Policy Title:	Unable to Reach/Refusing Member
Department:	Government Programs
Business Unit:	State Public Programs
Approved By:	Director of SPP Products
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PRODUCTS AFFECTED

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

DEFINITIONS

Care Coordinator (CC): An employee or Delegate of Medica 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.

Engagement Coordinator (EC): A non-clinical employee of Medica that provides outreach efforts to MSC+ and SNBC members on their caseload that have refused Care Coordination or are unable to be reached with the goal of successfully engaging members. Upon engagement and acceptance of ongoing care coordination, the EC will transfer the member to a CC who begin the Care Coordination process.

Member Unable To Be Reached: A member that is unable to be reached via contact by phone or by mail and therefore is not available to complete the health risk assessment. Commonly referred to as "missing member" (MM) or "unable to reach member" (UTR).

Refusing Member: A member that has been located either by mail or phone but will not consent for an initial assessment or reassessment and/or Care Coordination.

PURPOSE

To ensure that all Care Systems, Agencies, and Counties that provide Care Coordination for Medica members have a policy and/or procedure to clarify the role of the CC in offering a Health Risk Assessment (HRA) and all necessary activities when a member is unable to be reached or will not consent for an HRA and/or Care Coordination

POLICY

Care Coordinators (CC) and/or Engagement Coordinators (EC) are required to account for outreach activities to the members who are not reached for the HRA or who will not consent for assessment and/or Care Coordination.

Timeliness and proper documentation need to occur for these types of members in the Medicaid Management Information System (MMIS) as well as the member's chart or case file.

All members will be contacted by CC/EC upon initial or transfer enrollment in the product as well as annually thereafter to offer a HRA and care coordination. CC's/EC's should follow assessment timelines as described in detail in the Medica Assessment Schedule Policy. Annual assessment must occur for unable to reach/refusal members within 365 days of the most recent completed HRA or within 365 days of member's enrollment date if member has not had a completed HRA and has been enrolled in the product for over 365 days.

PROCEDURE

UNABLE TO REACH

1) If CC/EC is unable to make contact with a member after a minimum of 3 (three) non-automated phone call attempts and sending a letter, the member is considered unable to be reached.
   a. CC/EC must document a minimum of 3 (three) non-automated phone call attempts to reach member and send an ongoing no contact letter in an attempt to reach the member. Best practice is to attempt phone calls on three different days, at different times. After attempting to reach the member via phone, the CC/EC should send an ongoing no contact letter to the member.
   b. If the CC does not have a valid phone number or address for the member, suggested additional contacts for attempts to obtain may include reaching out to the following: county financial worker, waiver worker, Primary Care Physician (PCP), primary care clinic, primary pharmacy, providers (Durable Medica Equipment (DME), Personal Care Assistant (PCA), homecare), PAR (Provide a ride)/Qryde, Medicaid Management Information System (MMIS), Restricted Recipient Program (RRP), MNITS, and other internet searches. Attempts to obtain additional member contact information must be documented in the members case notes.
   c. The date of the unable to reach assessment should be considered the date of the last attempt to contact the member.
   d. CC/EC will enter an assessment in MMIS to meet required timelines. See below for MMIS entry guidance.
   e. CC/EC should make additional attempts to reach and engage member during the year; at a minimum, this should occur annually or based on Enhanced Care Coordination (ECC) report, change in condition, or Daily Admit Reports (DAR) showing member admission to facility.
   f. CC/EC is required to send a mailed Health Risk Assessment (HRA), supplemental documents, and corresponding member letters to all unable to reach members.
   g. Required for MSHO members & SNBC Enhanced members:

i. CC will complete Medica unable to reach/refusal care plan (optional for MSC+ and SNBC members). The care plan will be updated as the CC is made aware of changes or on an annual basis.
ii. When/if the mailed HRA is returned to the CC, the CC will note this in the member's case notes, update the members care plan with provided information (including primary physician contact information, health concerns, mental health concerns, assistance being needed, and current supports, etc.), and follow up with the member accordingly and consistently with the members wishes..
iii. If the member provides information indicating who their Primary Care Physician (PCP) is, or if CC has identified the member's PCP from another source, the CC will complete the PCP letter and send it indicating that they have been unable to find the member to complete a HRA and provide the CC contact information to the PCP.
iv. The PCP, when identified and available, as well as other individuals that the member identifies as part of the ICT (Interdisciplinary Care Team) should be documented in the care plan, if known. If a PCP is not identified, the ICT will consist of the member/responsible party and the CC.
v. If the CC is informed of a member transition of care, the CC will note this in the member's case notes and/or create a Transition of Care (TOC) log (required for MSHO and SNBC Enhanced (optional for MSC+, SNBC), update the members care plan with transition information, attempt to follow up with the member to complete transition of care activities, and address any areas of question or concern.

h. If the member is on the Elderly Waiver or is receiving PCA services and the waiver span has time remaining, authorize the services necessary until the waiver span is due to close. If a new assessment isn't completed by the end of the waiver span or PCA service authorization, a Denial, Termination, Reduction (DTR) for the waiver and/or all applicable services will be needed if the member is not able to be found to complete a new assessment by the end of the waiver span. Please review DTR policy for more guidance. Consultation with Medica Clinical Liaison may be warranted in these situations.
i. If the member was on the Elderly Waiver or is receiving PCA services and the waiver span is due to close, a Denial, Termination, Reduction (DTR) for the waiver and/or all applicable services will be needed if the member is not able to be found to complete the required annual reassessment. Please review DTR policy for more guidance. Consultation with Medica Clinical Liaison may be warranted in these situations.
j. Member is due for an annual HRA within 365 days of the most recent fully completed assessment or within 365 days of member's enrollment date if member has not had a completed HRA and has been enrolled in the product for over 365 days.

REFUSAL

2) If CC/EC is able to make contact with member or responsible party, but member has refused care coordination and/or the HRA, the member is considered a refuser. Note: to be considered a refusal, CC must speak to member or responsible party. Group home staff or other Case Managers cannot refuse the HRA on a member's behalf.
   a. CC/EC must document all discussions regarding member refusal in case notes.

b. The date of refusal is considered the date the CC/EC spoke with the member and the member or the responsible party reported they were refusing assessment and/or care coordination at that time.
c. CC/EC will enter a Refusal assessment in MMIS to meet required timelines. See below for MMIS entry guidance.
d. CC/EC should make additional attempts to reach member during the year; at a minimum this should occur annually or based on Enhanced Care Coordination (ECC) report, change in condition, or Daily Admit Reports (DAR) showing member admission to facility. If the member indicates they do not want to be contacted via phone or mail. The CC will respect the member's wishes and document this in the case file.
e. CC/EC is required to send a mailed Health Risk Assessment (HRA), supplemental documents, and corresponding member letters to members who refuse a health risk assessment.
f. Required For MSHO members & SNBC Enhanced members:
    i. CC will complete Medica unable to reach/refusal care plan (optional for MSC+ and SNBC members). This care plan will be updated as the CC becomes aware of changes or on an annual basis.
    ii. When/if the mailed HRA is returned to the CC, the CC will note this in the member's case notes, update the members care plan with provided information (including primary physician contact information, health concerns, mental health concerns, assistance being needed, and current supports, etc.), and follow up with the member accordingly and consistent with the members wishes.
    iii. If the member provides information indicating who their Primary Care Physician (PCP) is, or if CC has identified member's PCP from another source, the CC will complete the PCP letter and send it indicating that they have refused to complete a HRA and provide the CC contact information to the PCP.
    iv. The PCP, when identified and available, as well as other individuals that the member identifies as part of the ICT (Interdisciplinary Care Team) will also be added to the care plan. If a PCP is not identified, the ICT will consist of the member/responsible party and CC.
    v. If the CC is informed of a member transition of care, the CC will note this in the member's case notes and/or create a Transition of Care (TOC) log (required for MSHO & SNBC Enhanced, (optional for MSC+, SNBC), update the members care plan with transition information, attempt to follow up with the member to complete transition of care activities, and address any areas of question or concern.
g. If the member is on the Elderly Waiver or is receiving PCA services and the waiver span has time remaining, authorize the services necessary until the waiver span is due to close. If a new assessment isn't completed by the end of the waiver span or PCA service authorization, a Denial, Termination, Reduction (DTR) for the waiver and/or all applicable services will be needed if the member is not able to be found to complete a new assessment by the end of the waiver span. Please review DTR policy for more guidance. Consultation with Medica Clinical Liaison may be warranted in these situations.
h. If the member was on the Elderly Waiver or is receiving PCA services and the waiver span is due to close, a Denial, Termination, Reduction (DTR) for the waiver and/or all applicable services will be needed if the member is not able to be found to complete the required

annual reassessment. Please review DTR policy for more guidance. Consultation with Medica Clinical Liaison may be warranted in these situations.
   i. Member is due for an annual HRA within 365 days of the most recent fully completed assessment or within 365 days of member's enrollment date if member has not had a completed HRA and has been enrolled in the product for over 365 days

3) If CC is able to contact member, but the member is not able to schedule an assessment within the required timeline per the assessment schedule policy (scheduling conflicts, illness, etc.):
   a. Document all member discussions in case notes.
   b. CC will enter a Refusal assessment in MMIS to meet required timelines per DHS guidance. Date of refusal is the date the CC spoke with member or responsible party and they were not able to schedule HRA within the required timelines.
   c. If the member is on the Elderly Waiver or is receiving PCA services and the waiver span has time remaining, authorize the services necessary until the waiver span is due to close. If a new assessment isn't completed by the end of the waiver span or PCA service authorization, a Denial, Termination, Reduction (DTR) for the waiver and/or all applicable services will be needed if the member is not able to be found to complete a new assessment by the end of the waiver span. Please review DTR policy for more guidance. Consultation with Medica Clinical Liaison may be warranted in these situations.
   d. If the member was on the Elderly Waiver or is receiving PCA services and the waiver span is due to close, a Denial, Termination, Reduction (DTR) for the waiver and/or all applicable services will be needed if the member is not able to be found to complete the required annual reassessment. Please review DTR policy for more guidance. Consultation with Medica Clinical Liaison may be warranted in these situations. CC should schedule assessment when member is available.
   e. Complete HRA on scheduled assessment date.
   f. Proceed with all standard paperwork and update MMIS accordingly.
   g. If member cancels the assessment, or a full HRA is not completed:
      i. Follow unable to reach/refusal protocol as described above.
      ii. For MSHO and SNBC Enhanced members: CC should complete Medica unable to reach/refusal care plan (optional for MSC+ and SNBC members) as described above. This care plan will be updated as the CC is notified of changes or on an annual basis.
      iii. Send out mailed Health Risk Assessment, supplemental documents and corresponding member letter. When/if the Mailed HRA is returned to the CC, the CC will note this in the member's case notes, update the members care plan with provided information (including primary physician contact information, health concerns, mental health concerns, assistance being needed, and current supports, etc.), and follow up with the member accordingly and consistent with the members wishes.

MMIS Entry

1) Delegate to enter refusal or unable to reach in MMIS by the last business day of the enrollment month (for MSHO members), by the 60th day of enrollment (for MSC+, SNBC, and SNBC Enhanced members), or by the last business day of the reassessment month. Timelines are required for both initial assessments and annual reassessments. (MSHO & MSC+ nursing facility members &

transferred members with an open elderly waiver (EW) span DO NOT get entered in MMIS). See DHS edoc #4669 and DHS edoc #5020A for detailed information related to MMIS entry.

MSHO/MSC+	• Complete screening document 3427H • Activity Type 07-Administrative Activity • Assessment Result 39 and Program Type 18 for members who have refused an assessment • Assessment Result 50 and Program Type 18 for unable to reach/member not found for the health risk assessment • Activity Type Date is the last day you attempted to reach the member verbally or via letter, or the date the member refused the HRA. • Do not enter refusal/UTR into MMIS for MSHO/MSC+ members in nursing facilities or transferred members with an open elderly waiver span. Members transferred to Medica with an open waiver span should remain eligible for EW until such time as CC is unable to complete the required reassessment required for EW. For these members, CC should complete MMIS entry to change the Care Coordinator using activity type 05, as directed in the Medica Assessment Schedule Policy.
SNBC/SNBC Enhanced	• Complete screening document 3427H • Activity Type 07 • Assessment Result 39 and Program Type 28 for members who have refused an assessment. • Assessment Result 50 and Program Type 28 for unable to reach/member not found for the health risk assessment. • Activity Type Date is the last day you attempted to reach the member verbally or via letter, or the date the member refused the HRA.

2) At any time, if a member who was previously unable to be reached for the HRA or refused a HRA is now requesting one or is agreeable to one when offered, the CC is to schedule time to meet with the member within 20 calendar days of the request.

Supplemental Documents CC is required to share with member annually:
Mail the following applicable documents to unable to reach/refusal members:

a. Ongoing No Contact Letter or Member Refusal Letter
b. Medica Care Coordinator Leave-Behind Document
c. Mailed Health Risk assessment
d. CC/EC contact information
e. Any other documents that may benefit the member such as “When and Where to Get Care,” etc.

Considerations

- If there is a safety concern with completing the assessment in the member’s home, it is recommended the CC request another CC or staff member to accompany them to the home assessment or offer to see member in a public venue. Note – if the CC has further concerns or questions, they may contact the Medica Clinical Liaison for consultation.
- Medica retains the ability, at any time, to reassign members who have not been found for the HRA or members who have refused the HRA and/or care coordination.

Unable to Reach/Unable to Locate Summary of Requirements	• 3 Non-automated phone attempts • If contact information is invalid, attempt to obtain updated information • Documentation of attempts to reach present in case notes. Send On-Going No Contact Letter (including Medica CC Leave Behind document, mailed Health Risk Assessment, other supplemental documents as indicated) • MMIS entry (Date of last contact attempt should be used, this is often the date the On-Going No Contact Letter is sent) • Review of Medica reports to identify PCP • If PCP identified, send PCP letter • Create UTR/Ref Care Plan (Required for MSHO/SNBC Enhanced member, optional for MSC+ SNBC Member • Update Care Plan with changes (return of mailed HRA, update re: PCP, transitions, etc.) at least annually.
Refuser Summary of Requirements	• The refusal must be obtained from the member or responsible party. • Documentation of refusal discussion present in case notes • Send Member Refuser Letter (including Medica CC Leave Behind document, Mailed Health Risk Assessment, other supplemental documents as indicated) • MMIS entry (Date of refusal) • Send PCP letter if member has provided PCP information and approves PCP contact and inclusion as part of ICT • If member did not provide PCP information, review of Medica reports to identify PCP letter. If PCP identified, send PCP letter. • Document if member refuses mailing of materials, ongoing contact, or PCP contact/inclusion in ICT • Create UTR/Ref Care Plan (Required for MSHO/SNBC Enhanced member, optional for MSC+/SNBC member) • Update Care plan with changes (return of mailed HRA, update re: PCP, transitions, etc.) at least annually.

CROSS REFERENCES:
Assessment Schedule Policy (MSHO/MSC+ & SNBC/SNBC Enhanced)
Part C Reporting Requirements
DHS edoc #4669
DHS edoc #5020A
MMIS online trainings available through DHS TrainLink

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