SNBC/ISNBC 101

Product and Model of Care Training

2020

SNBC – Specials Needs Basic Care Overview

Product Overview

- Medica product name: Medica AccessAbility Solution
- DHS product name: SNBC (Special Needs Basic Care)
- Eligibility
  - 18-64 years old
  - Eligible for Medical Assistance
- Members with Medicare
  - Medica will coordinate benefits with Medicare
  - Members must have a Part D Plan and will have their Medicare Part D copays
  - Medica covers OTC (over the counter) Rx.
- Members without Medicare
  - Medica is the primary payor for all covered services.
- SNBC is an opt-out program

SNBC New Member Packet

What is included in our new member/annual member packets for SNBC, is the Member Resource guide created by Marketing which also has the Notice of Electronic Delivery which tells members how to access vital documents online or to call Member Services to request a hard copy.

SNBC Benefits

- Medical
- Pharmacy
  - Over the Counter (OTC)
- Delta Dental - 866-303-8138
- Eye Kraft (ask for Jeannie 320-281-2617)
- Health Support Programs
- Medica Behavioral Health (MBH) Consultations: 800-848-8327
    - Referrals: Identify as CC, ask for Care Advocate
- Care Coordination
- Up to 100 day Institutional care

SNBC Benefits

- Transportation
  - Cab, volunteer, Metro Mobility, bus passes, etc.
  - Special Transportation-requires Certificate of Need (CON)
- 24/7 Nurse Line – Health Advocate
- Health Support Programs
- Child and Teen Checkup Screenings

*See Evidence of Coverage (EOC) for complete benefit listing

ISNBC – Special Needs Basic Care Enhanced Overview

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Special Needs Basic Care- Enhanced (ISNBC)

Product Overview

- Medica product name: Medica AccessAbility Solution Enhanced
- DHS product name: ISNBC (Integrated Special Needs Basic Care)
- Eligibility
  - 18-64 years old
  - Eligible for Medical Assistance
  - Eligible for Medicare part A and B
  - Have a certified disability
  - Reside in an ISNBC service area

- ISNBC is a voluntary program; member must elect

ISNBC New Member Packet

What is included in our new member/annual member packets for SNBC, is the Member Resource guide created by Marketing which also has the Notice of Electronic Delivery which tells members how to access vital documents online or to call Member Services to request a hard copy.

ISNBC Benefits

- Medical
- Pharmacy
  - Part D
  - Over the Counter (OTC)
- Dental-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 100 days of institutional care

ISNBC Benefits

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

FITNESS BENEFIT-SILVER SNEAKERS (ISNBC 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

State Plan Services – both products

- Home Health Aid
- Skilled Nurse Visits
- Medical transportation
- DME that is within the MA limits

Health Support Programs – both products

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

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

Assessment

- Within 60 days of enrollment
    - Health Risk Assessment (HRA) scheduled and completed
        - Face to Face/Telephonic
    - 3428H
    - Transfer HRA
    - https://www.medica.com/care-coordination/tools-and-forms
    - 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
    - Reassessment every 365 days

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 annual
- Available on the CC website

Role of Care Coordinator

Members on waivers

- Complete 3428H initially and annually
- Same Assessment Schedule Policy
- Same Care Planning Requirements
- Enter 3428H into MMIS
- Communication and collaboration with waiver case manager (CM) is essential and required

Collaboration with others

- Local agency case managers
- Lead agency case managers
- County case managers – communicate using the DHS 5841
- Financial workers – communicate using the DHS 5181 (notify FW when members move out of the service area, when members pass away, or their living setting changes (i.e. community to institutional)
- Other staff as appropriate

Caregiver Assessment

- Caregiver Assessment https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6914-ENG
- 3428H does not ask about an unpaid/informal Caregiver
    - If you think a member has an unpaid/informal caregiver, please conduct a Caregiver Assessment
    - 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

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

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

Pre-Admission Screening

- CC is notified via email by Operations once a PAS document has been received from the 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

Role of Care Coordinator

Institutional Members

- Complete 3428H initially and annually
- Same Assessment Schedule Policy
- Same Care Planning Requirements
- Enter 3428H into MMIS
- Communication and collaboration with facility staff is essential and required
    - Partner Nursing Home checklist
    - Attend care conferences, consultation rounds, phone consults
    - Nursing Facility Chart Coverage Guide

Unable to Reach & Refusing Member management

- Missing Members and Refusals
  - Attempt to reach member within 60 days of enrollment to schedule assessment.
  - Document attempts to contact in member chart – minimum of three attempts and a letter. If unable to reach enter #50 unable to contact refusal of HRA into MMIS,
  - If member refuses an assessment or is unable to contact, enter #39-refusal of HRA into MMIS,
  - Send out Member Letters & Self Report Health Risk Assessment (SRHA)
    - If SRHA is returned, retain in member file
    - No care plan for SNBC members – document missing/refusing in member notes
    - Care plan is needed for ISNBC members and update accordingly
  - If member continues to refuse or is unable to be reached, enter # 50 or #39 assessment annually

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)
    - Established based on members assessed needs and concerns.
    - Collaborate with the team as needed.

Role of Care Coordinator

- 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

Transfers

- DHS 6037 submitted to SPPEnrollmentQ@medica.com
- Must be submitted by the 24th of the month to be effective the 1st of the following month
- Able to complete Transfer HRA for new Transfer Members
- Including review of current 3428H, care plan, and member signature sheet

Members turning 65

- Look to the Medica Full Enrollment report received approx. 10th-12th of month for members turning 65
- Member will receive a letter from DHS outlining their options
- CC's to assist member in understanding the transition
- Member receiving services from an OON provider (i.e. PCA) and staying with Medica will need to change providers within 120 days
- If members are leaving a delegate agency, the transfer process is to be followed
- SNBC and Enhanced Members Turning 65 (PDF)

Care Plan

- Care plan 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
- Service Agreement completed as part of the care plan
- Care Plan Signature Page
- Living document…updated as necessary/change in condition
- Audited annually

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

Ongoing Follow-up

- Schedule follow-up contacts and communications with member based on member request, identified risks, needs and fragility.
- Medica requires 6 month follow-up on a minimum.
- 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
    - https://www.medica.com/care-coordination/letter-templates
- 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 Inquiries and Denial, Terminations and Reductions

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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) – (DOC). 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.
- BEI forms should **not** be submitted for the following:
    - Pharmacy
    - Mental Health Services
    - Dental
    - Chiropractic
    - 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 Resources

Care Coordination Website

Policies

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

- Assessment Schedule Policy
- Case Management Accountability (SNBC)
- Member Transfer Responsibilities Policy
- Missing Member Refusing Member Policy
- SNBC Members Turning 65 Policy
- Telephonic Assessment Policy
- Transition of Care

Care Coordination Website

Tools and Forms

- https://www.medica.com/care-coordination/tools-and-forms

SNBC (Medica AccessAbility Solution® and Medica AccessAbility Solution Enhanced) —

Note: All documents are to be used for both products unless otherwise specified

Assessment and Care Plan

- Care Plan (DOC)
- Care Plan Instructions (PDF)
- Member Signature Sheet (DOC)
- Unable to Contact/Refusal Care Plan (DOC) – *SNBC Enhanced only*
- Assessment Checklist (SNBC) – (DOC)
- Caregiver Assessment (DOC)
- Medica Care Coordinator Leave-Behind Document (PDF)
- Medication List Form (DOC)
- Self-Report Health Risk Assessment (PDF)
- Transfer Member Health Risk Assessment (DOC)

Care Coordination Website

Tools and Forms Continued

Operations

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

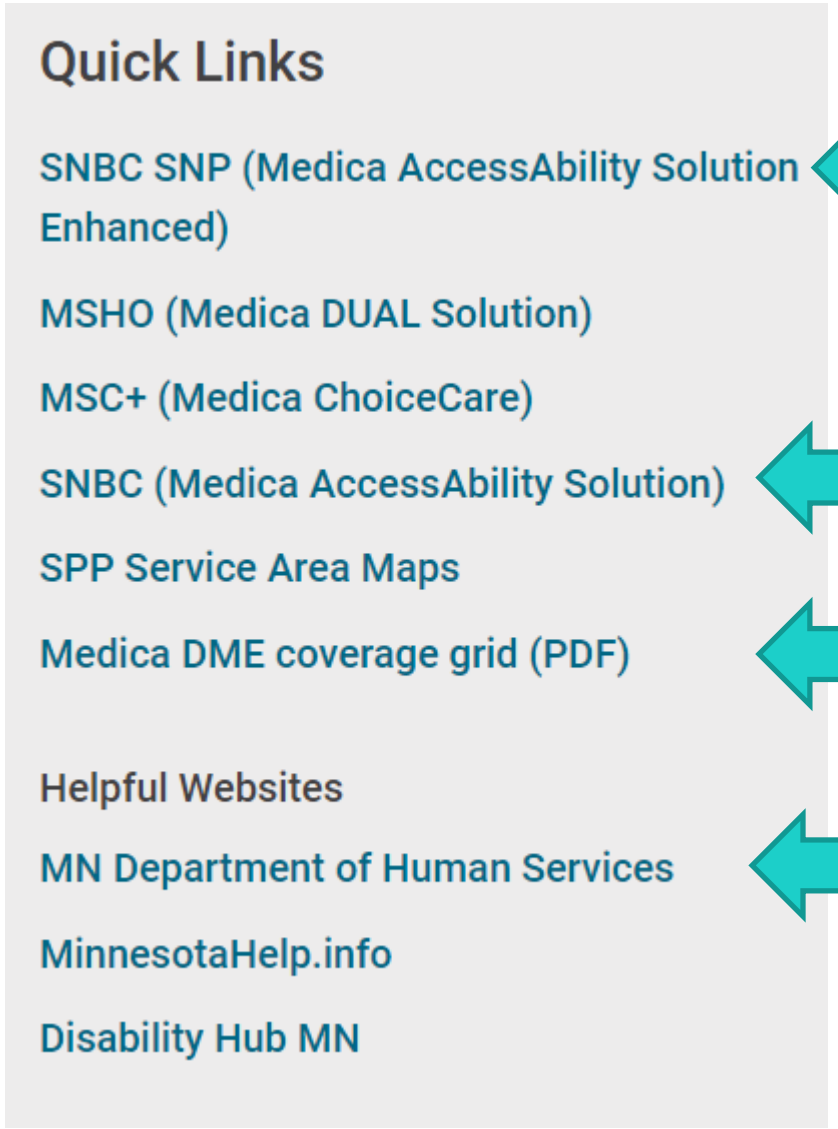
Contacts and Group Numbers

- 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)

Institutional

- AccessAbility Solution (SNBC) Nursing Facility Chart Coverage Guide (PDF)
- AccessAbility Solution (SNBC Enhanced) Nursing Facility Chart Coverage Guide (PDF)
- Medica Partner Nursing Home Checklist for SNBC/SNBC Enhanced (DOC)

Care Coordination Website



ISNBC Product page

SNBC Product page

Look-up what is covered

Here you can access edocs

Resources Continued

Communications from Medica

- 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

Medica Contacts

Sales Team

- Medica Sales Consultants: 866-538-5608

Self Enrollment:

- https://www.medica.com/shop-plans/medicaid-plan-options/plans-for-people-under-age-65
- Choose MN Health Care Programs member
- Then click Medica AccessAbility Solution (SNBC)

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

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