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PRODUCTS AFFECTED

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

DEFINITIONS

Care Coordinator (CC): A person who assesses the member, creates a person centered care plan, and then coordinates the provision of services and supports for those members among different health and social services professionals and across settings of care.

Change of Condition: Any change in the health of the member that triggers an increase or decrease in the need for services. Changes in activities of daily living (ADL's), independent activities of daily living (IADL's), or other supports may indicate the change in condition. It is up to the professional judgment of the CC to determine if a change in member condition merits a face- to-face reassessment. In addition, 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 client's needs.

CMS: Centers for Medicare and Medicaid Services under the U.S. Department of Health and Human Services.

DHS: Minnesota Department of Human Services

Elderly Waiver (EW) Program: Medical Assistance (MA) program that funds home and community-based services for people 65 and older who require the level of care provided in a nursing facility, are eligible for long term care under Medical Assistance, and who choose to reside in the community

Future End Date: Future end dates indicate members who have lost their Medicaid eligibility and Medica is covering services for 90 days. This information is located on the enrollment report sent to each care system, agency, and county lead. Future end dates only applied to members on MSHO and SNBC Enhanced products who meet criteria.

HRA and Assessment Tools for MSHO/MSC+
NOTE: Medica owned tools can be found on the Medica Care Coordination website under Tools and Forms. All DHS tools can be found on the DHS Edocs site.

- DHS form 3426 OBRA Level I Criteria – Screening for Developmental Disabilities or Mental Illness (OBRA)
- DHS 3428 Minnesota Long Term Care Consultation Services Assessment Form (LTCC)- used for all MSHO/MSC+ EW members, and MSHO/MSC+ members with PCA services.
- DHS 3428D Supplemental Waiver PCA Assessment – used for assessing for PCA services. This is used in addition to completing the LTCC (DHS 3428).
- DHS 3428G Minnesota Service Change Form for EW and AC Participants- used for items/needs that have changed since the last assessment or reassessment completed resulting in need for changes in services or service plan. This does NOT represent a full reassessment.
- DHS 3428H Health Risk Assessment– used for MSHO/MSC+ Non-EW members without PCA services and for MSHO/MSC+ members on other waivers (used for members on Community Access for Disability (CADI), Brain Injury (BI), or Developmental Disability (DD) waivers).
- Elderly Waiver Residential Services Tool- Completed based on the assessment findings. This will allow proper payment to providers as waiver eligibility start dates may be effective back to the date of assessment.
- Institutional Member Assessment- used for MSHO/MSC+ members identified as institutional or Rate Cell D, these members may reside in a nursing facility or ICF/DD home.
- Transfer Member Health Risk Assessment- for MSHO/MSC+ community members that have transferred into Medica or transferred between MSHO and MSC+ and have had an LTCC/HRA/MnCHOICES assessment within the past 365 days. Can only be used if CC is able to obtain a copy of the full assessment previously completed with the member. This does NOT represent a full assessment. NOTE: The Transfer Member Health Risk Assessment is NOT used for members residing in an institutional living setting. The Transfer Member Health Risk Assessment can NOT to be used when a member transfers to MSHO/MSC+ from SNBC, unless the assessment is reflective of determination for opening Elderly Waiver (65th birthday assessment and must be a full LTCC or Full MnCHOICES assessment).

MMIS: Medicaid Management Information System. A complex, highly integrated claims payment, information management, and retrieval system implemented by the State of Minnesota Department of Human Services to manage Medicaid enrollee data.

MSHO Rate Cell A: Community Non-Elderly Waiver Enrollees who, at capitation for MSHO, are coded in MMIS to be in a community living arrangement and are not enrolled in the Elderly Waiver for the first of the following month. These members are not 'nursing home certifiable" or not receiving at least one EW service.

MSHO Rate Cell B: Community Elderly Waiver Enrollees who, at capitation for MSHO are coded in MMIS to be in a community living arrangement and are enrolled in the Elderly Waiver for the first of the following month. These members are 'nursing home certifiable' and are receiving at least one EW service.

MSHO Rate Cell D: MSHO member who has been a resident of a nursing home for more than 30 days. Members considered to be "institutional" are shown on the full enrollment report to be in DHS designated living settings 41, 42, or 43.

MSC+ Non-EW: Community Non-Elderly Waiver Enrollees who, at capitation for MSC+, are coded in MMIS to be in a community living arrangement and are not enrolled in the Elderly Waiver for the first of the following month. These members are not "Nursing Home Certifiable" or not receiving at least one EW service.

MSC+ EW: Community Elderly Waiver Enrollees who, at capitation for MSC+ are coded in MMIS to be in a community living arrangement and are enrolled in the Elderly Waiver for the first of the following month. These members are "Nursing Home Certifiable" and are receiving at least one EW service.

MSC+ Institutional: MSHO/MSC+ member who has been a resident of a nursing home for more than 30 days. Members considered to be "institutional" are shown on the full enrollment report to be in DHS designated living settings 41, 42 and 43.

Nursing Facility (NF) Level of Care: Standard to allow entry to nursing facilities and the home and community-based waivers for individuals demonstrating one or more of the following characteristics: a high need for assistance in four or more activities of daily living (ADL); a high need for assistance in one ADL that requires 24 hour staff availability; a need for daily clinical monitoring; significant difficulty with cognition or behavior; qualifying nursing facility stay of 90 days; or living alone and risk factors are present.

Screening Document Type "H": All HRAs for the following member types: Non-EW, Rate Cell A without PCA services, and members who have refused or are unable to be located will need to be entered in MMIS as a screening document type "H". Institutional assessments are not entered in MMIS.

Screening Document Type "L": For MSHO & MSC+ members on EW or who are receiving PCA services, the assessment should continue to be entered as a screening document "L". Assessments conducted using the LTCC assessment tool due to a member's request and/or need to determine eligibility for services can also be entered a screening document "L" even if the member is not opened to elderly waiver. This includes case management or document changes using activity type 05 and assessment result 98.

Transfer Member: A member that has transferred from County Fee For Service or from another Managed Care Organization to Medica for Care Coordination; has changed from one Medica product to another (i.e.: MSC+ to MSHO or MSHO to MSC+) or has changed from one Medica Care Coordination

Delegate to another Medica Care Coordination Delegate.

PURPOSE
To ensure all Medica members are assessed in a timely manner using the appropriate tools in accordance with the DHS, CMS, and Medica requirements.

POLICY
Counties/Tribes, Agencies, and Care Systems that provide services for Medica members must complete assessments and reassessments with members in accordance with the DHS, CMS, and Medica requirements. Assessment and reassessment dates will be audited items as part of the care plan audit.

HRA/ASSESSMENT REQUIRED
All members are required to have a face-to-face assessment offered to them upon enrollment with Medica, and at least annually (365 calendar days) thereafter. MSHO members, MSC+ members receiving EW services or PCA services a required to have a face-to-face assessment annually. Care Coordinators (CC) are also required to complete a face-to-face assessment upon member request or as indicated following a change of condition. Members are able to decline the face-to-face assessment HRA (note: to continue Elderly Waiver and PCA services, members must receive a face-to-face assessment by their annual assessment due date to continue services). If the face-to-face assessment is declined, telephonic assessments may be offered for MSC+ non-EW members without PCA services. See Telephonic Assessment Policy.

MEMBERS WHO LOSE ELIGIBILITY
Care Coordinators are required to support members in understanding why they have had a loss in Medicaid eligibility and assist them in re-establishing their eligibility, if possible. It is important to note the reason for member's loss of eligibility. The reason for the loss of eligibility is found on your full enrollment report from Medica each month. The CC needs to determine if the enrollment report states "eligibility", "spenddown", or "other".

For all members who lose "***eligibility*"**, but are due for an annual reassessment within 90 days of their Medical Assistance (MA) term, per DHS and CMS guidance, CC's are to complete the HRA by the due date. If the member is reinstated without a lapse in coverage, this HRA can then be entered into Medicaid Management Information System (MMIS) using the appropriate activity date.

For any member who had been on EW: <u>If the member is not reinstated within 60 days,</u> the CC is to complete and send the DHS 6037 to the county of residence for communication purposes. The county will determine if they need to enter a service agreement for continued payment of EW services the member is receiving-see DHS #6037A for more information.

If a member loses eligibility but is reinstated and there is no lapse in coverage with Medica a new HRA does not need to be completed provided the CC has maintained regular scheduled contact with the member, the HRA/Care Plan is current, and there has been no change of condition or a change in the supports identified or requested. A new HRA would need to be completed if there was a change in condition or change in the supports needed or requested during that time. Documentation in case notes should include notes on efforts made to assist member with eligibility issues.

If a member on EW loses eligibility due to a managed care enrollment exclusion such as a nonpayment of their ***"spenddown"*** as determined by DHS or the financial worker, the CC is to complete and send the DHS 6037 form to the county of residence immediately, this allows the county to determine whether they need to enter a service agreement for continued payment of EW services the member is receiving.

For MSHO members who lose their MA eligibility, most will remain on the program for 90 days. This future term date is called the future end date. During this time, all care coordination requirements remain in place to include any HRA's due. Also during this time, the CC is to be assisting the member and the county related to the members MA paperwork. CC's are to refer to their Full Enrollment report to identify if they have members with a future end date as they are to offer assistance with the Medicaid renewal process.

PROCEDURE:

1. The County, Agency, or Care System must contact new members via phone or approved letter within 10 business days of enrollment to inform the member of the CC and provide contact information. Best practice is to set up an initial assessment during the introductory call.

2. Initial Assessments
    a. **MSHO** - must be conducted within the first 30 calendar days of enrollment. If the member requests a deferment or if the assessment does not take place within 30 calendar days, the CC must document all attempts to schedule the HRA and document why the assessment was not completed timely. At a minimum the documentation must include at least 3 phone call attempts to reach the member and documentation that a follow-up letter in its attempt to reach the member was sent.
        i. For initial assessment, if the CC cannot schedule an assessment, a refusal/unable to find screening document type "H" should be entered in MMIS by the last business day of the enrollment month.
        ii. When the CC is able to complete an assessment, MMIS should be updated.
        iii. Medica will honor any previous PCA authorizations. The CC will not complete a PCA assessment due to a transition to Medica. The following scenarios will help guide the CC as to when to complete or not complete a new PCA assessment.
            1. The CC will only complete a PCA Assessment at the time of the initial HRA if the CC is unable to obtain the most recent PCA Assessment or authorization, there is a change in condition or supports, the member requests a new PCA Assessment, or the PCA authorization will end within 30 calendar days of the HRA date.
            2. A PCA reassessment will not be completed if member has a current authorization for PCA services and can obtain the current authorization and PCA assessment from the provider or the member.
            3. The CC will not complete the PCA assessment if the CC does not have the previous LTCC/HRA and needs to complete a new LTCC/HRA. It is likely that the CC will need to conduct another LTCC and PCA Assessment before the end of the PCA authorization.
            4. If a member is on a waiver managed by the county, the county is responsible for the PCA assessment. The CC will review and authorize PCA services and communicate with the waiver case manager and may

use DHS 5841.

iv. Medica will honor any previous EW service authorizations. The CC will not terminate these services during the previously approved open waiver span.

b. **MSC+** - members receiving EW or PCA services must have assessment conducted within the first 30 calendar days of enrollment. Non- EW, Non-PCA MSC+ member assessments must be conducted within the first 60 calendar days of enrollment. If the member requests a deferment or if the visit does not take place within 30/60 calendar days, the CC must document all attempts to schedule the assessment visit and document why the assessment was not completed timely. At a minimum the documentation must include at least 3 phone call attempts to reach the member and documentation that a follow-up letter in its attempt to reach the member was sent.

   i. For initial assessment, if the CC cannot schedule an assessment, a refusal/unable to find screening document type "H" should be entered in MMIS by the last business day within 60 calendar days of the enrollment month.
   ii. When the CC is able to complete the assessment, MMIS should be updated.
   iii. Medica will honor any previous PCA authorizations. The CC will not complete a PCA assessment due to a transition to Medica. The following scenarios will help guide the CC as to when to complete or not complete a new PCA assessment.
      1. The CC will only complete a PCA Assessment at the time of the initial HRA if the CC is unable to obtain the most recent PCA Assessment or authorization, there is a change in condition or supports, the member requests a new PCA Assessment, or the PCA authorization will end within 30 calendar days of the HRA date.
      2. A PCA reassessment will not be completed if member has a current authorization for PCA services and can obtain the current authorization and PCA assessment from the provider or the member.
      3. The CC will not complete the PCA assessment if the CC does not have the previous LTCC/HRA and needs to complete a new LTCC/HRA. It is likely that the CC will need to conduct another LTCC and PCA Assessment before the end of the PCA authorization.
      4. If a member is on a waiver managed by the county, the county is responsible for the PCA assessment. The CC will review and authorize PCA services and communicate with the waiver case manager and may use DHS 5841.
   iv. Medica will honor any previous EW service authorizations. The CC will not terminate these services during the previously approved open waiver span.

c. **Institutional-**- must be conducted within the first 30 calendar days for MSHO and 60 calendar days for MSC+ of enrollment. If the member requests a deferment or if the visit does not take place timely the CC must document all attempts to schedule the HRA and document why the assessment was not completed timely. At a minimum the documentation must include at least 3 phone call attempts to reach the member and

documentation that a follow-up letter in its attempt to reach the member was sent.

i. When the CC is able to complete the assessment, the members file should be updated.

3. The CC will complete the LTCC/HRA & OBRA Level 1, PCA Assessment, and RS Tool (as applicable) or Transfer HRA at the first assessment for all MSHO and MSC+ community members. The CC will complete the Institutional Assessment at the first assessment for all MSHO and MSC+ members residing in an institutional living setting.

4. The CC will complete MMIS entry following all LTCC/HRA or Transfer HRA's. Institutional Assessments are NOT entered in MMIS.

5. The CC will determine appropriate Rate Cell/EW eligibility/NF level of care status based on outcome of assessment. If the CC initially completed the DHS 3428H and it appears the member may be appropriate for Elderly Waiver, the CC will need to complete the DHS 3428, LTCC to determine rate cell and open the Elderly Waiver. Members who request PCA or Elderly Waiver services must have an LTCC completed to determine eligibility.
   a. To be eligible for EW the Enrollee must receive Care Coordination, and have authorized and delivered at least one additional formal waiver service as documented in the EW care plan. Enrollees are eligible for EW for a maximum of sixty (60) days without the authorization of an additional waiver service, beyond case management. If the reason for not authorizing an additional waiver service is the result of a transition between providers, services or settings, an additional sixty (60) days to authorize waiver services may be allowed. If services are not authorized during this time frame, the participant must exit the waiver until determined eligible and additional waiver services can be authorized.

6. Upon completion of assessment, the CC will set up a follow-up contact schedule with the member. Follow up frequency and purpose will be noted on the care plan. Frequency of contact should be based on professional judgment and member input as well as Rate Cell/EW eligibility/NF level of care status. CC should consider member's care level on Medica's Enhanced Care Coordination/Impact Report when setting contact schedule. Refer to the Care Coordination Assessment and Follow up Activities Grid at the end of this policy. These are the minimum required contacts.

   a. MSHO/MSC+ Community Based Members (MSC+ EW or Non-EW Community Based members or MSHO Rate Cell A, B):
      i. Annual face-to-face visits using approved assessment tool
      ii. MSC+ Non-EW, Non PCA may complete a telephonic visit using approved assessment tool.
      iii. Minimum contact every 6 months (additional contacts per CC judgement and identified member needs)
      iv. Contacts related to member transitions

   b. MSHO/MSC+ Institutional Members (MSHO Rate Cell D) or Members residing in an ICF-

DD:

i. Annual face-to-face visits using approved assessment tool
ii. Participation in care conferences
iii. Minimum contact every 6 months (additional contacts per CC judgement and identified member needs)
iv. Contacts related to member transitions

c. MSHO/MSC+ members who have been determined eligible for another waiver (DD, BI, CADI):

i. Annual face-to-face visits using approved assessment tool
ii. Minimum contact every 6 months (additional contacts per CC judgement and identified member needs)
iii. Contacts related to member transitions
iv. Annual and PRN contact with county case manager

7. CC will document all work related to care coordination, for example, attempted contacts with the member, family, providers, county social services, and case management systems.

8. If the member resides in a residential setting and recently had a change of condition or change of living setting, the CC would complete the RS Tool as well. A new assessment must take place as soon as reasonable.). CCs would complete a new DHS 3428, 3428H, or 3428G for a change in condition. If the member has PCA services and recently had a change of condition, the CC would complete the PCA assessment along with DHS 3428 during a face-to-face visit.

9. Care Coordinators may use the 3428G in cases where specific criteria is met. Use this form to update only information that has changed since the last assessment or reassessment completed. Activity Type 10 does NOT represent a full reassessment. Please refer to DHS guidance for more information.

10. Annual reassessments must be completed within 365 calendar days of the previous assessment. Note: For members who last had a Transfer HRA completed, the annual reassessment date is to be no more than 365 calendar days from the date of the last full LTCC/3428H or MnCHOICES assessment, NOT the transfer HRA completion date. If the member requests a deferment or if the visit does not take place within 365 calendar days, the CC must document all attempts to schedule the assessment and document why the assessment was not completed timely. At a minimum the documentation must include documentation of member refusal of assessment or at least 3 phone call attempts to reach the member and documentation that a follow-up letter in its attempt to reach the member was sent. A screening document type “H” should be entered in MMIS within 30 calendar days of member refusal or member unable to be located.

11. Refer to grid at the end of this policy to determine what care coordination actions are required to be completed.

MMIS ENTRY PROCESS

The following steps in MMIS should be taken for entry for MSHO and MSC+ members:

Activity Type 01: Telephone Screen

- For use with initial and reassessment Health Risk Assessments conducted by telephone for MSC+ members. Assessment Result 35. Program Type 18.
- For use with nursing facility admission. MCO staff complete the Pre-Admission Screening (PAS) process using DHS 3427T

Activity type 02: Face to Face Assessment

- MSHO Rate Cell A: For use with initial and reassessment Health Risk Assessments conducted through a face-to face visit. Assessment result is 35. Program Type 18
- MSHO Rate Cell B: For use with only initial opening to EW
- MSC+ Non EW: For use if not using Activity Type 01, Use for initial and reassessments, assessment result is 35. Program Type 18.
- MSC+ EW: For use only for initial opening to EW

Activity Type 05: Document Change

- For use when showing a change in Care Coordinator , Care Coordination Delegate, or Managed Care Organization (MCO)
    - A member that has been internally transferred and assigned to a new Care Coordinator assigned within the same Care System, County, or Agency or to a new Medica Delegate without a change in product.
    - A member that has been transferred and assigned to Medica as the new MCO
- Activity Date can be the same as the assessment result date
- Assessment Result should be 98
- Health Plan: MED
- Assessment team: 02
- Program Type 18

Note: Activity Type 05 cannot be used to open a waiver span

Activity Type 06: Reassessment

- For use only for MSHO Rate Cell B and MSC+ EW members to continue waiver eligibility.

Note: Activity Type 06 cannot be used for MSHO rate cell A reassessments or for MSC+ non-EW reassessments.

Activity Type 07: Case Management/Administrative Activity

- For use when a HRA was not successful due to the member declining to complete. Assessment result 39. Program Type 18.
- For use when a HRA was not successful due to the member not being located. Assessment result 50. Program Type 18.
- For use when a review of the last HRA occurred with the member due to a change in products (MSHO to MSC+ or MSC+ to MSHO). Activity date: date CC completes review. Assessment result 51. The Effective Date field must match the Effective Date of the last Assessment Result 35 and not be more than 366 days from the current date. Program Type 18.
- To exit EW members due to SNF admission, Death, or no longer using EW services.
- Updating MMIS for members who are already on EW but choosing to start CDCS.

Activity Type 09: Eligibility Update

- Only used when additional eligibility determination(s) unrelated to the assessment have not

been completed by the county within the 60 day window.

- See MMIS manual for more details.
- Allows the earliest effective date of eligibility to be the date of the face-to-face assessment, if the eligibility update occurs within 90 days of the face-to-face assessment and all other eligibility requirements are met

Activity Type 10: Annual Reassessment is Not Due & Member has Change in Needs which result in a change in services, requiring additional resources

- Used if the member's case mix classification has changed, if the change results in eligibility for 24 CL rate limits, or additional funding under CDCS.

Note: Activity type 10 cannot be used when updating the person's service plan with existing resources or when an annual reassessment is due within 30 days, in this case, perform a reassessment.

Scenario	Action
Newly enrolled in Managed Care Organization (No previous Care Coordinator, No previous Fee For Service (FFS))	▪ Complete new assessment and paperwork per CC assessment and follow-up activities grid below. ▪ **Send member Welcome letter OR contact member,** introduce self and provide updated CC contact information. If contact is other than a Welcome letter, this must be documented in members file in case notes.
Transfer from FFS - Able to obtain current assessment, member signature sheet or DHS 6791, and Collaborative Care Plan or CSP & CSSP for the transferred member.	▪ **Review received paperwork** including, but not limited to DHS-6037-ENG Home and Community- Based Services Case Management Transfer Form**,** copy of current assessment, care plan, member signature sheet or DHS 6791, and PCA assessment/RS Tool, if applicable. *Institutional members will only have of copy of the current assessment.* ▪ If you are unable to obtain the required paperwork from the previous Case Manager, member must be reassessed and all assessment paperwork will need to be completed. ▪ **Send member Welcome letter OR contact member,** introduce self and provide updated CC contact information. If contact is other than a Medica Change of CC letter, this must be documented in members file in case notes. ▪ **Health Risk Assessment (HRA) -** CC will conduct initial assessment with member/responsible party within 30 calendar days for MSHO/60 calendar days for MSC+ of transfer/enrollment **OR** review previous assessment telephonically or in person **with member.** CC will document that review occurred on the Transfer Member HRA, including the date and if there are any updates or changes. If it is determined by the CC that a change of condition has occurred or change in living setting has occurred CC will proceed with new assessment (see change of condition or change of living setting scenario below). For institutional members, the CC will document that a review of the current Institutional Assessment occurred in the member's case notes.

Scenario	Action
	▪ **Care Plan-** CC will review previous care plan telephonically or in person **with member**. CC will document that review occurred on the Transfer Member HRA, including the date and if there are any updates or changes. CC will create a new care plan within 30 calendar days of date of review of assessment or update health related goals section of Transfer Member HRA if there are updates needed. CC will address remaining elements on Transfer Member HRA if they are not addressed on the current Care Plan/Community Support Plan (CSP)/Collaborative Care Plan (CCP). ▪ **Member Signature Sheet or DHS 6791**- must be included in the transfer paperwork received or CC should review elements with member and obtain new signature sheet. ▪ **Update MMIS** (See MMIS Entry Process above) ▪ **Update Financial Worker, Primary Care Physician, and Waiver Worker:** CC will document date notification of change in CC or that change in product occurred on Transfer Member HRA.
Internal Transfer- New Care Coordinator assigned within your Care System, County, or Agency	▪ **Review received paperwork** copy of current assessment, care plan, member signature sheet or DHS 6791, and PCA assessment/RS Tool if applicable. *Institutional members will only have of copy of the current assessment.* ▪ Transfer HRA is NOT required when internal transfer occurs. Review member documents and document in member case notes. ▪ If you are unable to obtain the required paperwork from the previous Medica CC, member must be reassessed and all assessment paperwork will need to be completed. ▪ **Send member Medica Change of CC letter OR contact member**, introduce self and provide updated CC contact information. If contact is other than a Medica Change of CC letter, this must be documented in members file in case notes. ▪ **Update MMIS** (See MMIS Entry Process above) ▪ **Update Financial Worker, Primary Care Physician, and Waiver Worker:** CC will document date notification of change in CC or that change in product occurred in member’s file in case notes.

Scenario	Action
External Transfer: **MSHO/MSC+ Member Transfer with current assessment, member signature page, and care plan for the transferred member. This includes:** ▪ One Managed Care Organization (MCO) to another Medica Care System/County/Agency to another Care System/County/Agency ▪ Does NOT include internal Care System/County/Agency transfers within your own agency, see Internal Agency Transfer above	▪ **Review received paperwork** including, but not limited to DHS-6037-ENG Home and Community- Based Services Case Management Transfer Form, copy of current assessment, care plan, member signature sheet or DHS 6791, and PCA assessment/RS Tool, if applicable. *Institutional members will only have of copy of the current assessment.* ▪ If you are unable to obtain the required paperwork from the previous Medica CC, member must be reassessed and all assessment paperwork will need to be completed. ▪ **Send member Medica Change of CC letter OR contact member**, introduce self and provide updated CC contact information. If contact is other than a Medica Change of CC letter, this must be documented in members file in case notes. ▪ **Health Risk Assessment (HRA) -** CC will conduct initial assessment with member/responsible party within 30 calendar days of transfer/enrollment **OR** review previous assessment telephonically or in person **with member.** CC will document that review occurred on the Transfer Member HRA, including the date and if there are any updates or changes. If it is determined by the CC that a change of condition has occurred or change in living setting has occurred CC will proceed with new assessment (see change of condition or change of living setting scenario below). For institutional members, the CC will document that a review of the current Institutional Assessment occurred in the member's case notes. ▪ **Care Plan-** CC will review previous Care Plan/CSP/CSSP telephonically or in person **with member**. CC will document that review occurred on the Transfer Member HRA, including the date and if there are any updates or changes. CC will create a new care plan within 30 calendar days of date of review of assessment or update health related goals section of Transfer Member HRA if there are updates needed. CC will address remaining elements on Transfer Member HRA if they are not addressed on the current Care Plan/CSP/CPP. ▪ **Member Signature Sheet or DHS 6791**- must be included in the transfer paperwork received or CC should review elements with member and obtain new signature sheet

Scenario	Action
	▪ **Update MMIS** (See MMIS Entry Process above) ▪ **Update Financial Worker, Primary Care Physician, and Waiver Worker:** CC will document date notification of change in CC or that change in product occurred in member's file on Transfer HRA.
Transfer (FFS, External, Internal)-No current assessment (Member not assessed within the last 365 calendar days),**OR** unable to obtain required transfer documents for review, **OR** inconsistent documentation as listed below: ▪ Health Risk Assessment not aligned with member needs ▪ Collaborative Care Plan/CSP/CSSP goals and interventions not consistent with HRA review.	▪ Complete new assessment and paperwork per CC assessment and follow-up activities grid below.
Change in Product (<u>even if CC did not change</u>)- ▪ MSC+ to MSHO ▪ MSHO to MSC+	▪ **Review paperwork** including, but not limited to DHS-6037-ENG Home and Community-Based Services Case Management Transfer Form (if member was transferred to a new CC), copy of current assessment, care plan, member signature sheet/DHS 6791, and PCA assessment/RS Tool, if applicable. *Institutional members will only have of copy of the current assessment, others NA.* ▪ **Send member Welcome letter OR contact member,** introduce self and provide updated CC contact information. If contact is other than a Welcome letter, this must be documented in members file in case notes. ▪ If you are unable to obtain the required paperwork from the previous Medica CC, member must be reassessed and all assessment paperwork will need to be completed. ▪ **Health Risk Assessment (HRA) -** CC will conduct initial assessment with member/responsible party within 30 calendar days of transfer/enrollment **OR** review previous assessment telephonically or in person **with member.** CC will document that review occurred on the Transfer Member HRA, including the date and if there are any updates or changes. If it is determined by the CC that a change of condition has occurred or change in living setting has occurred CC will proceed with new assessment

Scenario	Action
	(see change of condition or change of living setting scenario below). For institutional members, the CC will document that a review of the current Institutional Assessment occurred in the member's case notes. ▪ **Care Plan-** CC will review previous Care Plan/CSP/CSSP telephonically or in person **with member**. CC will document that review occurred on the Transfer Member HRA, including the date and if there are any updates or changes. CC will create a new care plan within 30 calendar days of date of review of assessment or update health related goals section of Transfer Member HRA if there are updates needed. CC will address remaining elements on Transfer Member HRA if they are not addressed on the current Care Plan/CSP/CCP. These elements will include at a minimum: Preventive Care & Advance Directive discussion. *NA for Institutional members.* ▪ **Member Signature Sheet or DHS 6791**- must be included in the transfer paperwork received or CC should review elements with member and obtain new signature sheet. *NA for Institutional members.* ▪ **Update MMIS** (See MMIS Entry Process above) ▪ **Update Financial Worker, Primary Care Physician, and Waiver Worker:** CC will document date notification of change in CC or that change in product occurred in member's file on Transfer HRA.
Change in Program (even if CC did not change)) ▪ SNBC/ISNBC to MSHO/MSC+	▪ **Review paperwork** including, but not limited to DHS-6037-ENG Home and Community-Based Services Case Management Transfer Form (if member was transferred to a new CC), copy of current assessment, care plan, member signature sheet/DHS 6791, and PCA assessment/RS Tool, if applicable. *Institutional members will only have of copy of the current assessment, others NA.* ▪ **Send member Welcome letter OR contact member,** introduce self and provide updated CC contact information. If contact is other than a Welcome letter, this must be documented in members file in case notes. ▪ If you are unable to obtain the required paperwork from the previous Medica CC showing that the member has been assessed for turning 65, the member must be reassessed and all assessment paperwork will need to be completed.

Scenario	Action
	▪ **Health Risk Assessment (HRA) -** CC will conduct initial assessment with member/responsible party within 30 calendar days of transfer/enrollment **OR** review previous assessment telephonically or in person **with member.** CC will document that review occurred on the Transfer Member HRA, including the date and if there are any updates or changes. If it is determined by the CC that a change of condition has occurred or change in living setting has occurred CC will proceed with new assessment (see change of condition or change of living setting scenario below). For institutional members, the CC will document that a review of the current Institutional Assessment occurred in the member's case notes. ▪ **Care Plan-** CC will review previous Care Plan/CSP/CSSP telephonically or in person **with member**. CC will document that review occurred on the Transfer Member HRA, including the date and if there are any updates or changes. CC will create a new care plan within 30 calendar days of date of review of assessment or update health related goals section of Transfer Member HRA if there are updates needed. CC will address remaining elements on Transfer Member HRA if they are not addressed on the current Care Plan/CSP/CCP. These elements will include at a minimum: Preventive Care & Advance Directive discussion. *NA for Institutional members.* ▪ **Member Signature Sheet or DHS 6791**- must be included in the transfer paperwork received or CC should review elements with member and obtain new signature sheet. *NA for Institutional members.* ▪ **Update MMIS** (See MMIS Entry Process above) ▪ **Update Financial Worker, Primary Care Physician, and Waiver Worker:** CC will document date notification of change in CC or that change in product occurred in member's file on Transfer HRA.
Change in Program - With PCA (even if CC did not change)- ▪ SNBC/ISNBC to MSHO/MSC	▪ **Review received paperwork** including, but not limited to DHS-6037 Home and Community Based Services Case Management Transfer Form. ▪ **Send member Welcome letter OR contact member,** introduce self and provide updated CC contact information. If contact is other than a Welcome letter, this must be documented in members file in case notes.

Scenario	Action
	▪ **Complete new HRA/LTCC assessment** and paperwork per CC assessment and follow-up activities grid below ▪ **PCA Authorization-** Obtain the most recent PCA Assessment (PCA Legacy Assessment or MnCHOICES Assessment) from the PCA Provider, member or the county. Contact the PCA agency by phone or by using the Flexible Verification Form to receive the number of units remaining in the authorization using the MSHO/MSC+ enrollment date and the end date on the current authorization. If the PCA provider is an out of network provider, the CC will assist the member in transitioning to an in network provider as soon as possible. The authorization for an out of network provider cannot extend beyond 120 days. ▪ **PCA Assessment-** the CC will NOT complete a new PCA Assessment at the time of the initial HRA. The CC will only complete a new PCA assessment at the time of this HRA if: o The CC is unable to obtain the most recent PCA Assessment or authorization o There is a change in condition or a change in member supports o Member requests a new PCA Assessment o The PCA Authorization will end within 30 days of the HRA date ▪ **Missing Member or Refusing Member**-The CC will complete the referral for PCA services through the initial authorization period. The member will require an HRA and PCA Assessment completed before the end of the authorization. If the CC is unable to complete an HRA and PCA assessment during the required time period, the member will be considered Unable to reach/Refusing and the CC will need to enter a screening document type “H” and complete a DTR for the PCA services. ▪ **Waiver managed by the county**: If the member is on a waiver managed by the county (ex: CADI), the CC will obtain the most recent PCA Assessment or MnCHOICES assessment from the county waiver Case Manager and utilize the DHS 5841 to communicate the authorization. ▪ **Note:** Because in most cases the HRA and PCA Assessment will not be aligned, it will require the CC to do an additional visit to complete another HRA and a PCA Assessment prior to the end of the initial PCA authorization. This will align the assessments going forward.

Scenario	Action
Change of Condition or Change in Living Setting	▪ Complete new DHS 3428 and paperwork per CC assessment and follow-up activities grid below. If member has PCA and recently had a change of condition, CC to do PCA assessment during face-to-face visit.

	MSHO/MSC+EW	**MSHO/MSC+ NON EW**	**MSHO/MSC+ INSTITUTIONAL**	**MSHO/MSC+ NON EW WAIVER (BI, CADI, DD)**
ASSESSMENT & MMIS ENTRY	Initial, 3428 including OBRA Level 1, PCA & RS Tool (if applicable) within 30 calendar days of enrollment For initial assessment Transfer HRA may be used if required documentation present	MSHO/MSC+ with PCA: Initial, 3428 or 3428H including OBRA Level 1, PCA (if applicable) within 30 calendar days of enrollment For initial assessment Transfer HRA may be used if required documentation present MSC+ without PCA : Initial, 3428H including OBRA Level 1 within 60 calendar days of enrollment For both MSHO/MSC+:	MSHO/MSC+: Institutional Assessment within 60 calendar days of admission	MSHO: Initial, 3428H including OBRA Level 1,within 30 calendar days of enrollment For initial assessment Transfer HRA may be used if required documentation present MSC+: Initial, including OBRA Level 1 within 60 calendar days of enrollment For both MSHO/MSC+:

	MSHO/MSC+EW	MSHO/MSC+ NON EW	MSHO/MSC+ INSTITUTIONAL	MSHO/MSC+ NON EW WAIVER (BI, CADI, DD)
	For both MSHO/MSC+: LTCC Annually (every 365 calendar days) Screening document type "L" in MMIS before DHS cutoff date	LTCC/HRA Annually (every 365 calendar days) For 3428 (LTCC's) completed: Screening document type "L" in MMIS before DHS cutoff date PCA: PCA Assessment with LTCC annually to authorize PCA services For 3428H (HRA's) completed: Screening document type "H" in MMIS before DHS cutoff date	For both MSHO/MSC+: Institutional Assessment Annually (every 365 calendar days) Not entered in MMIS	HRA Annually (every 365 calendar days) Screening document type "H" before DHS cutoff date PCA: The waiver case manager is responsible for the PCA assessment. The CC reviews and authorizes the PCA services
CARE PLAN	Collaborative Care Plan sent within 30 calendar days of assessment Member Signature Sheet	Collaborative Care Plan sent within 30 calendar days of assessment Member Signature Sheet	Review institutional care plan and document review & recommendations	Collaborative Care Plan sent within 30 calendar days of assessment Member Signature Sheet
MEMBER DOCUMENTS MADE AVAILABLE AFTER ASSESSMENT	• Entire Care Plan • PCA Assessment (if applicable) • Medica Leave Behind Document	• Entire Care Plan • PCA Assessment (if applicable) • Medica Leave Behind Document	• Nursing Facility Chart Coverage Guide provided to Nursing Facility for member chart	• Entire Care Plan • Medica Leave Behind Document

	MSHO/MSC+EW	MSHO/MSC+ NON EW	MSHO/MSC+ INSTITUTIONAL	MSHO/MSC+ NON EW WAIVER (BI, CADI, DD)
	• Medication Disposal Flyer (For MSHO face-to-face visits) • Medica Post Visit Member Letter	• Medication Disposal Flyer (For MSHO face-to-face visits) • Medica Post Visit Member Letter	• Medica Leave Behind Document	• Medication Disposal Flyer (For MSHO face-to-face visits) • Medica Post Visit Member Letter
FOLLOW-UP	• Annual face-to-face assessment within 365 calendar days of previous assessment • PCP contact annually, with changes in condition, and with transitions • Contact every 6 mo. minimum or PRN; or as indicated from ECC/Impact Report • Follow-up with each notice of transition • Send Care Plan documents to EW providers and PCA	• Annual face-to-face assessment within 365 calendar days of previous assessment; MSC+ Members who are Non EW, Non PCA may have their assessment completed telephonically. • Note: All MSHO members require face to face HRA's. • PCP contact annually, with changes in condition, and with transitions • Contact every 6 mo. minimum or PRN ; or as indicated from ECC/Impact Report • Follow-up with each notice of transition • Send Care Plan documents to Housing Stabilization Service	• Annual face-to-face assessment within 365 calendar days of previous assessment • PCP contact annually, with changes in condition, and with transitions • Contact every 6 mo. minimum or PRN; or as indicated from ECC/Impact Report • Follow-up with each notice of transition • Participation in Care Conferences	• Annual face-to-face assessment within 365 calendar days of previous assessment • PCP contact annually, with changes in condition, and with transitions • Contact every 6 mo. minimum or PRN; or as indicated from ECC/Impact Report • Follow-up with each notice of transition • Annual contact with waiver case manager

	MSHO/MSC+EW	MSHO/MSC+ NON EW	MSHO/MSC+ INSTITUTIONAL	MSHO/MSC+ NON EW WAIVER (BI, CADI, DD)
	providers (for EW members) per member discussion within 30/60 calendar days • Send Care Plan documents to Housing Stabilization Service providers within 30/60 calendar days	providers within 30/60 days	• If applicable: Transfer to Medica Care System after 100 days in NF	

CROSS REFERENCES
DHS MSHO/MSC+ Contract
Medica.com Care Coordination site
DHS edoc 4669
MMIS Training found on DHS TrainLink

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