Policy Title:	**Assessment Schedule SNBC/ SNBC Enhanced**
Department:	**Government Programs**
Business Unit:	**State Public Programs**
Approved By:	**Director of SPP Products**
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PRODUCTS AFFECTED

- Special Needs BasicCare (SNBC) – Medica AccessAbility Solution®
- Special Needs BasicCare (SNBC) Integrated – Medica AccessAbility Solution Enhanced®

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

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 Assessment Tool for SNBC/SNBC Enhanced
NOTE: Medica owned tools can be found on the Medica Care Coordination website under Tools and Forms. All DHS tools can be found the DHS Edocs site.

- DHS form 3426 OBRA Level I Criteria – Screening for Developmental Disabilities or Mental Illness (OBRA)
- DHS form 3428H Health Risk Assessment- used for all SNBC members regardless of product, waiver status, or living setting.
- Transfer Member Health Risk Assessment- for SNBC/SNBC Enhanced members that have transferred into Medica or transferred between SNBC and SNBC Enhanced and have had a 3428H 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.

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.

Screening Document Type "H": This should be used for all SNBC members regardless of product, waiver status, or living setting. This also includes members who have refused an HRA or are unable to be located.

SNBC/SNBC Enhanced Community: SNBC/SNBC Enhanced member who is residing in a community living arrangement or may be experiencing a short term rehabilitation stay.

SNBC/SNBC Enhanced Institutional: SNBC/SNBC Enhanced member who is permanently residing in a nursing facility or identified institutional living setting. Members considered to be "institutional" are shown on the full enrollment report to be in DHS designated living settings 41 and 43.

Transfer Member: A member that has transferred from another Managed Care Organization to Medica for Care Coordination; has changed from one Medica product to another (i.e.: SNBC to SNBC Enhanced or SNBC Enhanced to SNBC) 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, 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. Assessments and reassessment dates will be audited items as part of the care plan audit.

HRA/ASSESSMENT REQUIRED
All members are required to have an assessment offered to them upon enrollment with Medica, and at

least annually (365 calendar days) thereafter. Members who are not currently on a waiver program are required to have a face-to-face assessment offered annually.. Members are able to decline the face-to-face assessment. If the face-to-face assessment is declined, telephonic assessments may be offered. See Telephonic Assessment Policy. 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 WHO LOSE ELIGIBILITY

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".

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 identified or requested during that time. Documentation in case notes should include notes on efforts made to assist member with eligibility issues.

For SNBC Enhanced 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. The initial assessment for SNBC/SNBC Enhanced must be conducted within the first 60 calendar days of enrollment. If the member requests a deferment or if the assessment does not take place within 60 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. If the CC cannot schedule an assessment, a refusal/unable to reach 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

3. The CC will complete the 3428H & OBRA Level 1 or Transfer HRA at the first assessment for all SNBC/SNBC Enhanced members.

4. The CC will complete MMIS entry following all HRA's or Transfer HRA's.

5. 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 plan of care. Frequency of contact should be based on professional judgment and member input. 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.

i. SNBC/SNBC Enhanced Community
    1. Annual HRA using 3428H
    2. Minimum contact every 6 months (additional contacts per CC judgement and identified member needs)
    3. Contacts related to member transitions

ii. SNBC/SNBC Enhanced Institutional
    1. Annual HRA using 3428H
    2. Participation in care conferences
    3. Minimum contact every 6 months (additional contacts per CC judgement and identified member needs)
    4. Contacts related to member transitions

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

7. A new assessment must take place as soon as reasonable if the member has a change of condition or a change in the supports needed or requested such as a change of living setting. CCs would complete a new 3428H for a change in condition.

8. 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 3428H assessment, NOT the transfer HRA completion date. If the member requests a deferment or if the assessment does not take place within 365 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 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.

9. 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 SNBC and SNBC Enhanced

members. All entries are to be completed in H Screen. **Activity Type 01: Telephone**

Screen

- For use with initial and reassessment Health Risk Assessments conducted by telephone, Assessment Result 35. Program Type 28.
- 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

- For use with initial and reassessment Health Risk Assessments conducted through a face-to-face visit, Assessment Results 35. Program Type 28.
- For members residing in a nursing home,
    - Current Living Arrangement 04 – living in a congregate setting
    - Current Housing Type 02 – institution ICF/DD, or 11 Institution NF/certified boarding care

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 a new MCO
- Activity Date can be the same as the assessment result date
- Assessment Result is 98
- Health Plan: MED
- Assessment team: 02
- Program Type 28

Activity Type 06: Reassessment

- Does not apply to SNBC/SNBC Enhanced, do not use. See Activity types 01, 02, 05 or 07.

Activity Type 07: Case Management/Administrative Activity

- For use when a HRA was not successful due to the member declining to complete Assessment Result is 39. Program Type 28.
- For use when a HRA was not successful due to the member not being located. Assessment Result is 50. Program Type 28.
- For use when a review of the last HRA occurred with the member due to a change in products (SNBC to SNBC Enhanced or SNBC Enhanced to SNBC). Activity date: date CC completes review. Assessment result 51. The Effective Date filed must match the Effective Date of the last Assessment Result 35 and not be more than 366 days from the current date. Program Type 28.

Scenario	Action
Newly enrolled in Managed Care Organization (No previous Care Coordinator)	• Complete new assessment and paperwork per care coordinator 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.
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. • Transfer HRA is NOT required when internal transfer occurs. Review member documents and document in member 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. • **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.

External Transfer: **SNBC/SNBC Enhanced Member Transfer with current 3428H, member signature page, and care plan for the transferred member. This includes:** ▪ **Non-Medica Managed Care Organization (MCO) to Medica Care System or a Medica Care System/County/Agency to another Medica Care System/County/Agency**	• **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. • 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 60 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 the CC will proceed with a new assessment (see change of condition or change of living setting scenario below). • **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/CSSP. • **Member Signature Sheet**- must be included in the transfer paperwork received or CC should review elements with member and document attempts to 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 occurred in member's file on Transfer HRA.

Change in Product (even if CC did not change) SNBC to SNBC Enhanced SNBC Enhanced to SNBC	• **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. • 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 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. • **Health Risk Assessment (HRA) -** CC will conduct initial assessment with member/responsible party within 60 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). • **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. • **Member Signature Sheet** - 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.

Transfer (External, Internal)- No current assessment (Member not assessed within the last 365 days), OR unable to obtain required transfer documents for review, OR Inconsistent documentation	• Complete new assessment and paperwork per care coordinator assessment and follow-up activities grid below
Change of Condition or Change in Living Setting	• Complete new assessment and paperwork per care coordinator assessment and follow-up activities grid below

	SNBC/SNBC Enhanced (all community members)	SNBC/SNBC Enhanced Institutional
ASSESSMENT & MMIS ENTRY	• Initial, 3428H including OBRA Level 1 within 60 calendar days of enrollment • For initial assessment Transfer HRA may be used if required documentation present • HRA annually, within 365 calendar days • Screening document type "H" in MMIS by last business day of enrollment month or within 30calendar days of completion of HRA or determination of refusal of assessment	• Initial, 3428 including OBRA Level 1 within 60 calendar days of enrollment • For initial assessment Transfer HRA may be used if required documentation present • HRA annually, within 365 calendar days • Screening document type "H" in MMIS by last business day of enrollment month or within 30calendar days of completion of HRA or determination of refusal of assessment
CARE PLAN	• Medica AccessAbility Solution (SNBC)/AccessAbility Solution Enhanced Care Plan or other Medica approved care plan to be sent within 30 calendar days of assessment • Member Signature Sheet	• Medica AccessAbility Solution (SNBC)/AccessAbility Solution Enhanced Care Plan or other Medica approved care plan to be sent within 30 calendar days of assessment • Member Signature Sheet
MEMBER DOCUMENTS MADE AVAILABLE AFTER ASSESSMENT	• Care Plan • Emergency plan • Medica Leave Behind Document • Medication Disposal Flyer (For SNBC Enhanced face-to-face visits) • Medica Post Visit Member Letter	• Care Plan • Emergency Plan • Medica Leave Behind Document • Medica Post Visit Member Letter • Nursing Facility Chart Coverage Guide provided to Nursing Facility for member chart

FOLLOW-UP	• Annual 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 • Contact with waiver case manager annually and with changes in member's needs, if applicable (DHS 5841) • Contact with behavioral health providers with changes in member's behavioral health needs, if applicable	• Annual 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 • Contact with waiver case manager annually and with changes in member's needs, if applicable (DHS 5841) • Contact with behavioral health providers with changes in member's behavioral health needs, if applicable • Participation in Care Conferences • If applicable: Transfer to Medica Care System after 100 days in NF

CROSS REFERENCES
DHS SNBC Contract
Community Based Services Manual (CBSM)
DHS edoc: 5020A Instructions for Completing and Entering the Health Risk Assessment into the MMIS for the Special Needs BasicCare (SNBC) Program
MMIS Training found on DHS TrainLink

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