Policy Title:	**Case Management Accountability 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:

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/Wellness Navigator Qualifications:

SNBC/SNBC Enhanced Care Coordinator - Medica prefers SNBC/SNBC Enhanced Care Coordinators be a Registered Nurse, Licensed Social Worker, County Social Worker evaluated by the Minnesota Merit System, Physician Assistant, Nurse Practitioner or Physician. At a minimum, Case Manager/Navigation Assistant must be supervised by a Licensed Social Worker, Registered Nurse, Physician Assistant, Nurse Practitioner or Physician.

In lieu of these requirements, an individual with specialized expertise working with people with disabilities may be allowed to act as a Care Coordinator if they have a four-year degree in a closely related field and two or more years of experience in home and community based services. The individual must also be trained on assessments and consultation for long-term care services and other training required by Department of Human Services (DHS).

Medica must approve the individual's qualifications before they can function in a Case Manager/Navigation Assistant capacity if they are not a Registered Nurse, Licensed Social Worker, County Social Worker evaluated by the Minnesota Merit System, Physician Assistant, Nurse Practitioner or Physician. Medica requires these staff to have at a minimum 24 clock hours of training that is relevant to their role as a Case Manager/Navigation Assistant and/or the population served every two years. It is the responsibility of the contracted entity to ensure this training occurs and to provide Medica with documentation upon request.

Care Coordination: 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. Any Care Plan that meets the DHS audit protocol requirements and all of the elements of the Community Support Plan (CSP) DHS e-doc form #2925 may be used. If a delegate plans to use a care plan other than those provided by Medica (Collaborative Care Plan or Medica AccessAbility Solution® / Medica AccessAbility Solution® Enhanced Special Needs BasicCare (SNBC and SNBC SNP) Member Care Plan), prior approval is required by the Medica Regulatory Oversight & Improvement Department.

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 (I ADL'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.

HRA Assessment Tool for SNBC

- DHS Form 3428H LTC Screening Document- use for all SNBC members regardless of product, waiver status, or living setting.
- Transfer Member Health Risk Assessment (HRA)-for members who go from Medica's AccessAbility Solution plan to Medica AccessAbility Solution Enhanced plan. This can also be used for members who go from Medica's AccessAbility Solution Enhanced plan to Medica's AccessAbility Solution plan. In order to complete a Transfer HRA the previous HRA must have been completed in the past 365 days and the care coordinator has a copy of that previously completed HRA, care plan, and member signature sheet. NOTE: NOT to be used when a member is a new member to Medica.

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 or 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 Planning: Allows for the person to make meaningful and informed choices about the settings in which the person receives the services, and the setting in which the person lives (in addition to making meaningful and informed choices about the services they receive).

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.

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/Case Management/Navigation Assistant services that are designed to ensure coordinate the delivery of all Medicare, and Medicaid preventive, primary, acute, post-acute, rehabilitation, specialty and pharmacy services, and long term care services, including State Plan Home Care Services for SNBC and SNBC Enhanced members. Care Coordinators serve as member advocates; they are instrumental in identification and coordination of activities that strive to keep members in the least restrictive settings, promote appropriate utilization, and self-management.

POLICY:
Every Medica SNBC or SNBC Enhanced member is assigned a Care Coordinator (CC)/Engagement Coordinator (EC). Medica will assign a CC based on the member demographic location and identified special needs, willingness to participate in care coordination, and/or the primary care provider (PCP). The CC will coordinate the provision of services to enrollees and must promote and assure service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, culturally appropriate care, and fiscal and professional accountability. The CC serves as the primary contact for the member's needs.

PROCEDURE:

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

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

3. CC's/EC'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 Health Risk Assessment (HRA) using the appropriate HRA within sixty (60) days of enrollment. The Health Risk Assessment may be conducted through telephonic or face-to-face contacts.

a. Members have a right to make choices about assessments, contacts, and transition planning. If the member declines Care Coordination/Case 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 services. Best practice is for 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.
c. Use of alternate assessments and alternate forms of assessment contact type must be approved by Medica.

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 use the HRA to assesses quality and appropriateness of care given to members, this includes an evaluation of care between settings and a comparison of services and supports received against what is documented in the member's case management plan.

7. CC's will enter the required information collected through the health risk assessment into Medicaid Management Information System (MMIS) for all members.

8. 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.

9. CC's will develop, monitor, and update the member's Care Plan based on the Health Risk Assessment (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. In addition, the Care Plan should incorporate unique primary care, acute care, long-term care, behavioral health, and social service needs that the member identifies.
    c. 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.
    d. The Care Plan will identify if essential services are in place and if so what the backup plan is.
    e. The Care Plan will identify person-centered SMART goals, target dates, interventions/supports needed, notes monitoring progress/goal revision, and outcome or goal achievement dates.

f. Members have a right to decline goals. When a member declines a goal, if safety concerns are involved a Risk Plan/Emergency Plan/Self Preservation/Evacuation Plan needs to be created. These findings may be medical or environmental and should be among the highest priority when working with members. 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. 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.
h. Discussion with the member and/or authorized members or legal guardians will occur prior to finalizing the Care Plan. This will include written documentation that informs them of the agreed upon State Plan supports that will be provided.
i. 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.
j. 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.

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 provide self-management and educational materials to members with disability related conditions, as applicable.

12. 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.

13. 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.

14. 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.

15. 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 visits.

16. CC's will provide assessment and care plan results to the primary care physician (PCP) annually.

17. 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.

18. CC's will have interventions and protocols for management of disability related conditions common among members with disabilities such as skin breakdown & urinary tract infections.

19. 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 settings.

20. CC's will make referrals to specialists and sub-specialists.

21. CC's will work in partnership with the member and/or authorized family members or alternative decision makers, and Primary Care Physicians (PCP) in consultation with any specialists caring for the member, to develop and provide services and to assure consent to the medical treatment or service.

22. CC's will coordinate care for American Indian members on their caseload.

23. CC's will coordinate with Individual Education Plan (IEP), an Individual Family Service Plan (IFSP) or Individual Community Support Plan (ICSP) including services and supports.

24. CC's will coordinate with Case Management services provided by children's mental health collaborative, and family services collaborative and adult county mental health initiatives.

25. CC's will coordinate with transitional care for children between the ages of eighteen (18) and twenty-one (21) who require ongoing services as they transition to adult programs covered under the DHS Contract.

26. CC's will coordinate with county social service agencies, community agencies, nursing homes, residential and home care providers and case management systems involved in providing care for SNBC members using Health Insurance Portability and Accountability Act (HIPAA) compliant electronic communication vehicles.
    a. Referrals and/or coordination with County Social Service staff will be required when the member is in need of the following services:

i. Pre-petition screening
ii. Preadmission screening for Home and Community Based Services (HCBS)
iii. County Case Management for HCBS,
iv. Child protection
v. Court ordered treatment
vi. Case Management and service providers for people with developmental disabilities
vii. Relocation service coordination
viii. Adult protection
ix. Assessment of medical barriers to employment
x. State medical review team or social security disability determination,
xi. Local Agency social service staff or county attorney staff for Members who are the victims or perpetrators in criminal cases.

27. CC's will coordinate with Local Agency human service agencies for assessment and evaluation related to judicial proceedings.

28. 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.

29. 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 Care Coordinators and with lead agencies, waiver workers, or county case managers.

30. CC's will collaborate with other providers for members identified as having special needs requiring additional Intensive Case Management, other Care Management, and risk assessments including Long Term Care Consultation and other screenings to identify special needs such as: common medical conditions, functional problems, difficulty living independently, polypharmacy problems, health and long term care risks due to lack of social supports; behavioral and/or substance use disorders developmental disabilities; high risk health conditions; and language or comprehension barriers. Medica CC's shall share with other providers serving the member with special health care needs the results of its identification and assessment of that member's needs to prevent duplication of those activities.

31. Medica has been advised by DHS that CC 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.

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

33. CC will utilize secure email for all email communications containing PHI.

34. CC will collaborate with the Senior Linkage Line and other social service staff to ensure that the Pre Admission Screening (PAS) process is completed.
    i. CC is responsible to: Perform determinations of the need for NF level of care for facility admissions;
    ii. 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. Forward, if appropriate, to the county of financial responsibility for relocation assistance;
    vi. Enter PAS information into MMIS using the Long Term Care Screening document, if the member is not a waiver program participant at the time of admission.

35. CC 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. This includes completing documentation in the members file, following specified timeframes, communication with members or responsible parties about changes to the member's health status and plan of care, collaboration with providers of services, providing education on how to prevent unplanned transitions, and coordinating services for members at high risk for having transitions.

36. CC will make reasonable efforts to coordinate with services and supports provided by the Veteran's Administration (VA) if applicable.

37. CC will help determine if members with HIV/AIDS and related conditions may have access to federally funded services under the Ryan White CARE Act, 42 U.S.C. § 300ff-21 to 300ff-29 and Public Law 101-381, Section 2.

38. CC will assist in coordination of Substance Use Disorder (SUD) Treatment Services
    a. CD treatment services do not include detoxification (unless it is required for medical treatment).
    b. The MCO is responsible for the continuum of SUD services identified in Minnesota Statutes, §254B.05, excluding room and board.

39. CC will assist in coordination with Intensive Case Management 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.

40. CC will notify members under the age of 21 of the availability of Child and Teen Checkup (C&TC) screenings annually. CC is to assist members in arranging appointments and/or finding new providers as requested by the member.

41. CC will participate in Performance Improvement Projects (PIP) as requested by Medica.

42. CC 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 will use the DHS form "HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form" DHS 6037 as provided and directed by the state.

43. CC will assist members turning 65 years old in transitioning to MSC+ or MSHO per DHS requirements.

44. 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.

45. 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:
SNBC Contract
Medica Assessment Schedule Policy SNBC
Medica Member Transfer Responsibilities Policy
Medica Unable To Reach/Refusing Member Policy
SNBC Members Turning 65 Policy

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