MSHO/MSC+ 101

Product and Model of Care Training

2020

MSHO Overview

MEDICA®

Minnesota Senior Health Options (MSHO)

Overview

- Medica product name: Dual Solution
- DHS product name: MSHO (Minnesota Senior Health Options)
- Eligibility
  - 65+ years old
  - Eligible for Medical Assistance
  - Has Medicare A and B
- MSHO is a voluntary program; member must elect

MSHO NEW MEMBER PACKET

- The MSHO Member Resource Guide (MRG)
  - welcome letter
  - privacy notice
  - women's cancer rights notice
  - advance directive
  - also includes summaries of other benefits and services

- Their ID card arrives in a separate mailing

MSHO BENEFITS

- Medical
- Pharmacy
  - Part D
  - Over the Counter (OTC)
- Delta Dental - 866-303-8138
- Vision- Eye Kraft (ask for Jeannie 320-281-2617)
- Behavioral Health (Medica Behavioral Health-MBH): 800-848-8327
  - Consults: when calling MBH identify yourself as a Medica CC, ask to speak to a Care Advocate or Clinical Supervisor
- Care Coordination
- Up to 180 days institutional care

MSHO BENEFIT

- Transportation
  - Cab, volunteer, Metro Mobility, bus passes, etc)
  - Special Transportation-requires Certificate of Need (CON)
- Elderly Waiver Services (if applicable)
- 24/7 Nurse Line – Health Advocate
- Health Support Programs
- Pharmacy
  - Medication Therapy Management (MTM)
- Added benefits
- Silver Sneakers

*See MSHO Member Handbook for complete benefit listing
https://www.medica.com/-/media/documents/medicare/dual-solution/2019_dual_member_handbook.pdf

MSHO PHARMACY

- Pharmacy Benefits

  Plan includes pharmacy benefits that cover certain:

  - Drugs covered by Medical Assistance
  - Drugs covered by Medicare Part B or Part D
  - Medication Therapy Management services
  - 2020 List of Covered Drugs (Formulary) – (PDF)

- Overrides
  - PCP must complete Prior Authorization Request and Exception form
  - PCP will be notified of decision
  - Member will receive letter regarding decision

FITNESS BENEFIT-SILVER SNEAKERS (MSHO ONLY)

- Members will receive Silver Sneakers card after enrollment
- Member will need to show Medica ID card to enroll at facility of their choice
- Transportation provided to closest facility
- The Standard Membership Program
    - Access to full or basic coed facilities, gender-specific fitness facilities, or exercise centers
    - Group fitness classes
- SilverSneakers.com for list of classes/sites

MSC+ Overview

MEDICA®

Minnesota Senior Care Plus (MSC+)

- Overview
    - Medica product name: Medica Choice Care
    - DHS product name: MSC+
    - Eligibility
        - 65+ years old
        - Eligible for Medical Assistance
        - May have Medicare

        - MSC+ is a default program

MSC+ New Member Packet

- The MSC+ Member Resource Guide (MRG)
  - welcome letter
  - women's cancer rights notice
  - advance directive
  - also includes summaries of other benefits and services

- Their ID card arrives in a separate mailing

MSC+ BENEFITS

- Medical
- Pharmacy
  - Over the Counter (OTC)
- Delta Dental - 866-303-8138
- Vision- Eye Kraft (ask for Jeannie 320-281-2617)
- Behavioral Health (Medica Behavioral Health-MBH): 800-848-8327
  - Consults: when calling MBH identify yourself as a Medica CC, ask to speak to a Care Advocate or Clinical Supervisor
- Care Coordination
- Up to 180 day Institutional care

MSC+ BENEFITS

- Transportation
  - Cab, volunteer, Metro Mobility, bus passes, etc)
  - Special Transportation-requires Certificate of Need (CON)
- Elderly Waiver Services (if applicable)
- 24/7 Nurse Line – Health Advocate
- Health Support Programs

*See MSC+ Member Handbook for complete benefit listing
https://www.medica.com/-/media/documents/medicaid/2019_msc_member_handbook.pdf

HEALTH SUPPORT PROGRAMS – both MSHO and MSC+

- Disease Management
  - Diabetes
  - Asthma
  - Cardiac Disease
- Tobacco Cessation
    - No cost
- Complex Case Management
- How members get involved?
  - Preselected/Referred/Self-Refer

Elderly Waiver and State Plan Services

MSHO and MSC+

MEDICA®

ELDERLY WAIVER (EW)

- Elderly Waiver (EW) is a program that funds home and community-based services (HCBS) for people age 65 and older who require the level of care provided in a nursing home, but choose to live in the community.

- The EW program is a federal Medicaid waiver program.

- EW recipients can receive waiver services and MA services funded through a managed care organization (MCO). The products offered are Minnesota Senior Health Options (MSHO)

- Members could have an Elderly Waiver Obligation
    - Eligibility for EW is based on two income limits:

  - People with incomes equal to or less than the Special Income Standard (SIS) are eligible for EW without an MA spenddown. They must contribute any income over the maintenance needs allowance and other applicable deductions to the cost of services received under EW. This is known as the waiver obligation.

  - People with incomes greater than the SIS may still be eligible for EW but they will have an MA spenddown. The lead agency's financial assistance unit is responsible for determining the financial obligation of the EW client. The client receives a notice if they have a waiver obligation or will be responsible for a spenddown.

EW (CONTINUED)

For EW, the lead agency can be a county, tribe or health plan. Lead agencies are responsible for the following:

Long-Term Care Consultation

Medica provides Long-Term Care Consultation (LTCC) services, including the following:

- Assistance with the application process
- A community assessment of the needs of the member
- Development of a community support plan

A member approved for EW will receive care coordination from a nurse or social worker who does the following:

- Helps develop the community support plan based on the person's needs
- Implements and monitors the community support plan (the community support plan must ensure that the health and safety needs of the recipient are reasonably met)
- Assures informed choice and consent
- Helps with referrals
- Arranges for and coordinates service delivery

EW COVERED SERVICES/DME/SUPPLIES:

Services

- Adult day service, adult day service bath
- Adult foster care, family and corporate
- Family caregiver coaching and counseling/caregiver assessment
- Family caregiver training and education
- Case management
- Case management aide
- Chore service
- Companion services
- Consumer directed community supports (CDCS)
- Customized living, 24-hour customized living, residential services
- Environmental accessibility adaptations
- Extended home health service aide
- Extended personal care assistance
- Extended home care nursing, LPN and RN
- Home delivered meals (HDM)
- Homemaker services
- Individual Community Living Support (ICLS)
- Personal emergency response systems (PERS)
- Respite care services, in home and out of home
- Specialized supplies and equipment
- Transitional services
- Non-medical transportation (EW transportation)

DME Supplies

- https://www.medica.com/care-coordination/policies-and-guidelines
- https://mn.gov/dhs/assets/medical-supply-coverage-guide_tcm1053-293319.pdf
- Medica Customer Service 952-992-2980 or 888-347-3630
- DME Provider

Examples of EW covered DME/Supplies:

- Incontinence products that exceed MA limit
- Cloth/reusable incontinence products
- Wipes
- Wheeled walker with seat
- Walker accessories: basket/tray
- Grab bars & installation
- Scale
- Air conditioner
- Reacher
- PERS
- Nutritional supplements
- Adaptive equipment for eating
- Lift chair (mechanism is MA and chair EW)

STATE PLAN SERVICES:

Members do not need to be open to a waiver to obtain the following:

- Home Health Aid
- Personal Care Assistant
- Skilled Nurse Visits
- Medical transportation
- DME that is within the MA limits – add link

Operations and Enrollment

Enrollment

- Enrollment reports are sent 2 times per month via emailed excel reports.
- The first enrollment report is sent either on the 1st or 2nd business day of the month and contains members that are newly enrolled.
- The second enrollment report is sent around the 10th of each month and contains 5 tabs of information.
    - Full Enrollment
    - Adds – New and Transferred members
    - Terms
    - MA Renewal Date
    - Members turning 65
- Member Transfers
    - Notify Enrollment via the DHS- 6037 enrollment transfer form of any members that need to be transferred to another care coordination partner.
    - Transfers are processed monthly
    - Transfer forms need to be received 5 business days prior to the end of the month in order to be effective the 1st of the following month.

Any questions regarding enrollment or transfers can be sent to SPPEnrollmentQ@medica.com

Operation Team

- Delegates are each assigned a CC Specialist (this person enters your referrals)
- Referral Request forms:
  - Need to be submitted to your assigned CC Specialist
  - For Services that require a Referral in Medica's system, see the Claims Referral Guidelines for MSC+, MSHO and SNBC (PDF) on Medica.com.
    - https://www.medica.com/care-coordination/tools-and-forms
- Communications from Operations:
  - Daily Admissions Reports
  - PAS (Pre–Admission Screening) Notifications

Assessment and Care Plan

ROLE OF CARE COORDINATOR

- Within first 10 days of enrollment month
  - Contact with member identifying Care Coordinator
  - Providing CC name and contact phone number

ROLE OF CARE COORDINATOR

Initial Assessment within 30 days/60 days of enrollment

Tasks due within 30 days of Health Risk Assessment (HRA)

- Collaborative Care Plan completed & sent to member
- Member Signature Sheet signed & dated
- OBRA Level 1 completed (DHS 3426)
- Medica Care Coordinator Leave Behind Document left with member
- Complete Referral Request Form as needed to authorize services; submit to Operations
- Primary Care Physician (PCP) letter completed & sent to PCP
- Member Post Visit letter completed & sent to member.
- Care Plan sent to EW providers, when indicated (send again at day 60 if needed)

Repeat by 365 days

If Unable to reach/Refuser

- 3428 H entered indicating Unable to reach or Refusal in MMIS
- Member Refusal or On-going No Contact letter completed & sent, include Self-Report HRA.
- UTR/Ref Care Plan completed (MSHO)

ROLE OF CARE COORDINATOR

Medica Care Coordinator Leave-Behind Document

- CC name and contact information
- How your CC can help you
- How you can help your CC
- Grievance process
- Shared with member annually
- Available on the CC website

- Important for the member and family to identify you as their Medica Care Coordinator!

ROLE OF CARE COORDINATOR

Assessments	
Elderly Waiver (EW)	EDOCS DHS-3428
Non-Elderly Waiver	EDOCS DHS 3428H
Members on another waiver (non-EW)	EDOCS DHS 3428H
Institutional	Institutional Member Assessment (Medica CC Website)
Unable to Reach/Refusing	EDOCS DHS 3428H
Transfer Members (With no changes identified)	Transfer HRA
All	Annual MMIS entry, except institutional members

ROLE OF CARE COORDINATOR

Assessment for members as needed:

- Personal Care Assistance (PCA)
  - PCA assessment (DHS-3428D)
  - Complete during LTCC/HRA
  - Only a Public Health Nurse (PHN) can complete a stand alone PCA assessment
- Communication to Physician of PCA Services
  - DHS-4690

MODEL OF CARE-ROLE OF CARE COORDINATOR

Assessment for members in this setting or wanting to move to this setting:

Customized Living, Adult Foster Care

- RS Tool process in MnSP (MnChoices)
  - CC's are to review the training via TrainLink as well as complete the Handling MN modules on data privacy.
  - DHS CountyLink Home Page

ROLE OF CARE COORDINATOR

Members on other waivers (other than EW)

- Complete 3428H (used for members on other waivers, i.e. CADI, DD, BI)
- Same Assessment Schedule Policy
- Same Care Planning Requirements
- Communication and collaboration with waiver case manager (CM) is essential.

- Important to know that care coordinator is still involved, county is considered "lead agency" and assesses for continued waiver eligibility. County would also complete PCA assessment and Medica MSHO Care Coordinator would complete a referral request form as Medica is the payer of PCA services.

ROLE OF CARE COORDINATOR

Change of Condition Assessments

- If your member has had a marked improvement or decline, the Care Coordinator may need to reassess.
- See the Assessment Schedule policy for more information.

ROLE OF CARE COORDINATOR

Caregiver Assessment

- If the member has identified and unpaid caregiver, the CC is required to conduct a Caregiver Assessment-included as part of the DHS 3428 assessment form.
- Supplemental version on Medica.com site to go with the DHS 3428H
- Determine if the Caregiver is in need of any additional support
- Information obtained from the Caregiver is important in the development of the individualized care plan

ROLE OF CARE COORDINATOR

OBRA Level 1

- Omnibus Budget Reconciliation Act (OBRA) 1987: Federal law that mandates the screening and review of all persons with a diagnosis or suspected diagnosis of developmental disability who seek admission to a nursing facility regardless of the source of payment for the NF services.
- Determine the need for NF level of care.
- Evaluate whether a DD diagnosis condition is present or suspected.
- Refer for a Level II evaluation to the county of financial responsibility if developmental disability is present or suspected. If mental health is present or suspected, refer to county of residence for evaluation
- Required on an annual basis

ROLE OF CARE COORDINATOR

Pre-Admission Screening (PAS)

- CC is notified via email by Operations once a PAS document has been received from the DHS Senior Linkage Line.
- CC is responsible for following up with the Nursing Facility (NF) and providing the OBRA Level I and any additional documentation as requested.
- Partner Nursing Home Checklist
    - Nursing facilities do not need a prior authorization.
    - For claims payment the facility needs to fax the Nursing Facility Communication form to Medica at 952-992-2299 or via email to NFCommunications@medica.com
- Refer to Assessment Schedule Policy as needed
    - Members in a Nursing Facility at 30 days must be exited from EW.

ROLE OF CARE COORDINATOR

Members residing in a nursing facility

- Collaborate with facility staff
- Collaborate with county staff
- Complete Institutional Assessment, as needed
- Partner Nursing Home checklist
- Relocation discussion annually
- Collaborate with facility staff
  - attending care conferences
  - consultation rounds
  - phone

- Nursing Facility Chart Coverage Guide
  - MSHO
  - MSC+

ROLE OF CARE COORDINATOR

Unable to Reach & Refusing Member management

- Attempt to reach member in enrollment month to schedule assessment.
- Document attempts in member chart – minimum of three attempts documented plus a letter.
- Document member refusals
- If member refuses an assessment or is unable to reach, enter #39-refusal or #50-unable to find on LTCC/HRA into MMIS
    - Unable to Find & Refusals must be entered before cut-off
    - Send out Self Report Health Risk Assessment (SRHA)
        - If SRHA is returned, retain in member file
        - Update and complete care plan based on information you've collected either from the SRHA or through transition notification. If member continues to refuse or is unable to reach, enter #39 or #50 assessment annually

ROLE OF CARE COORDINATOR

Transitions of Care

- Managing transitions is a CMS requirement
- Operations send daily admissions report as applicable
    - Hospitals are not required to report
- CC's are to manage and record transitions within 24 hours of notification.
- Transition resources:
    - Transition Log (MSHO required)
    - Transition Log Instructions
    - Notice of Transition Fax sheet
    - Transition Scenarios

ROLE OF CARE COORDINATOR

Interdisciplinary Care Team (ICT)

- ICT
  - Established based on members assessed needs and concerns.
  - Document team members in members CCP.
  - Collaborate with the team as needed.

ROLE OF CARE COORDINATOR

Ongoing Member Education

- Assist member with navigating health plan departments, programs and processes.
- Educate members about good health practices including wellness and preventive activities and self-management techniques.
- Educate members regarding ways to avoid emergency room and hospital admissions as needed
- Educate members on the benefits of annual physician visits for primary and preventive services.
- Educate members on the benefits of annual Advance Directive discussions

ROLE OF CARE COORDINATOR

Transfers

- If a transfer needs to occur
  - DHS 6037 A or 6037 B submitted to Medica at the SPPEnrollmentQ@medica.com email box.
  - Must be submitted by 24th of the month to be effective the 1st of the following month
  - Future end date members cannot be transferred
- Upon receipt of transfer
  - Transfer HRA – completed within 30 days
  - Review and inclusion of current HRA/MNCHOICES and CCP/CSP/CSSP
- Refer to Member Transfer Responsibilities Policy & Assessment Schedule Policy.

ROLE OF CARE COORDINATOR

Collaborative Care Plan (CCP)

- CCP completed and sent within 30 days of assessment
- Develop, monitor, update person-centered plan of care and communicate with Interdisciplinary Care Team (ICT)
- SMART goals
- Home and Community Based Service Agreement completed as part of the care plan.
- Care Plan Signature Page
- Living document…updated as necessary/change in condition
- Audited annually
- Provider signature requirements for EW members

Examples of Person Centered SMART Goals

Not Smart or Person Centered Goals	SMART Person Centered Goals
Member will stay living in his home	Sam would like to stay living in his home over the next 12 months
Member will lose weight	Sam would like to lose 15 pounds within the next 6 months
Member will be compliant with high blood pressure medications daily	Sam would like to take his high blood pressure medication every morning for the next 12 months
Member will be free from falls	Sam would like to be free from falls for the next 6 months

Example of Care Plan Goals, Supports, Monitoring & Outcomes

Rank by Priority	My Goals	Support(s) Needed	Target Date	Monitoring Progress/Goal Revision date	Date Goal Achieved/ Not Achieved (Month/Year)
☐ Low ☒ Medium ☐ High	Sam would like to improve his mental health by sleeping atleast 4-6 hours per night	Sam will take sleep aid medication as prescribed. Sam will go for daily walks to help with his sleep Sam will not drink coffee past noon Care Coordinator will provide information on mental health supports and refer as needed.	12/20/19		
☐ Low ☒ Medium ☐ High	Sam would like to find a dental provider that is close to his home within the next 3 months.	Care Coordinator will provide information on dental care providers.	3/1/19	12/31/18 Sam had appointment at ABC Dental.	12/31/18 Achieved

ROLE OF CARE COORDINATOR

Ongoing Follow-Up

- Schedule follow-up contacts and communications with member based on member request, identified risks, needs and fragility.
- Document follow-up contacts

COMMUNICATION AND LETTERS

- Only use approved member letters found on Medica.com Care Coordination website, Letter Templates
    - Medica | Letter Templates for Care Coordinators
        - Care Plan Change letter
        - Change of Care Coordinator letter
        - Documents letter
        - Eligibility Renewal Reminder letter
        - Member Refusal letter
        - Ongoing No Contact letter
        - Post-Visit letter
        - Welcome Letter
        - PCP letter

- Communicate with member Waiver Worker and Targeted Case Manager as needed via DHS-5841 or via phone
- DHS-5181 to communicate with Financial Worker
- Document all communications in member chart

BENEFIT EXCEPTION INQUIRY (BEI)

The Benefit Exception Inquiry process is a way for care coordinators to ask Medica if a member can receive an item or service outside of the benefit set

- Benefit Exception Inquiry Process
  - Care Coordinators should discuss BEI requests with their supervisor prior to submitting to Medica
    - Care Coordinators must submit requests using the Benefit Exception Inquiry (BEI) form. Incomplete forms will be returned.
      - Documentation to support the need must be submitted with the BEI form.
    - Include the cost of the item that you are requesting.
  - Once BEI forms are reviewed, the Care Coordinator will be informed of the result and contacted with questions.

  - BEI forms should not be submitted for the following:
    - Pharmacy
    - Mental Health Services
    - Dental
    - Claim Denials or Previously Denied services
    - Out of Network Physician services

DENIAL/TERMINATION/REDUCTION (DTR)

- DTR's are a contract requirement by DHS.
- If a service is being denied (based on lack of need), terminated (based on members request or other reason) or reduced (based on members request or other reason) a care coordinator must complete a DTR form and submit it to Medica as soon as they are notified of the request or make a determination that services need to have a DTR.
- Medica will review and assign a date which the denial, termination or reduction will be effective based on when the review has been completed. The care coordinator will be alerted to the final decision.
- Letters are automatically sent to members with their appeal rights.

Care Coordination Website

Policies

https://www.medica.com/care-coordination/policies-and-guidelines

- Assessment Schedule Policy
- Care Coordination Accountability (MSHO, MSC+) – (PDF)
- Member Transfer Responsibilities Policy
- Missing Member Refusing Member Policy
- Telephonic Assessment Policy (MSC+)
- Transition of Care

WEBSITE

MSHO (Medica DUAL Solution®)

Assessment and Care Plan

- Assessment Checklist (MSC+ and MSHO)
- Caregiver Assessment (DOC)
- Collaborative Care Plan - Version 3 (DOC)
- Collaborative Care Plan Instructions (PDF)
- Medica Care Coordinator Leave-Behind Document (PDF)
- Medication List Form (DOC)
- My Move Plan Instructions (PDF)
- Self-Report Health Risk Assessment (PDF)
- Transfer Member Health Risk Assessment (DOC)
- Unable to Contact Refusal Care Plan (DOC)

MSC+ (Medica ChoiceCare℠)

Assessment and Care Plan

- Assessment Checklist for MSC+ and MSHO (DOC)
- Caregiver Assessment (DOC)
- Collaborative Care Plan - Version 3 (DOC)
- Collaborative Care Plan Instructions (PDF)
- Medica Care Coordinator Leave-Behind Document (PDF)
- Medication List Form (DOC)
- My Move Plan Instructions (PDF)
- Self-Report Health Risk Assessment (PDF)
- Transfer Member Health Risk Assessment (DOC)

Operations

- Claims Referral Guidelines for MSC+, MSHO and SNBC (PDF)
- Benefit Exception Inquiry (BEI) Form (DOC)
  - Form Instructions (PDF)
- DTR Form (PDF)
  - Form Directions (PDF)
  - Frequently Asked Questions (PDF)
- Flexible PCA Verification Form (DOC)
- Referral Request Form (DOC)

Website

Contacts and Group Numbers

- Care Coordination Product Group Numbers for Special Needs Plans and MSC+ (PDF)
- Care Coordination Products (CCP) Operations Team Contacts (PDF)
- Contact Numbers for Key Staff in Medica Care Coordination Products (PDF)
- County, Care System and Agency Contact Numbers (PDF)
- PCA Provider List (PDF)

Institutional

- Institutional Member Assessment (DOC)
- Nursing Facility Chart Coverage Guide for MSHO (PDF)
- Medica Partner Nursing Home Checklist for MSHO/MSC+ (DOC)

Institutional

- Institutional Member Assessment (DOC)
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Website

Quick Links

SNBC SNP (Medica AccessAbility Solution Enhanced)

MSHO (Medica DUAL Solution)

MSC+ (Medica ChoiceCare)

SNBC (Medica AccessAbility Solution)

SPP Service Area Maps

Medica DME coverage grid (PDF)

Helpful Websites

MN Department of Human Services

MinnesotaHelp.info

Disability Hub MN

MSHO Product Page

MSC+ Product Page

Look up what is covered

Here you can access edocs

COMMUNICATIONS TO DELEGATES

- Monthly CC Newsletter
- Quarterly Care Coordination Meetings
- Pre-Admission Screenings (PAS)
- Admissions Reports
    - Hospitalizations and SNF admissions
- Notification of Mental Health inpatient stay via MBH

MSHO Enrollment Sales

Sales Team

- 888-347-3630
- MedicaCCPSales@medica.com
- Ryan.Hoffman@medica.com

Other Contacts

- Delta Dental of Minnesota® 651-994-5198 or 866-303-8138 **Number only for Care Coordinators**
- Health Support Programs 866-905-7430
- Nursing Home Admissions Fax: 952-992-2299 or NFCommunications@medica.com
- Medica NurseLineTM by HealthAdvocateSM 866-715-0915 Available 24 hours a day
- Medica Customer Service 888-347-3630 or 952-992-2580
- Medica Behavioral HealthSM (MBH) 800-848-8327
- MMIS Liaison (MMIS set-up or resets) SNPReferralCommunications@medica.com
- ProviderOversight@medica.com
  - PAR, interpreter, special transportation
- MedicaCCSupport@medica.com or 888-906-0971

MEDICA®