training** under the **Stay up-to-date** on the first page of the Care Coordination Hub. Use the dropdown for the Archive of quarterly care coordination meetings, proceed to June 2021 training video (time stamp 22:17) & June Quarterly CC Meeting follow-up MSHO/MSC+ only (time stamp 36:58).

EAA vehicle modifications covers an assessment to determine the member's vehicle modification needs. EAA (T2039 UD) does **not** cover a driving assessment/evaluation for safety and training unless it is for a vehicle modification.

If the member needs a driving evaluation due to a medical condition such as a stroke, verify coverage under Occupational Therapy through the medical assistance benefit and not the Elderly Waiver.

Any questions/concerns or consult feel free to reach out to the Benefit Managers at **BenefitManagers@medica.com**.

MSHO Added Benefit Spotlight: Additional Dental Services

There are some additional dental benefits available to our MSHO members are eligible to receive additional dental services:

- Two porcelain-fused-to-metal crowns on any two teeth per year
- One additional dental exam each year in addition to the one covered by Medical Assistance
- One full mouth x-ray once every five years
- One molar root canal per tooth per lifetime
- One molar root canal retreatment per tooth per lifetime; only covered if completed at least 24 months after the original root canal

Please reach out to Delta Dental with any questions.

Provider signature requirements

The Letter Templates section of the CC Hub has been updated. The Provider Signature Care Plan Letters have had a name change. For these there has been NO content change to these letters.

The Cover Letter should be used when the member has requested the entire care plan be shared with the EW provider/HSS provider/or PCA provider (of member on EW).

The Summary letter should be used when the member does not want the entire care plan shared with the EW provider/HSS provider/or PCA provider (of member on EW).

Regardless of which version of the letter is used, it is still a requirement to obtain the provider signature indicating that they have reviewed the plan, acknowledge, and agree to provide the services and supports as outlined. If a signed version is not return upon initial notification a second attempt must be completed within 60 days of completion of the care plan.

A Provider Signature Care Plan Sharing Requirements tool has been added to this page to specify which services require care plan sharing to be offered.

The Provider Signature Requirements FAQ has also been updated.

If you have questions about the provider signature care plan sharing requirements, please reach out to your auditor or email **MedicaSPPRegQuality@Medica.com**.

Senior Living Insights Email Blast reminder:

Reminder of service provider that offers fall detection and medication dispensing devices for our senior Metro and surrounding area members.

Senior Living Insights is a locally owned and a DHS enrolled waiver service provider that offers solutions to promote proactive and successful aging that enable seniors to remain in their homes for as long as possible. They are a based in the Twin Cities area and offer services in the 12-county metro area including PERS units, medication dispensers and a non-wearable fall risk detection system.

Unique to Senior Living Insights is their non-wearable fall detection system that is used in areas and situations where PERS pendants/watches are rarely worn and ensures members can still get help if they are unable to push a button for assistance. Members who may benefit from this service include those who have fall risks and prefer not to wear a device or forget to put it on and/or may not be able to recall or report when and where a fall occurred.

Attached is a flier of their products and contact information. If you have questions, you can reach them at **senior.living.insight@gmail.com** or (763) 300-1924.

Special Needs Basic Care (SNBC) + SNBC Enhanced

SNBC Enhanced Added Benefit Spotlight: Additional Dental Services

SNBC Enhanced members are eligible to receive additional dental services:

- One porcelain-fused-to-metal crown on any tooth per year
- One additional dental exam each year in addition to the one covered by Medical Assistance
- One full mouth x-ray once every five years
- One molar root canal per tooth per lifetime

- One molar root canal retreatment per tooth per lifetime; only covered if completed at least 24months after the original root canal

Please reach out to Delta Dental with any questions.

SNBC Members turning 65

The Care Coordinator will assist members turning 65 years old in understanding their transition to a senior product. SNBC and SNBC Enhanced members are not able to remain on the SNBC programs after age 65; members are required to choose a senior program. Minnesota Department of Humans Services (DHS) requires that SNBC and SNBC Enhanced members either default into the MSC+ program, or actively enroll into MSHO if they are eligible.

It is important for Care Coordinators to be aware of member's service providers and investigate whether these providers are in Medica's network. This is especially important for members who are receiving PCA services. Please refer to the SNBC & SNBC Enhanced Members Turning 65 policy and the Home Care policy on the Care Coordination Hub for more details.

Members who choose to disenroll from ISNBC

Effective 7/1/23, DHS has made a change to the disenrollment process for members on Integrated SNBC (ISNBC). When a member on the ISNBC program decides that they would like to disenroll, they will be disenrolled from ISNBC and return to Fee-For-Service. Before 7/1/23, if someone disenrolled from ISNBC, they were put into the Medicaid only SNBC program.

If a Medica member is disenrolling from ISNBC but would like to enroll into the Medicaid only SNBC program, they will need to enroll into that program. Members/Responsible parties interested in enrolling into the SNBC program or any of Medica's products can contact the Medica sales department directly at 1 (888) 221-1825.

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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