Policy Title:	**Transfer Responsibilities**
Department:	**Government Programs**
Business Unit:	**State Public Programs**
Approved By:	**Director of SPP Products**
Approved Date:	**3/7/2011**
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PRODUCTS AFFECTED:

- Medica DUAL Solution® – for Minnesota Senior Health Options (MSHO) enrollees
- Medica Choice Care℠ – for Minnesota Senior Care Plus (MSC+) enrollees
- Medica AccessAbility Solution® – for Special Needs Basic Care (SNBC) enrollees
- Special Needs BasicCare (SNBC) Integrated – Medica AccessAbility Solution Enhanced®

DEFINITIONS:

Continuity of Care: The members experience of a continuous caring relationship with an identified health care professional. Service provided through integration, coordination and the sharing of information between different providers.

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.

Home and Community Based Services Case Management Transfer and Communication Form (DHS form 6037A or 6037B): Universal form used 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 when a member moves from one Care Coordination entity to another Care Coordination entity.

Care Coordination Entity: an entity that Medica contracts with and delegates some portion of its Care Management to (e.g. Care Systems, Agencies, and Counties).

Transfer: A member moving from a product, a County, a Care System, an Agency, or a Health Plan to another product, County, Care System, Agency, or Health Plan.

Transfer Documents: To include but not limited to: Home and Community Based Services Case Management Transfer and Communication Form (DHS form 6037), HRA (Health Risk Assessment), Care Plan, Member Signature Sheet, OBRA Level 1, Residential Services (RS) Tool when applicable, Personal Care

Assistant (PCA) Assessment when applicable, PCA Service Authorization dates when applicable, case notes when applicable. If member is in a Skilled Nursing Facility (SNF)/Nursing Facility (NF) stay, the number of SNF/ NF days used should also be included.

PURPOSE:
This policy will help guide Care Coordination entities to ensure continuity of care for members during the time the member is transferred from one Care Coordination entity to another Care Coordination entity.

POLICY:
Care Coordinators will assist in maintaining member continuity of care during transition periods. Care Coordinators will complete assessments and other required documentation, to ensure that Medicaid Management Information System (MMIS) requirements, Department of Human Services (DHS) contract requirements, Center for Medicare and Medicaid Services (CMS) contract requirements, and Medica operational requirements are met.

PROCEDURE:

1. MEMBER TRANSFERS TO OTHER MEDICA CARE COORDINATION ENTITY

1. The sending entity will contact the receiving entity and obtain confirmation of the receiving entities ability to accept the member prior to notification of Medica Enrollment Staff. Care Coordination Entity contact information can be located on the Medica Transfer Contact List located in ShareFile. If you are unsure who the receiving entity should be email SPPEnrollmentQ@medica.com including the member name, date of birth (DOB) and PMI and they will assist you.
    a. If the receiving entity is a Care System, you should be contacting them to verify that the physician the member is seeing is their primary care physician and not a specialist.
    b. If the receiving entity is an Agency, you should be contacting them to verify that the request is appropriate and that the agency is able to take the member in that location.
    c. If the receiving entity is a County, you should be contacting them to verify that the member resides in their service area.
    d. If the receiving entity is Medica Care System, you should be sending an email to SPPEnrollmentQ@medica.com to verify if the member can be transferred.
    e. In the event that Medica is informing you of a member transfer, this step is not necessary as it has already been verified that the receiving entity is accepting this member.
2. Transfer requests must be submitted to Medica by the 24th of the month prior to transfer effective date barring any enrollment issues from Department of Human Services (DHS)/Center for Medicare & Medicaid Services (CMS). Transfer requests received after this date will not be considered for the next month, but for a future month.
3. The sending entity staff will complete the Medica Excel Transfer Grid and submit it to Medica via ShareFile or email to SPPEnrollmentQ@medica.com.
4. Once Medica Operations has reviewed the submitted Medica Excel Transfer Grid an email will be sent to the sending delegate indicating if the transfer has been approved or not approved. Upon receipt of approval the sending entity will complete and send the Home and Community Based Services Case Management Transfer and Communication Form (DHS form 6037) and any additional supporting transfer documents directly to the receiving setting. **This information should not be submitted to Medica Enrollment Team.**
5. The sending entity is responsible for ongoing Care Coordination until the transfer effective date.

6. Members who cannot be transferred include:
    a. Members who have a future end date cannot be transferred.
    b. Members receiving care coordination for a transition of care cannot be transferred until they have discharged and returned to their "usual" setting or transitioned to a new "usual" setting long term.
    c. Member cases where any required activities/documents such as Residential Services tools, care plans, and assessments due that month are not completed cannot be transferred until these are completed.
    d. Members who have moved out of the Medica service area.

2. MEMBER TRANSFERS BETWEEN HEALTH PLANS

a. The Care Coordinator may learn that a member has changed to another Health Plan via a member call, from the Medica Enrollment Report, or through a call from the new Health Plan.
b. The Care Coordinator will check Mn-ITS to verify the new Health Plan.
c. Upon verification of new Health Plan status, the Care Coordinator will complete and send the Home and Community Based Services Case Management Transfer and Communication Form (DHS form 6037) including any additional supporting transfer documents directly to the contact at the new Health Plan**. This information should not be submitted to Medica Enrollment Team.**

3. MEMBER TRANSFERS TO FEE FOR SERVICE

a. Refer to Members Who Lose Eligibility section of the Assessment Schedule Policy.

4. RECEIVING MEMBER TRANSFERS

a. The receiving entity is informed of a transfer member via the Medica Enrollment Report sent in ShareFile after the 10th of each month.
b. The receiving entity will contact new members via phone or approved letter within 10 business days of enrollment to inform the member of the Care Coordinator (CC) and provide contact information.
c. The receiving CC will refer to Medica Assessment Schedule Policy to determine required assessment activity.
d. The receiving CC will review the previous assessment and care plan telephonically with the member.
    - For MSHO, MSC+ EW & MSC+ PCA members this must occur within 30 days of the transfer.
    - For SNBC &ISNBC members this must occur within 60 days of the transfer.
e. The receiving CC will notify the Financial Worker (FW) of change in Care Coordinator.
f. The receiving CC will notify the county Case Managers (CM) of change in Care Coordinator, when applicable.
g. The receiving CC will notify the Primary Care Physician (PCP) of change in Care Coordinator.
h. The receiving CC will complete a MMIS document change to reflect the change in Care Coordinator.

5. LARGE GROUP ENROLLMENT TRANSFERS

a. In the event of a large group transfer resulting from a delegate change, product change, etc., Medica will work with the delegates to formulate a plan for the transfer of information.
b. For large group transfers of enrollees with the same initial enrollment date Medica will determine if the assessment schedule timelines can be met and may choose to submit a transition plan to DHS, for review and approval, indicating the timeline in which they expect to be able to conduct this initial assessment required for new enrollees. Care Coordination entities will be notified if an exception is being made to the Assessment Schedule Policy.

6. **ENROLLMENT REPORTS**
    a. Enrollment reports are sent to Medica Care Coordination Entities at the beginning of each month.
    b. The Full Membership Enrollment is sent after the 10th of each month.
        i. The Medica Enrollment Team will highlight transferred members under the "Adds" tab on the Full Enrollment report sent after the 10th of each month for the receiving entity.
        ii. For the sending entity the member will appear on the "Terms" tab of the Full enrollment report.

Cross References:
MSHO/MSC+ DHS Contract
SNBC DHS Contract
Medica Assessment Schedule Policy MSHO/MSC+
Medica Assessment Schedule Policy SNBC/SNBC Enhanced
Home and Community Based Services Case Management Transfer and Communication Form & Scenarios (DHS Form 6037 and scenario documents 6037A or 6037B)

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