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| **Policy Title:** | **Care Coordination Accountability MSHO/MSC+** |
| **Department:** | **Government Programs** |
| **Business Unit:** | **State Public Programs** |
| **Approved By:** | **Director of SPP Products** |
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**PRODUCTS AFFECTED**

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

**DEFINITIONS:**

**Barrier:** Any issue that may be an obstacle to the member receiving or participating in a care management plan or self-management plan.

**Care Coordinator/Case Manager Qualifications:** MSHO/MSC+: Care Coordination must be provided by an individual that is a Registered Nurse, a Licensed Social Worker, County Social Worker evaluated under the Minnesota Merit System, Physician Assistant, Nurse Practitioner or Physician.

**Care Coordination for MSHO MSC+ Enrollees:** The assessment, care planning, providing support, and coordination of needed services between members, involved health professionals, and care settings.

**Care Management for all Enrollees** means the overall method of providing on-going health care in which Medica manages the provision of primary health care services with additional appropriate services provided to an Enrollee.

**Care Plan:** Medica does not require the use of a specific Care Plan. Medica strongly encourages the use of the Collaborative Care Plan. However, any Care Plan that meets the DHS EW and or Non-EW Audit Protocol requirements and all of the elements of the Community Support Plan (CSP) DHS e-doc form #2925 may be used. Delegates must obtain prior approval from Medica to utilize an alternative Care Plan form.

**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), Instrumental Activities of Daily Living (IADL's), or other supports may indicate the change in condition. 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.

**Essential Services:** Services that must remain uninterrupted to ensure the life, health, and/or safety of the enrollee.

**Legal Guardian:** Authority to make decisions on behalf of the person, limited by court-issued documents which state the roles and responsibilities of the guardian. Whenever possible the guardian should support the choices of the person. Unless specifically stated in the guardianship documents, the person retains decision making authority.

**Personal Health Information (PHI):** Information that directly identifies an individual from which there is reasonable basis to believe an individual could be identified. PHI relates to either past, present or future physical or mental health condition of the individual; or (1) the treatment provision, coordination, or management of health care to the individual; or (2) the payment the provision, coordination, or management of health care to the individual; or (3) is obtained through an insurance transaction that permits judgments to be made about an individual's character, habits, finances, credit, health or any other personal characteristics. PHI includes oral information and information records in any form or medium. PHI does not include data that is de-identified or aggregated information.

**Person-Centered Principles and Practices:** Assurance that people have the opportunity for meaningful choice and self-determination, and that their civil and legal rights are affirmed and respected. This includes: (1) Treating each person with dignity, respect, and trust; (2) Building on his or her strengths and talents; (3) Helping him or her connect with his or her community and developing relationships; (4) Listening to and acting on his or her communication to you; (5) Making a sincere effort overall to understand him or her as a unique person realizing that quality of life is different for each individual; (6) Understanding and demonstrating how to balance preferences and health and safety; (7) Honoring the person's ability to express choice and preferences; (8) Promoting and establishing a shared vision between the person and his or her team.

**Person-Centered Service Plan:** The services and supports that are important to the individual to meet the needs identified through an assessment of functional need as well as what is important to the individual with regard to preferences for the delivery of such services and supports.

**Self-Management Interventions:** Interventions that are carried out by the enrollee to take responsibility for all or part of their medical and/or social needs.

**PURPOSE:**

To clarify the role of Care Coordination/Care Management services that are designed to ensure access and integrate the delivery of all Medicare and Medicaid preventive, primary, acute, post-acute, rehabilitation, and long term care services, including State Plan Home Care Services, and Elderly Waiver (EW) services to MSHO/MSC+ Enrollees. Care Coordinators serve as member advocates; they are instrumental in identification and coordination of person centered principles and practices to keep members in the least segregated settings, promote appropriate utilization and self-management.

**POLICY:**

Every Medica MSHO/MSC+ member is assigned a Care Coordinator (CC). Medica will assign a CC based on the members identified Primary Care Provider (PCP). CC's will perform the duties of Care Coordination and care management as described in Department of Human Services (DHS) and Centers for Medicare & Medicaid Services (CMS) contracts as well as perform other duties assigned by Medica. The CC serves as the primary contact for member needs.

**PROCEDURE:**

1. CC's will perform the duties of CC's listed in the DHS contract, CMS regulatory requirements, and Medica policies & procedures.

2. CC's will be informed of basic member protection requirements, including data privacy.

3. CC's will provide the name and telephone number of the CC to the member within ten (10) days of new assignment or change of CC.

4. CC's will conduct the initial HRA, using the appropriate HRA tool within thirty (30) days of enrollment for MSHO members and MSC+ EW members or within sixty (60) days of enrollment for MSC+ Non-EW members.
    a. Members have a right to make choices about assessments, contacts, and transition planning. If the member declines Care Coordination/Care Management services, CC's should reach out at least annually and upon notification of high risk via the Enhanced Care Coordination/Impact Report or transition to readdress if the member wants Care Coordination/Care Management services. Best practice is for the CC to reach out quarterly to engage member in Care Coordination/Care Management services.
    b. If the member is unable to be reached or refuses assessment and/or Care Coordination/Care Management, documentation of attempted contact is required in the member notes. Note: Members receiving EW services and/or PCA services must receive a face to face assessment annually in order to maintain eligibility for these services.
    c. Use of alternate assessments and alternate forms of assessment contact type must be approved by Medica. Medica will accept tribal assessments by Tribal Assessors.

5. CC's will conduct periodic reassessments, at least annually, within three hundred and sixty five (365) days of the previous assessment, and as necessary with change in member condition.

6. CC's will enter the required information collected through the health risk assessment into Medicaid Management Information System (MMIS), for all members excluding those identified as institutional members.

7. CC's will facilitate Advance Directive discussions annually with the member and/or authorized family members or legal guardians based on individual member needs and cultural considerations.

8. CC's will develop, monitor, and update the member's Care Plan based on the HRA and person-centered principles and practices within thirty (30) days of HRA completion.
    a. The Care Plan will include risks and needs identified through the HRA prioritizing members, authorized family members, legal guardians, and caregiver's goals, preferences, desired level of involvement, and self-management plans.
    b. The Care Plan will incorporate the individual member's unique strengths, assets, interests, wishes, expectations, hopes, resources, cultures, goals, and need for support.
    c. The Care Plan will identify if essential services are in place and if so what the backup plan is.
    d. The Care Plan will identify person-centered SMART goals, target dates, supports needed, notes monitoring progress/goal revision, and outcome or goal achievement dates.
    e. In addition to the prioritized goals listed above, those risk findings related to member identified medical or environmental safety should be considered among the highest priority.

f. Members have a right to decline goals. When a member declines a goal, if safety concerns are involved a Safety Plan needs to be created. If this occurs, documentation on the HRA, Care Plan, or in the member's clinical notes should indicate why a goal is being declined.
g. Only person-centered prioritized goals belong on the Care Plan. Documentation on the HRA, Care Plan, or in the member's clinical notes should indicate why an assessed need is not included on the member's care plan.
h. The Care Plan should attempt to increase quality of life, not simply maintain it. CC's will evaluate, identify, & coordinate available medical and non-medical supports and services identified in the HRA.
i. The Care Plan should incorporate unique primary care, acute care, long-term care, behavioral health, and social service needs that the member identifies.
j. The Care Plan should incorporate covered Medicare services, Medicaid services, and services available through the formal, informal, and quasi formal Health and Home Based Community Services (HCBS) as identified on the HRA. The Care Plan should also include services that were offered to the member, but declined.
k. Discussion with the member and/or authorized family members, legal guardians, or other people of members choosing will occur prior to finalizing the Care Plan. The member must approve the plan.
l. The member maintains control of the Care Plan and information included. The member drives the planning process and formulating the plan, to the level he or she chooses. The member determines how Care Plan information is shared, who will receive it, and which sections of the Care Plan will be shared. The CC supports the member's decisions. At a minimum, for members receiving EW services (excluding Community Directed Community Supports (CDCS), Specialized Supplies & Equipment, & Personal Emergency Response System), PCA services for EW members, or Housing Stabilization Services (HSS), CC's must attempt to obtain agreement from providers of the services and supports in the Care Plan and their agreement to deliver them as outlined. This must be updated with changes to the Care Plan that affect how these services are provided. Changes may include:
    i. Change in hours/units
    ii. Change in provider
    iii. Addition of new provider
m. The member can request a change in the Care Plan at any time. Plans should be revised to address changes in the member's life and changes in the member's choices re: services, supports, and providers. Any changes in services and supports require the CC to send a copy of the revised care plan to the member.

9. CC's will assist the member and/or authorized family members or legal guardians to maximize informed choices of services and control over services and supports based on information and experience, unrestricted by current resources or services.

10. CC's will schedule follow-up contacts and communication with the member and/or authorized family members or legal guardians based on member request, identified risk, needs, and fragility.

11. CC's will monitor the progress toward achieving the member's and/or authorized family members or legal guardians prioritized goal outcomes in order to evaluate and adjust the timeliness and adequacy of services in the Care Plan.

a. If Self-Management interventions are in place, the CC will clarify with the member and/or authorized family members or legal guardians that the interventions are acceptable and doable.
b. Underlying barriers to meeting outcomes and complying with the plan will be identified. Revision and enhancement of the Care Plan may be completed through written or verbal communication with the member and/or authorized family members or legal guardians.
c. Assessment of member's Care Plan outcome goal achievement progress may be completed during telephonic follow-up, during home visits, during change in member condition, and following transitions.
d. Documentation of the goal outcomes will be completed at a minimum annually. It should include the date the goal has been achieved or revised and if it will be carried forward to the updated Care Plan.

12. CC's must verify the member has been offered a choice of supports and services, also that the member agrees with the Care Plan, and agrees with services and providers authorized by the CC.

13. CC's will educate the member and/or authorized family members or legal guardians about good health practices, the importance of wellness and preventative health care, ways to avoid emergency room use, and ways to prevent hospital admissions/readmissions. CC's will promote self-management activities, when applicable.

14. CC's will facilitate annual physician visits for primary and preventive care. CC's may assist the member and/or authorized family members or legal guardians in scheduling annual visits. CC's will provide assessment and care plan results to the primary care physician at least annually.

15. CC's will collaborate with the Interdisciplinary Care Team (ICT) based on members assessed physical, emotional, and service needs. ICT team members will be listed in the member's chart.

16. CC's will collaborate with Local Agency case managers, financial workers and other staff, as necessary, including use of the DHS form "Case Managers/Financial Worker Communication," Form # 5181 as provided by the State.

17. CC's will collaborate with lead agencies, waiver workers, or county case managers on the authorization of medical assistance home care services to prevent duplication of services and to coordinate services in the most seamless way possible for the member using the DHS form "Managed Care Organization/Lead Agency Communication Form - Recommendation for Authorization of MA Home Care Services State Plan Home Care Services, DHS-5841 as provided by the State. It is expected that a response will occur within 10 (ten) business days of submission for this form. This response time is required by both the CC's and with lead agencies, waiver workers, or county case managers.

18. CC's will collaborate with other providers for members identified as having special needs requiring additional intensive Case Management. Care Coordinators will collaborate with other Care Management and risk assessment functions conducted by appropriate professionals, including Long Term Care Consultation and other screenings to identify special needs. Medica CC's will share with other providers the results of its identification and assessment of that member's needs to prevent duplication of those activities.

19. Medica has been advised by DHS that CC's and waiver workers are permitted to share enrollee information without a release of information. Medica expects that information will be the minimum amount necessary to perform the required activity.

20. CC's will include cover sheets, not including Protected Health Information (PHI) that incorporates a confidentiality statement for all fax transmissions.

21. CC's will utilize secure email for all email communications containing PHI.

22. CC's will collaborate with Residential Services Living Providers when indicated.

23. Intensive Case Management may be provided within the Care System or County or externally by another provider.
    a. Case Management for serious and persistent mental illness
    b. Case Management for pre-petition screening
    c. Court ordered treatment, developmental disabilities, assessment of medical barriers to employment
    d. A State medical review team or social security disability determination
    e. Services offered through social service staff or county attorney staff for enrollees who are visits or perpetrators in criminal cases

24. CC's will collaborate with social service staff and other community resources such as Area Agencies on Aging (AAA). Coordination with Local Agency social service staff is required when a member is in need of the following services:
    a. Pre-petition Screening
    b. OBRA Level II Screening for Mental Health and Developmental Disability
    c. Spousal Impoverishment Assessments
    d. Adult Foster Care
    e. Group Residential Housing Room and Board Payments
    f. Substance Use Disorder (SUD) room and board services covered by the Consolidated
    g. SUD Treatment Fund
    h. Adult Protection
    i. Local Human Service Agencies for assessment and evaluation related to judicial proceedings

25. CC's will collaborate with services and supports provided by the Veterans Administration (VA) for Enrollees eligible for VA services.

26. CC's will make referrals to specialists and sub-specialists including those with geriatric expertise when appropriate.

27. CC's will inform, educate, and assist the member and/or authorized family members or guardians with health plan related issues & accessing needed resources and services beyond the limitations of the Medicaid and Medicare benefit sets; including identifying available benefits, services, providers, resolving claims or cost sharing inquiries, rights to pursue grievances and appeals under the Medicaid program or Medicare program.

28. CC's will provide information regarding services including procedures for promoting rehabilitation of members following acute events, and for ensuring smooth transitions and coordination of information between acute, sub-acute, rehabilitation, Nursing Facilities, and Home and Community Based Services (HCBS) settings.

29. CC's will provide access to an adequate range of Elderly Waiver and Nursing Facility Services and for providing appropriate choices among Nursing Facilities and/or Elderly Waiver services to meet the individual needs of members who are found to require a Nursing Facility Level of Care. These must include methods for supporting and coordinating services with informal support systems provided by families, friends and other community resources. These procedures must also include strategies for identifying Institutionalized members whose needs could be met as well or better in non-Institutional settings and methods for meeting those needs, and assisting the Institutionalized members in leaving the Nursing Facility.

30. CC's will collaborate with the Senior Linkage Line and other social service staff to ensure that the Pre Admission Screening (PAS) process is completed.
    a. CC's are responsible to:
        i. Perform determinations of the need for NF level of care
        ii. Complete OBRA Level I Screening
        iii. Provide documentation of the PAS result to the admitting nursing facility
        iv. Forward, if appropriate, to the county for OBRA Level II activity
        v. Enter PAS information into MMIS using the Long Term Care Screening document, if the consumer is not on a waiver program participant at the time of admission and
        vi. Follow the process related to exiting individuals from the Elderly Waiver program if the admission exceeds 30 days
        vii. Provide relocation assistance to all of their enrolled members

31. CC's will ensure that planned and unplanned transitions between settings of care are well managed and smooth with a consistent person supporting the member and/or authorized family members or guardians.

32. CC's will participate in Performance Improvement Projects (PIP) and Chronic Condition Improvement Plan (CCIP) as requested by Medica.

33. CC's will assist and support members during transition periods between programs, care systems, agencies, counties, and health plans to ensure that timely, effective, and efficient communication occurs in order to maintain continuity of services and avoid unnecessary disruption that may negatively impact the member. CC's should use the DHS form "HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form". DHS 6037 as provided and directed by the State.

34. CC's will ensure that members are living in the most integrated setting that is the preferred option, unless the person is opposed to moving. (See DHS Person-Centered, Informed Choice, and Transition Protocol and My Move Plan Summary DHS 3936). The My Move Plan is required to be offered when an EW member is moving from his or her home. Information about the My Move Plan can be located here: https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-312487

35. Annually, CC's will share the process for filing a grievance, reporting dissatisfaction with services received from their CC, or how members can request a different CC.

36. In the event of large transfers of new enrollees into Medica with the same enrollment date, and if Medica determines that meeting the DHS timelines indicated in this section cannot be met, Medica may submit a transition plan to DHS indicating the timeline in which they expect to be able to conduct the initial assessment. Medica will notify the Care Systems, Agencies, and Counties affected if an extension has been granted by DHS.

**Cross References:**

DHS Person-Centered, Informed Choice, and Transition Protocol and My Move Plan Summary DHS 3936
MSHO/MSC+ DHS Contract
Medica Assessment Schedule Policy (MSHO MSC+)
Medica Telephonic Assessment Policy (SNBC MSC+)
Medica Interdisciplinary Care Team Policy
Medica Member Transfer Responsibilities Policy
Medica Unable to Reach/Refusing Members Policy
Medica Transitions of Care Policy
DUAL Solution Model of Care

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