MEDICA®

# Medica Care Coordinator Training Manual:

## Medica AcessAbility Solution®
## and
## Medica AcessAbility Solution® Enhanced

### For Special Needs BasicCare (SNBC and SNBC SNP) Members

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# Introduction

As a representative of Medica, the Care Coordinator (CC) helps members build and maintain an independent and healthy life. Although SNBC and SNBC SNP do not include waiver benefits, personal care attendant (PCA), or home care nursing benefits (formerly called private duty nursing), the Medica CC still has the responsibility to assist the member in understanding their SNBC and SNBC SNP benefits, coordinating care across payers including Medicare, assisting across all settings of care, and being involved with member transitions. In addition, the CC will also communicate with any county case managers and others to coordinate efforts and advocate for the member. The CC is the member's primary contact for accessing all benefits under SNBC and SNBC SNP.

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# Job Duties of a Medica AccessAbility Solution and AccessAbility Solution Enhanced Care Coordinator

1. Care Coordinators (CC) will work to develop a care plan, arrange for services, and to assure consent to the medical treatment or services in partnership with:

   - The member and/or authorized family members or alternative authorized decision makers
   - The primary care provider, if known, in consultation with any specialists caring for the member

   The Care Coordinator collaborates with the member in developing, coordinating and, in some instances, providing supports and services identified in the member's care plan and obtaining consent to the medical treatment or service. Care Coordination is provided at a level of involvement based on the needs and choices made by the Member and/or authorized family members or alternative authorized decision makers, as appropriate to implement and monitor the care plan.

2. Upon receiving the enrollment information, within ten (10 days) contact the member to:

   - Introduce yourself to the member
   - Provide contact information (including phone number and contact person knowledgeable about the SNBC program that the member can call for assistance in transitioning to managed care)
   - Answer any questions about the plan the member has

   Medica provides the member a letter containing the general contact information for the entity or partner providing their care coordination along with Medica Customer Service numbers.

3. Care Coordinators conduct a **Health Risk Assessment (HRA)** of each member's health needs within the first thirty (30) calendar days of enrollment and annually (within 365 days) thereafter. HRA's will be offered to all members at least annually using the *DHS 3428 H.* See the *Assessment Schedule Policy SNBC* found on the Medica Care Coordinator site for information related to timelines.

   **Note:** Upon implementation of MnCHOICES with a Medica SNBC or SNBC SNP member Care Coordinators will be required to use the state's MnCHOICES tool.

4. Facilitate annual physician visits for primary and preventive care, and assist in removing any barriers member is facing related to obtaining this care.

5. Care Coordinators are to assist members in locating and accessing specialists and sub-specialists including those with experience in working with persons with disabilities.

6. Develop an individualized Care Plan with the member and/or authorized family members or alternative authorized decision makers following the completion of the Health Risk Assessment (HRA) process. This

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care plan includes goals identified during the HRA as well as the monitoring of progress towards those goals. This care plan serves as a “living document” which is updated as the members needs and services change.

7. Arrange and coordinate supports and services identified through the assessment and care planning process.

8. Assist the member and/or authorized family members or alternative authorized decision makers, if any, to maximize informed choice of services and control over services and supports.

9. Monitor and record outcomes in order to evaluate the adequacy of services and interventions.

10. Assist the member with health plan related issues as needed. This could include referring the member, family or provider to the appropriate contact point within Medica. Care Coordinators are not the primary contact for billing issues for providers. For these issues providers should be referred to Medica Provider Services.

11. Coordinate with primary care, including assisting a member locate appropriate providers if needed.

12. Educate member about good health practices, including wellness and preventative activities. The CC will obtain and distribute self-management materials and education to members regarding disability related conditions common among persons with disabilities.

13. Participate in Performance Improvement Projects (PIPS) or Chronic Condition Improvement Projects (CCIP) for applicable members.

14. Assist members in accessing resources and services beyond the Medical Assistance and Medicare benefit sets including formal and informal supports.

15. Assist members by making appropriate referrals for services outside of the SNBC and SNBC SNP benefit set such as waiver services, PCA services, etc. With these referrals, the Care Coordinator will provide the county with information related to the members assessed need which may include a copy of the member’s last HRA and care plan.

16. Care Coordinators may need to complete a referral for some services that require an authorization in our system.

    - The *Referral Request Form* can be found on the Care Coordination website under *Tools and Forms.*

    - Refer to *Claims Referral Guidelines for MSC+, MSHO, and SNBC* for a list of services that require a service authorization. The guide can be found on the Care Coordination website under *Tools and Forms.*

17. Ensure smooth transitions and coordination of information between acute, sub-acute, rehabilitation and nursing facilities and home and community based settings. A transition log is required for SNBC SNP members, highly recommended for SNBC as all transition tasks remain the same.

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18. Stay up to date with changes that relate to Medical Assistance benefits and program changes. Attend trainings put on by Medica, DHS, PIP collaborative and other entities as needed.

19. Care coordinators are to have experience working with people with disabilities, primary care, nursing, behavioral health, social services and/or community based services.

20. Complete all necessary activities surrounding nursing home placements including but not limited to DHS-3427T *LTC Screening Document - Telephone Screening* per the DHS pre-admission screening process (PAS). The document can be found on the DHS eDocs site by clicking here and searching for 3427T.

21. Conduct DHS-3426 *OBRA Level 1 Criteria - Screening for Developmental Disabilities or Mental Illness* and convey any information obtained during the screening to the Local Agency and send copy to nursing facility (NF). The document can be found on the DHS eDocs site by clicking here and searching for 3426. Follow the OBRA Level II process if indicated.

22. Care Coordinators are to be familiar with the Medica twenty four (24)-hour, seven (7)-day-per-week nurse line members can access. Care Coordinators are to direct members to the nurse line phone numbers on their member ID cards for use by the member when needed and educate members on the importance of this resource. More information is found in the NurseLine by HealthAdvocate section of this document.

23. **Communication and Coordination with Counties, Tribes and Providers:**

    - The Care Coordinator is responsible for communications with county social service agencies, community agencies, nursing homes, residential and home care providers involved in providing care under fee for service to SNBC and SNBC SNP members. Communication will include HIPAA compliant electronic communication vehicles.

    - With any referrals of the member to the county for waiver services, the Care Coordinator is required to submit to the county a summary of the member's strengths and needs, and services the managed care organization has authorized to meet the members identified needs. The Care Coordinator will provide, at minimum, a copy of the complete health risk assessment and current care plan.

    - The Care Coordinator will coordinate with local agency/county as necessary, including use of the DHS-5181 *Lead Agency Assessor/Case Manager/Worker LTC Communication Form* with any new Care Coordinator assignment, change of address, change of living setting, death, or disenrollment. The document can be found on the DHS eDocs site by clicking here and searching for 5181.

    - The Care Coordinator will communicate with lead agencies (counties/tribes) on the authorization of or need of services. This communication should be completed using the DHS-5841 *Managed Care Organization, County and Tribal Agency Communication Form - Recommendation for State Plan Home Care Services*. The document can be found on the DHS eDocs site by clicking here and searching for 5841.

    - Care Coordinators are required to communicate with the receiving health plan if the member has changed health plans or with the lead agency (county/tribe) if the member has dis-enrolled and is receiving services which may need to be paid for Fee-For-Service. This communication is to be done

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using the DHS-6037 *Home and Community-Based Services Case Management Transfer Form*. The document can be found on the DHS eDocs site by clicking here and searching for 6037. See the instructions for this form related to communications that are required.

- Care Coordinators will coordinate and communicate with tribal assessors and case managers. Care Coordinators will accept the results of home care assessments, reassessments and the resulting service plans developed by tribal assessors for Tribal Community Members as determined by the tribe. Referrals to non-tribal providers for home care services resulting from the assessments must be made to providers within the Medica network. This applies to home care services requested by Tribal Community Members residing on or off the reservation.

24. Care Coordinators must be aware of services that include 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.

25. **Coordination with the Local Agency (county or tribe).** Referrals and/or coordination with county social service staff will be required when the member is in need of the following services (as outlined in the DHS contract):

    - Pre-petition screening
    - Preadmission screening for Home and Community Based- Waiver Services (HCBS)
    - County Case Management for HCBS
    - Child protection
    - Court ordered treatment
    - Case Management and service providers for people with developmental disabilities
    - Relocation service coordination
    - Adult protection
    - Assessment of medical barriers to employment
    - State medical review team or social security disability determination
    - Working with Local Agency social service staff or county attorney staff for members who are the victims or perpetrators in criminal cases

26. Medica Care Coordinators shall make reasonable efforts to coordinate with services and supports provided by the Veteran's Administration (VA) for members eligible for VA services.

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27. Medica Care Coordinators will be aware of the contract requirement stating that members with HIV/AIDS and related conditions may have access to federally funded services under the Ryan White CARE Act, 42 USC § 300ff-21 to 300ff-29 and Public Law 101-381, Section 2.

28. Advance Directive Planning is important and the Medica Care Coordinator shall inform members of resources available for advance directive planning based on individual member needs and cultural considerations. Members receive an advance directive document in their new member packets.

29. Assist members turning 65 years old in understanding their transition to a senior product. SNBC and SNBC SNP members are not able to remain on the SNBC and SNBC programs after age 65; these members are required to choose a senior program. DHS requires that SNBC and SNBC SNP members turning 65 years old either default into the MSC+ program, or actively enroll into MSHO if they are eligible. See the policy on the Medica Care Coordinator site for more information.

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# Health Risk Assessments (HRA) and Medicaid Management Information System (MMIS)

## Assessments

- Per our contract with DHS, Care Coordinators will make a best effort to conduct a health risk assessment (HRA) of each member's health needs within sixty (60) calendar days of the enrollment date. Reassessments will be completed within 365 days of the previous HRA. At a minimum, face to face assessments must be offered to SNBC and SNBC SNP members not currently on a waiver program. The assessment addresses medical, social, environmental and mental health factors. See the Assessment Schedule Policy (SNBC, SNBC Enhanced) – (PDF) and Telephonic Assessment Policy (MSC+, SNBC, SNBC Enhanced) – (PDF) policies for more information.

## Assessment requirements

## SNBC and SNBC SNP

- All members are required to have an assessment offered to them annually and at reassessment. For members not on a waiver program, this offer is to be for a face to face assessment. If the face to face assessment is declined, a telephonic assessment should be offered.
- If a member has requested an HRA, the CC is to schedule this with the member at their earliest convenience.
- Upon completion of the assessment, the CC is required to enter specified information into MMIS for all members.
  - The SNBC assessment completed with members is **not** the Long Term Care Consultation (LTCC), but is an assessment designed specifically to the needs of the SNBC population.
  - Entry in MMIS is done as "H" type screening documents.
  - The Medica health plan code in MMIS is MED

**NOTE:** Upon implementation of the MnCHOICES assessment for SNBC members Care Coordinators are required to use the HRA component of the state's MnCHOICES tool which will then meet the requirements of this section.

## Institutional SNBC Members

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- If a member is admitted to a nursing home (NH) an assessment is due within thirty (30) days. It is important to collaborate with the member's waiver worker (if applicable) as well as the facility staff on discharge planning.

- NH Members who have been determined will remain in long term care should be transferred back to the Medica Care System by day 100 unless the assigned delegate is contracted to provide institutional care coordination. CC's should notify the member's county of financial responsibility (COR) of the admission.

- MMIS entry of the Preadmission Screening activities (PAS) is needed to follow state and federal requirements that prohibit medical assistance payments for NF services provided prior to completion of required preadmission screening. It confirms the need for nursing facility level of care and screens people for mental illness or developmental disabilities. This MMIS entry should be done by day 30 of placement. Activity type would be 01 Telephone Screen. Communication of the nursing facility admission should be made to the financial worker using the DHS-5181 *Lead Agency Assessor/Case Manager/Worker LTC Communication Form* and the OBRA activities completed. The document can be found on the DHS eDocs site by clicking here and searching for 5181.

- Institutional members are to be assessed annually at a minimum and with changes in condition. CC to communicate with PCP, if known, annually at a minimum.

- See the Medica Partner Nursing Home Checklist for SNBC/SNBC Enhanced (DOC) for more information.

## Medicaid Management Information System (MMIS)

Per the contract with DHS, MMIS entry is required for all SNBC and SNBC SNP members, even if the member has refused to participate in an assessment, or is unable to be located. MMIS entry is to be completed timely, completely and accurately. DHS provides Medica some reporting which identifies when entry has been missed or entered late and you will be contacted if you have a member on this list.

Timeliness of when the assessment data is gathered and when it gets entered into MMIS are very important. Per DHS-5020A *Instructions for Completing and Entering the LTCC Screening Document/Health Risk Assessments into MMIS for the Special Needs Basic Care (SNBC) Program*:

> *"Because this document plays a critical role in establishing payments for a variety of long term care services, including nursing facility services, each agency must ensure timely submission of the LTC screening document information into MMIS. It is strongly recommended that no more than fourteen (14) calendar days lapse between completion of any LTCC or case management activity and the submission of the data into MMIS"*

The document can be found on the DHS eDocs site by clicking here and searching for 5020A.

### Missing members and refusing members

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If a member has refused an assessment or is unable to be located MMIS entry is required by DHS. See the SNBC Assessment Schedule Policy and Missing Member/Refusing Member Policy on the Medica Care Coordinator site for more information related to the MMIS specifics.

**DHS resources related to SNBC and SNBC SNP and MMIS entry:**

- DHS-3428H *Minnesota Health Risk Assessment Form*
  The document is found on the DHS eDocs site by clicking here and searching for 3428H.

- DHS-5020A *Instructions for Completing and Entering the LTCC Screening Document/Health Risk Assessments into MMIS for the Special Needs Basic Care (SNBC) Program*
  The document can be found on the DHS eDocs site by clicking here and searching for 5020A.

- Pre-Admission Screening Bulletin #19-25-02R

**OBRA level 1 activity - DHS contractual requirements**

Medica Care Coordinators are to complete an OBRA level 1 form for all SNBC and SNBC SNP members during the initial assessment as well as with annual reassessments. This is a DHS contract requirement. See below for the DHS form and for information on why this is completed as well as the instructions. Given the nature of the SNBC population many members will "trigger" for an OBRA Level II to be done. The OBRA Level II is done by the County so if your member is in need of NH placement and requires a Level II you will contact the county to complete that assessment.

- DHS-3426 *OBRA Level 1 Criteria - Screening for Developmental Disabilities or Mental Illness*
  The document can be found on the DHS eDocs site by clicking here and searching for 5020A

- Enter the LTCC screening document information into MMIS for SNBC and SNBC SNP

- Pre-Admission Screening Bulletin #17-25-06

The MMIS health plan code for Medica is MED.

**Note:** If you need more information related to MMIS DHS offers MMIS entry classes. Each entity is responsible to keep up with any MMIS changes related to SNBC and SNBC SNP.

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## Care Planning

Care Planning is an essential and required task completed by the Care Coordinator with the member and/or authorized family members or alternative authorized decision makers. Information obtained during the HRA is incorporated into an Individualized Care Plan (ICP) that is individualized to the member and reflective of their health care needs, goals, wishes and values. The ICP centers on the member goals and priorities as well as input received from the member's interdisciplinary care team (ICT) with the goal to improve or maintain their health and functioning. A comprehensive care plan is written and maintained for each member except for SNBC and SNBC SNP members who live long term in a nursing home, they do not require a care plan.

- A comprehensive care plan is written and maintained for each member on SNBC and SNBC SNP that is not identified as unable to contact or a refuser; for SNBC SNP members the *Unable to Contact Refusal Care Plan* must be completed. Members who reside in long term care do not require a care plan to be written.

- Care Coordinators develop, monitor, and update the member's care plan based on the HRA, including person-centered principles and practices within thirty (30) days of HRA completion.

  Care Plans must include the following components:

  1. **Interdisciplinary/holistic focus -** The Care Plan should incorporate the primary, acute, long term care, behavioral health and social service needs of each member with coordination and communication across all Providers.

     - For all members: this includes communication with primary care, attending appointments as needed and involving family in care planning process and visits.

  2. **Preventative focus**

     - For all members: this may include immunizations, vision, hearing, and dental exams, tobacco cessation, alcohol use, fall risk, medications and nutrition.

  3. **Disease Management**- Adoption of protocols and best practices are encouraged. Care Coordinators are to provide education to members as needed. See the Health Improvement Programs section under tools and forms on the CC webpage for more information.

  4. **Back up for emergency situation-** Assist the member/responsible party in planning for emergency situations, such as sudden illness, accident, worsening of chronic conditions. This planning should also include back up plans for essential services.

  5. **Advance Directive planning** - Care coordinators should review health care directives annually and with changes in care needs. These reviews should be documented on the care plan. This includes

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documentation of refusals. All Medica SNBC and SNBC SNP members receive an Honoring Choices health directives packet in their enrollment materials. These materials are also available in several other languages from the Honoring Choices website.

6. **Annual comprehensive primary care visit** - Care planning should document efforts to ensure all members have had an annual comprehensive PCP visit.

7. Care plans must written in SMART format and include:

   - Identified goals and member specific interventions; including who is responsible for each intervention (for example: "Jane Doe will…."; "care coordinator will….")

   - Monitoring and evaluation of goal outcomes must include dates; the date to evaluate outcomes will be the date of the next follow-up contact or at a minimum be the next scheduled reassessment date.

   - Identify possible barriers, such as lack of transportation, language, cognition, and design interventions that address these barriers so goals can be achieved

   - Underlying barriers/issues can be discussed under CC recommendations

   - A schedule for a follow-up plan and communication

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# Member Transitions

Monitoring and managing transitions, whether they are planned (ex. scheduled knee surgery) or unplanned (emergency admission due to an acute episode) are an important function of the CC. Not only does CC involvement make the transitions more seamless, it also is a requirement from the Centers for Medicare and Medicaid Services (CMS).

When a member goes to the hospital or other care setting due to a change in condition, this is considered a transition. Care Coordinators should remind members to inform them of both planned and unplanned transitions. A planned transition is typically due to a surgical procedure, the member and/or authorized family members or alternative authorized decision makers is involved in the planning and timing of the admission. An unplanned admission is usually due to illness or accident.

## Transition requirements

**Within one business day of notification of admission:**

- Communicate with the receiving facility to share key elements of the care plan. This may include but is not limited to:
  - Current services
  - Informal supports
  - Advance directives
  - Medication regimen
  - CC contact information
- Communicate admission with primary care provider (PCP), if known, within one business day of notification unless PCP was the admitting physician
- Communicate with the member/responsible party to learn about any changes in health status and/or care needs. Explain the transition process and provide CC contact information for additional support.

**As needed after notification of admission:**

- Start a new note if there are additional transitions that occur before return to the usual care setting.
- Update the member's plan of care.

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**Upon discharge to the member's usual or "new" usual care setting:**

- Communicate discharge with primary care provider (PCP), if known, within one business day of notification unless PCP was the admitting physician
- Communicate with the member and/or authorized family members or alternative authorized decision makers about:
  - The care transition process
  - Changes to the member's health status
  - Plan of care updates
  - Educating member/responsible party about transitions and how to prevent unplanned transitions/readmissions. Education should include but is not limited to:
    - The importance of keeping appointments
    - Understand discharge instructions
    - Medication self-management
    - Knowledge of warning signs and response needed
    - Addressing potential barriers (adequate food, housing transportation, home safety, vulnerability concerns etc.)

## Transition care resources

- Notification of Care Transition Fax
- Transition Log

The Transition Log is only required for SNBC SNP members and does not need to be completed for SNBC members. However, care coordinators should work to support and manage members during all transitions regardless of whether the log is required. If log is not used for SNBC, it is expected that the Care Coordinator will document transition management activities.

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# Communication

## Primary Care Provider (PCP) communication

Care Coordinators must communicate with the member's primary care provider, if known, at least annually, as well as with changes of a member's condition and member transitions. Medica encourages the use of the PCP letter template. The annual communication is documented in the member's case notes.

## Communication with Waiver program worker/Targeted Case Manager

Communication between a Medica CC and a member's waiver worker or a member's targeted case manager is **essential and required**. Joint visits may be an option if it is in the best interest of the member.

Per the DHS contract CC's are to communicate with a member's waiver worker if they want to put any state plan home care or therapy services in place for the member using the DHS-5841 *Managed Care Organization, County and Tribal Agency Communication Form - Recommendation for State Plan Home Care Services*. The document can be found on the DHS eDocs site by clicking here and searching for 5841. This is to ensure that the waiver case manager accounts for these services in the member's waiver budget and on their service agreement and to ensure duplication of services is not occurring.

A listing of county contacts, as well as county managed care advocate at each county is located on the DHS website.

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# Member Transfers

When members transfer between Care Coordinators (change of care system, member relocated, etc.), the exchange of the transfer paperwork is not only a requirement, but is important to the receiving Care Coordinator. It allows them to continue the work done by the previous Care Coordinator without always requiring the member to go through the assessment and care planning process again.

With all transfer requests transfer paperwork is required to accompany the request. At a minimum this includes:

- The DHS-6037 Home and Community-Based Services Case Management Transfer Form. The document can be found on the DHS eDocs site by clicking here and searching for 6037.

- A copy of the current assessment

- A copy of the current care plan.

- A copy of the member signature page

Note: The only exceptions to this is:

- Member is an unable to reach member or has refused an assessment, the minimum amount of information we require are notes related to your attempts to reach or engage the member.

If there are additional documents you are still completing and plan to send at a later date, indicate that with the transfer request so the receiving Care Coordinator knows when to expect it. Medica enrollment confirms the transfer. The transfer documents are sent via Sharefile.

The *Transfer Responsibilities* policy is found on the Medica Care Coordinator site under *Policies and Guidelines → Policies*.

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# Disease Management/Condition Management

Medica offers a Disease Management Program for members per our contract with DHS. Care Coordinators help support members in the following ways:

- Refer the member to leading organizations materials when providing education to members such as American Cancer Society, National Alliance of Mental Illness (NAMI), etc.
- Use websites such as Medline Plus, Center for Disease Control (CDC), etc. as a reference
- Use materials on the Medica Care Coordinator site under *Tools and Forms → Gaps in Care*
- Record all disease management intervention and education on the member's case notes.

Medica has a disease management program for the following conditions:

- Asthma
- Diabetes
- Cardiac

Members with these above diagnoses are identified for the program via a predictive modeling identification process and are contacted by Medica to be part of the disease management program. Members in the program can receive resources for their condition; an online "digital coaching" program or telephonic disease management with a nurse based on their risk factors and severity of their illness.

- Care Coordinators can refer members to the Disease Management program and the Tobacco Cessation program at Medica by completing the *Complex Case Management/Health Support Referral Form* found on the Medica Care Coordinator site under *Tools and Forms*.

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# Provision of Services

Following is a non-exhaustive list of benefits covered under the SNBC and SNBC SNP product. Care Coordinators use these formal benefits when developing the plan of care for a member in addition to informal and quasi-formal services.

See the Member Handbooks on each product page for detailed information regarding benefits.

Reminder: The SNBC and SNBC SNP do not include waiver benefits, personal care attendant (PCA), home care nursing (formerly private duty nursing). SNBC SNP does include Medicare benefits. Care Coordinators are to assist members in contacting the county if determined through the assessment there is a need for waivered services.

## Medical Services

- SNBC members receive their Medical Assistance benefits through Medica.
- SNBC members who do not have Medicare or another primary insurance- providers only bill Medica.
- SNBC members who have Medicare through other primary insurance- providers will bill Medicare first; Medica will coordinate benefits (refer to coordination of benefits or COB) with Medicare.
- SNBC SNP members receive their Medical Assistance and Medicare benefits through Medica.
- The role of the CC is not to make medical decisions. The CC often times will receive requests for approval of medical services. Providers are to call Medica Provider Service for verification of benefits and to inquire whether prior authorizations through care management are required. Care systems may choose to direct members to in-network care. Refer to the *Quick Links* on the CC website and choose which product you are coordinating for and from that product page choose *find care*.
- Prior Authorizations (PA): Medica has a list of selected procedures which require a prior authorization. These claims will not pay without a referral in the system. Medical procedures on the PA list are determined by Medica Health Management. The Health Services department at Medica reviews the requests for Medical Prior Authorizations.

### Home care services - state plan services

- SNBC and SNBC SNP covers state plan homecare services including skilled nurse visits (SNV) and home health aide (HHA). **Services must be obtained through a Medica contracted provider.** All services should be coordinated with the agency.

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- If an SNBC or SNBC SNP member on a waiver is receiving any state plan home care services, the Care Coordinator is **required** to communicate this to the county waivered worker using the DHS-5841 *Managed Care Organization, County and Tribal Agency Communication Form - Recommendation for State Plan Home Care Services*. The waiver worker must account for these services in their service agreement. The document can be found on the DHS eDocs site by clicking here and searching for 5841.

- Home Health Aide services require a referral in our system.

## Hospice

Hospice care is end of life care provided by health professionals and volunteers. They give medical, physiological, and spiritual support. The goal of hospice care is the help people who are dying have peace, comfort, and dignity. Caregivers and care providers try to control pain and other symptoms so a person can remain as alert and comfortable as possible. Hospice programs also provide services to support a person's family.

### Hospice Election

If the recipient eligible for both Medicare and Medicaid and elects hospice, they must elect Medicare hospice care in addition to Medicaid hospice care. Federal guidelines prohibit recipients from choosing hospice care through one program and not the other when they are eligible for both.

Members age 21 and under can still receive treatment for their terminal condition in addition to hospice services.

For a member who has elected hospice Care Coordinators continue to stay involved, complete all care coordination processes including annual reassessments and corresponding paperwork, and communicate and collaborate with the hospice provider.

### Initiating the Hospice Benefit

Hospice Election paperwork is presented to the member and/or authorized family members or alternative authorized decision makers by the hospice agency. There is both a Medicare and Medicaid Election. The hospice agency describes the coverage benefits to the member and/or authorized family members or alternative authorized decision makers at time of signing.

- Medicare Election: Sent by agency to CMS

- Medicaid Election: Sent by agency to DHS

  **NOTE:** A member may choose to dis-enroll from hospice at any time after their election. The member may re-enroll at any time beginning with the next hospice benefit period.

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**Providers are responsible to notify Medica when a member elects Hospice.** A "hold" is put on claims in Medica's system which prevents hospice related claims from paying in error. For hospice services and services covered by Medicare Part A or B that relate to the terminal prognosis, the hospice provider will bill Medicare for these services. Medicare will pay for hospice services related to the terminal prognosis.

### Hospice Certification

The hospice program must have physician certification that the member has a terminal condition with a prognosis of six (6) months or less (assuming that the clinical disease process follows its normal course). Patients can be "recertified" if necessary. Hospice is suitable for individuals with end stage chronic conditions as well as cancer diagnoses.

### Hospice and Waiver Services

When a member does enroll in hospice it is essential for the Care Coordinator to be in communication with the waiver case manager and the hospice provider to revise the service plan as needed to prevent duplication of services.

### Location for Hospice Care

May be whatever residence the member considers to be his/her home which can include nursing care facility.

### Medicare Hospice Benefit

- All hospitalizations, home care, and respite services for the care of the person's terminal condition.
    - Any hospitalizations, services or home care related to management of conditions unrelated to the terminal disease process are covered under the "regular" Medicare benefit. These services are billed directly to Medicare.
- Medical supplies (including oxygen) and Durable Medical Equipment (DME) coverage for equipment related to management of the terminal condition: Dressings, incontinence products, nutritional supplements, hospital bed, pressure mattress, commodes, etc.
    - At the time of a member's hospice election it is important to coordinate with the hospice program about what DME and supplies they will cover and with the waiver case manager (if member on a waiver program) related to what DME is being covered under the waiver program. Then, the CC must communicate with their Referral Associate to update related authorizations in the Medica system with an end date (the member's date of hospice election) for those services that will be covered by hospice and not Medica, and coordinate with the hospice to determine who will communicate with providers.
- Medications for management of the terminal condition.

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- Coordination with the hospice program concerning which, if any, medications they will not cover and for which Medica will continue to have responsibility is necessary.

- Usual core services of hospice include: Nursing, medical social work, counseling/spiritual care. Other services include volunteers, physical therapy (PT), occupational therapy (OT), speech therapy (ST), and home health aide. SNBC members may also still be receiving personal care assistant services paid for by Fee-for-Service. Coordination with the hospice program to maximize that benefit first will be necessary.

**Care Coordinator Role in Hospice Care**

- Continue to facilitate communication with the interdisciplinary care team involved in members care. Hospice will have regular care coordination conferences. Consider asking to join for case discussion.

- Continue to communicate with the member's waiver worker if applicable.

- For further information refer to the *Hospice Benefit Guideline* on the CC website under Policies and Guidelines.

**Note:** Hospice agencies can be found through the online provider directory.

## Interpreter services

- SNBC and SNBC SNP members are eligible for sign and spoken language interpreter services that assist the member in obtaining covered medical services. The health plan is not required to provide an interpreter for activities of daily living (ADL's) in residential facilities, or that are related to waivered or non-medical services.

- Medica has contracted providers for interpreter services and the use of non- par vendors is not permitted.

- Telephonic translation services are available for CC's to use when contacting members who speak a different language. TransPerfect is the vendor resource used for telephonic translation services. **CC's can reach out to ProviderOversight@medica.com for further information.**

## Medication Therapy Management (MTM)

MTM is a service is designed to help the member get the most benefit from their medications and avoid problems, get education on prescribed medications, and often results in reduced costs for medications. The analytical, consultative, educational, and monitoring services provided by pharmacists under this benefit facilitate the achievement of positive therapeutic and economic results from medication therapy.

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- How and when to take their prescriptions and over-the-counter medicines.
- How their medicines work and what they can expect them to do.
- What they should do if they think a medicine isn't helping them, or if they are having problems with side effects.
- Help them to identify medications that are interacting in negative ways, and improve how all medications work together.
- Review any non-prescription medications or supplements to make sure they are appropriate for the member's conditions and other medication therapy.
- Identifies goals that the member has for their medications, to engage the member in their own treatments.

**For SNBC SNP member**

Medica will determine if SNBC SNP members meet the criteria for MTM. Medica will then provide information to eligible members via mail or over the phone.

**For SNBC members with Medicare:**

The MTM benefit is provided through their Medicare part D benefit. Members must receive MTM services through providers who accept the member's Medicare coverage such as their pharmacy.

**For SNBC members without Medicare:**

This benefit is provided by DHS Minnesota Health Care Programs (MHCP) credentialed providers. DHS credentialed MTM pharmacists can be found on the DHS site DHS website.

How it works for SNBC members without Medicare:

1. The member calls a participating pharmacy to make an appointment to meet with a pharmacist.
2. The member brings their Medica ID card along with all of their prescription medications, over-the-counter (OTC) medications, and herbals/supplements.
3. The pharmacist reviews the medications with the member to identify any areas of concern, duplication, and cost savings for the member.

## Mental Health/Behavioral Health and Chemical Dependency Services

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Medica uses the Medica Behavioral Health (MBH) network. Mental Health Providers should contact MBH directly for authorizations.

- MBH assigns a “care advocate” to all inpatient mental health stays. Please contact MBH to coordinate care planning efforts.
- The CC should coordinate with county mental health providers for those services provided through the county.
- MBH is also a care coordination partner with Medica for SNBC and SNBC SNP members.
- MBH is available for case consultation by completing a consultation request form which can be found on the CC website under tools and forms-other forms.

## NurseLine™ by HealthAdvocate™

Our member’s health care needs do not always follow regular business hours. NurseLine by HealthAdvocate is an easy-to-use phone service staffed by registered nurses twenty-four (24) hours per day, seven (7) days per week. NurseLine by HealthAdvocate offers valuable health information resources that can help our members get the medical care they need quickly. With one call, the nurses can instruct the members on the care of minor illnesses and injuries at home, as well as help them find a doctor near their home.

Medica 24 hour nurse line is 1-866-715-0915. Hearing impaired members, call the National Relay Service at 1-800-855-2880 and request Medica 24 hour nurse line at 1-866-715-0915. These numbers are available twenty-four (24) hours per day, seven (7) days per week.

## Nursing Facility Services

Medica is responsible for paying a total of 100 days of nursing home room and board. If the member needs continued nursing home care beyond 100 days, the Minnesota Department of Human Services (DHS) will pay directly for their care. Upon enrollment into the plan, if DHS is currently paying for the member’s care in the nursing home, DHS, not Medica, will continue to pay for the care. Facilities are responsible to contact Medica related to admissions.

**Process if a SNBC member has entered the nursing home:**

Refer to the *Partner Nursing Home Checklist for SNBC* which can be found on the Medica Care Coordinator site under *Tools and Forms → SNBC*. Medica will track the days, and will place authorizations in the system when needed.

**For nursing home inquiries contact NFCommunications@medica.com**

## Palliative Care

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Palliative care treats pain and other physical symptoms, as well as emotional and spiritual concerns. It helps patients and their families understand their illness and treatment choices, as well as address financial and community resource options.

## Pharmacy Services

Please refer to the SNBC Member Handbook for detailed pharmacy information. For SNBC members on Medicare refer to their Medicare part D provider for questions regarding coverage. SNBC includes medications covered under Medical Assistance including over-the-counter medications.

- Formularies are available on Medica.com, under each specific product page.
- If a member does not have Medicare, Medica pays for all medications and medications must be obtained at a Medica contracted pharmacy.
- Medica Customer Service can be very helpful in terms of pharmacy questions for members and/or care coordinators.
- Members can download the CVS app to help manage their medications (see Medica.com for more information).

## Transportation

If a member does not have access to their own transportation, Medica Provide-A-Ride℠ will help schedule transportation to and from health care visits. More information regarding transportation can found on the Medica Care Coordinator site under *Tools and Forms → Provide-A-Ride*.

If a member has access to a vehicle and is interested in exploring whether mileage reimbursement for use of that vehicle for medical appointments is possible, Care Coordinators are to refer members to their county of residence.

Care Coordinators can also arrange transportation through the Qryde portal. If you are interested in learning more please contact ProviderOversight@medica.com to get started. Qryde allows for CC's to set-up rides for members on their behalf in the Qryde portal.

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# Benefit Exception Inquiry (BEI) Process

The Benefit Exception Inquiry process is a way for Care Coordinators to ask Medica if a member can receive something outside of the benefit set.

- The Care Coordinator may be asked by a member to authorize benefits outside the standard benefit set. Care Coordinators make these requests using the *Benefit Exception Inquiry (BEI) form* found on the Medica Care Coordinator site under *Tools and Forms*.
    - Supportive documentation of the need must be submitted with the form.
    - BEI forms are reviewed, and the Care Coordinator is informed of the decision.
    - Depending on the determination, the referral request is entered, or the request proceeds to a Denial, Termination, or Reduction (DTR).
- When sending in multiple BEI's be sure to send them separately. This allows the operations staff to easily identify them and process them accordingly.
- Include the cost of the item that you are requesting.
- On the BEI form, there is a section for the member's PCP information, as well as service provider information. "Service Provider" is the provider of the item or service you are requesting; note whether they are in network or out of network providers with Medica.

To begin the BEI process, the CC submits the BEI form as soon as possible after the member has made the inquiry. BEI's have a fourteen (14) day turn-around time once received.

- **Approvals:** After the inquiry is reviewed and if it has been approved, a Medica staff person enters a referral and alerts the CC. The member, member's PCP as well as the provider receive a letter showing the approval.

  **Note:** it is very important that the Care Coordinator documents on the form the provider of the item/service so an accurate referral is entered.

- **Denials:** If the inquiry is denied, the Care Coordinator is informed of the decision and directed to talk with the member about the inquiry denial. If the member is satisfied with the action taken, the CC documents that contact in the member's chart. If the member is not satisfied with the denial, the CC completes the DTR form **immediately** and submits it to Medica. The date on the DTR form is the date the CC communicated the inquiry decision to the member.

If an item has been approved through BEI, and the member continues to have the need past the approval timeline it is the Care Coordinator's responsibility to submit the new/updated BEI request prior to the end of the current authorization.

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All requests for care outside of the network are submitted to Medica Utilization Management by the primary care provider (PCP) or other referring provider, not through the BEI process. Documentation from a PCP or other medical professional regarding the medical necessity to access care outside of the network is required.

## Denial/Termination/Reduction (DTR)

If a service is being denied (based on lack of need), terminated (based on member's request or other reason) or reduced (based on member's request or other reason) a Care Coordinator must complete a DTR form found on the Medica Care Coordinator site under *Tools and Forms → SNBC* and submit to Medica.

Medica will review, and assign a date which the denial, termination or reduction will be effective. The Care Coordinator will be alerted to the final decision. This process takes the CC out of the position to make the final decision, and leaves the final decision with Medica, helping the CC to maintain the positive relationship with the member. DTR's and the timelines around them are a contract requirement by DHS.

## Other Resources for Care Coordinators

**Benefit guidelines:**

Medica has created benefit guidelines to help guide Care Coordinators in service planning. These can be found on the Medica Care Coordinator site under *Policies and Guidelines → Benefit Guidelines*.

**Care Coordinator Leave-Behind Document:**

This is required to be given to the member annually. This *Medica Care Coordinator Leave-Behind Document* can be found on the Medica Care Coordinator site under *Tools and Forms → SNBC*.

**Child and teen checkup:**

SNBC members under age 21 are eligible for Child and Teen Check-ups provided by their primary care provider or pediatrician. Care Coordinators are asked to educated members/responsible parties of the importance of annual PCP visits.

**Medica AccessAbility Solution Member Page**

The member webpage is a helpful resource to see what your members can see about the benefits and services available to them under their coverage and offers easy access to many member facing materials.
www.medica.com/accessability

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**Medica Care Coordinator website:**

The Medica Care Coordinator website (medica.com/care-coordination) is the main hub where most all care coordination resources can be found.

- Letter Templates - Prepared letters to correspond with Medica members and primary care providers. These are the letters that are to be used for member correspondence as they have gone through the appropriate approval process.
- News - Care Coordination Monthly Communications are found here which provide CC's with updates on policies, process and forms etc.
- Performance Improvement, Transition Care and Gaps in Care - Care Coordinator toolkits, fliers, and other information related to current performance improvement projects as well as transitions process details.
- Policies and Guidelines - This section has current policies, procedures and guidelines that guide care coordination activities and operations.
- Tools and Forms - Commonly used tools and forms for use in day-to-day work including assessments, care plans, contact information, health improvement, program flyers, and much more.
- Training Materials - The Medica Care Coordinator Training Manuals are provided to assist you with your job duties. The training manuals describe the Care Coordinator role and responsibilities, member classifications, provision of services, and benefit guidelines. All recorded trainings can also be found under this section.

**Medica Clinical Liaison:**

Medica has a Clinical Liaison devoted to assisting our care coordinators by developing trainings, communicating updates, and offering support. You can reach out with questions via email, medicaccsupport@medica.com or by phone at 1-888-906-0971

- The Medica Clinical Liaison will facilitate trainings to Care Coordinators in a variety of areas including but not limited to:
  - New processes
  - DHS policy changes
  - Form updates
  - Use of reports
  - Working collaboratively with county/tribes
  - Use and referral process for home care and mental health services covered by Medica

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- Relevant linkages to Fee for Service (FFS)

- Medica has clinical consultation services available to identity the health care needs of the member and develop a care plan that appropriately addresses the individual's health care needs. This is met and/or coordinated through our Medica Clinical Liaisons who are available to all SNBC Care Coordinators

- The Medica Clinical Liaison will reach out to assigned care coordinators related to member inquiries, service plans, etc.

- Special training requests or training topic requests can be sent to the Clinical Liaison

## Reporting

Delegates receive several reports form Medica. Some reports require action on the part of the Care Coordinator. Delegates are asked to review the reports training/overview on the CC website which can be found under **Training Materials** – *other trainings.*

**Restricted Recipient Program:**

The Restricted Recipient Program (RRP) is for members who have been determined by Medica, or a previous health plan to have received or is still receiving prescription drugs in a quantity or manner that might be harmful to their health. SNBC members who only have Medical Assistance and not a primary insurance such as Medicare, are eligible for RRP. Members in the RRP program are restricted to using only one in-network physician to prescribe all of their medications at one in-network pharmacy. The members remain on this program for 24 months, where they will be reevaluated to determine if they are eligible to be released from the program.

Each member is in the RRP is assigned a nurse from the Medica Special Investigative Unit (SIU). The member is given the nurse's first name and contact information. The care coordinator should redirect members with questions about the RRP to their assigned SIU nurse at Medica. A care coordinator can see the member's assigned PCP and pharmacy by looking up the member in MN-ITS. If a care coordinator would like to locate a member's RRP nurse call 1-888-906-0970.

Additional information on the RRP and referrals can be found on Medica.com and the Provider Administrative Manual.

# Resources:

**Medica Care Coordinated Products Customer Service**
888-347-3630 (toll-free); TTY: 711, 8 a.m. – 6 p.m. Monday – Thursday; 9 a.m. – 6 p.m., Friday

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**Provide-A-Ride/Interpreter Services**

888-347-3630 (toll-free); TTY: 711, 8 a.m. – 5 p.m. Monday – Thursday; 9 a.m. – 5 p.m., Friday

**Medica Behavioral Health**

800-848-8327 (toll free); TTY: 711, 8 a.m. – 5 p.m., Monday – Friday

**Behavioral health crisis services 24 hours a day, seven days a week**

**Delta Dental**

*Member services*

800-459-8574 (toll-free); TTY: 711, 8 a.m. – 5 p.m., Monday – Friday

***Care Coordinators only***

866-303-8138 (toll free); TTY: 711 8 a.m. – 5 p.m., Monday – Friday

**Member Pages**

SNBC SNP: https://partner.medica.com/members/medicaid/medica-accessability-solution-enhanced

SNBC: https://partner.medica.com/members/medicaid/medica-accessability-solution

**NurseLine by Health Advocate**

866-715-0915 (toll-free); TTY: 711, **24 hours a day, seven days a week**

**Care Coordination Support (Clinical Liaison)**

888-906-0971 (toll free); TTY: 711

Email: MedicaCCsupport@medica.com

**Care Coordination website**

https://partner.medica.com/care-coordination

**Medline Plus**

https://medlineplus.gov/

**Tobacco Cessation Program**

866-905-7430 (toll-free); TTY: 711, 8 a.m. – 5 p.m., Monday – Friday

**Transplant Program**

888-906-0958 (toll free); TTY: 711, 8 a.m. – 5 p.m., Monday – Friday

Email: caresupport@medica.com

**Restricted Recipient Program**

888-906-0970 (toll-free); TTY: 711, 8 a.m. – 5 p.m., Monday – Friday

**Minnesota Department of Human Services (DHS)**

http://mn.gov/dhs/

*eDocs*

https://mn.gov/dhs/general-public/publications-forms-resources/edocs/index.jsp

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| **Disability Hub MN** |
| --- |
| 866-333-2466 (toll free); TTY; 711, 8:30 a.m. to 5 p.m. Monday – Friday<br>Email: info@disabilityhubmn.org<br>Web: https://disabilityhubmn.org/ |
| **Honoring Choices Health Care Directive**<br>Honoring Choices website |

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