MSHO/MSC+ Care Coordinator Training Manual

MSHO – Minnesota Senior Health Options /Medica DUAL Solution®
As a representative of Medica, the care coordinator (CC) manages benefits provided by state plan home care services, Medicare, and Elderly Waiver (EW) services if applicable. This places the CC in the unique position of assisting the member across all settings of care, transitions, and stages of the aging process. The CC is the member’s primary contact for accessing all benefits under MSHO.

MSC+ - Minnesota Senior Care Plus
Although MSC+ does not include Medicare benefits, the CC responsibilities are similar to MSHO. The Care Coordinator is the member’s primary contact for accessing all benefits under MSC+ which could include the Elderly Waiver benefits if applicable.

Basic job duties of a Medica MSHO/MSC+ Care Coordinator are:

1. Upon receiving the enrollment information, contact the member to introduce yourself, and answer any questions about the plan the member is in.

2. Arrange for the initial assessment and periodic reassessments as necessary.

3. Facilitate annual physician visits for primary and preventive care.

4. Care Planning based on ongoing assessment

5. Arrange and coordinate supports and services identified through the assessment and care planning process, including annual physician visits.

6. Assist the Member and their legal representatives, if any, to maximize Informed Choices of services and control over services and supports.

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

8. Coordinate with Local Agencies as necessary, including use of the Minnesota Department of Human Service (DHS) form #5181 “Case Manager/Financial Worker Communication”. Also communicate with lead agencies using “Managed Care Organization/Lead Agency Communication Form” #5841
when necessary. (These forms can be found on DHS website under the edocs link).

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

10. Communications include the transfer of a member from one Managed Care Organization (MCO) to another MCO or local agency using the DHS form 6037A.

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.

13. Performance Improvement Projects (PIPS) or Quality Improvement Projects for applicable members.

14. Assisting members in accessing resources and services beyond the Medical Assistance and Medicare Benefit sets including informal and quasi-formal supports.

15. Ensuring smooth transitions and coordination of information between acute, sub-acute, rehabilitation and nursing facilities and home and community-based settings. Complete transition log if appropriate.

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

17. Complete all necessary activities surrounding nursing home placements including but not limited to DHS-3427T-ENG LTC Screening Document per the DHS pre-admission screening process.

18. Conduct OBRA Level 1 screenings and convey any information obtained during the screening to the Local Agency and send copy to the nursing facility. The following is summarized from language found in the current DHS manual regarding the role of the MSHO/MSC+ care coordinator.

19. Partnership with Member. The MCO shall ensure that the care coordinator works in partnership with the Enrollee and/or authorized family members, responsible parties or guardians and the primary care physician (PCP), and in consultation with any specialists caring for the Enrollee. The care coordinator
shall cooperate with the Enrollee in developing, coordinating and, in some instances, providing supports and services identified in the Enrollee’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 Enrollee and/or authorized family members or guardian, and as appropriate to implement and monitor the care plan.

20. **Risk Assessment.** Care coordinators will conduct a health risk assessment (HRA) of each member’s health needs within the first thirty (30) calendar days of enrollment and within 365 days thereafter. The care coordinator is to complete a face-to-face (MSHO, MSC+ EW, MSC+ with personal care attendant (PCA) or telephonic (MSC+ non-EW without PCA) assessment with all members annually using the appropriate HRA document for all community members or Medica approved HRA for long term care (nursing home) members. The assessment addresses medical, social and environmental and mental health factors, including the physical, psychosocial, and functional needs of the Enrollee. Member’s HRA must identify **Person-Centered Principles and Practices:** Assurance that people have the opportunity for meaningful choice and self-determination, and that their civil and legal rights are affirmed and respected. LTCC assessments and reassessments are used to determine access to home and community based services and/or home care services performed as part of this assessment process.

   a. Upon completion of the assessment, the care coordinator is required to enter specified information into MMIS for all community members (except those on another waiver such as Brain Injury waiver (BI), Community Access for Disability Inclusion waiver (CADI), Developmental Disabilities (DD)).

   b. Upon implementation of MnCHOICES with Medica MSHO/MSC+ members, care coordinators will be required to use the State’s MnCHOICES tool.

21. **Nurse Line.** Medica maintains a 24-hour, seven-day-per-week nurse line members can access. Care coordinators are to be familiar with this service and be able to direct members to the nurse line phone number on their member identification (ID) cards for use by the member when needed.

22. **Rehabilitative Services.** Care coordinators will be aware of services that include procedures for promoting rehabilitation of enrollees 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.

23. **Range of Choices.** Care coordinators will work with members to ensure access to an adequate range of elderly waiver and nursing facility services and will provide appropriate choices among nursing facilities and/or elderly waiver services to meet the individual needs of enrollees who are found to require a nursing facility level of care. These procedures must include methods for supporting and coordinating services with informal support systems provided by
families, friends and other community resources. These procedures must also include strategies for identifying institutionalized enrollees whose needs could be met as well or better in non-institutional settings and methods for meeting those needs, and assisting the institutionalized enrollee in leaving the nursing facility. (For purposes of this section, the word “assisting” includes, but is not limited to, discharge planning and care management responsibilities.)

24. **Coordination with Social Service Needs.** Care coordinators are to coordinate with local agency social service staff when an Enrollee is in need of the following services:

   a. Pre-petition Screening;
   b. OBRA Level II Screening for Mental Health and Developmental Disability;
   c. Spousal Impoverishment Assessments;
   d. Adult Foster Care;
   e. Group Residential Housing Room and Board Payments;
   f. Chemical Dependency room and board services covered by the Consolidated Chemical Dependency Treatment Fund;
   g. Adult Protection.
   h. The MCO shall coordinate with local human service agencies for assessment and evaluation related to judicial proceedings.

25. **Referrals to Specialists.** Care coordinators are to assist members in locating and accessing specialists and sub-specialists including those with geriatric expertise when appropriate.

26. **Identification of Special Needs.** Care coordinators will have capacity to implement and coordinate with when indicated, other care management and risk assessment functions conducted by appropriate professionals, including Long Term Care Consultation (LTCC) and other screenings to identify special needs such as common geriatric medical conditions, functional problems, difficulty living independently, polypharmacy problems, health and long term care risks due to lack of social supports; mental and/or chemical dependency problems; mental retardation; high risk health conditions; and language or comprehension barriers. This information will be shared with the new health plan in the event that the member chooses to transfer to that health plan.

27. **Coordination with Veterans Administration.** Medica and 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.

28. **Advance Directive Planning.** The care coordinator shall inform members of resources available for advance directive planning based on individual member needs and cultural considerations.
Member Classifications

MSHO Rate Cells

MSHO members are assigned to a rate cell. This is defined as the category which determines the monthly prepaid capitation payment which is paid by the state and CMS to the health plan. The information entered in the Medicaid Management Information System (MMIS) by the CC and the county financial worker (MAXIS), determines this assignment. The principle determinants are living arrangement, Nursing Home Certifiability [DHS-7028-ENG](https://www.medica.com/providers/administrative-resources/product-information) and Elderly Waiver Status.

A change in rate cells is an automated process through the state’s data system. The new rate cell will be assigned to members if the data is entered by the care coordinator by the capitation date for the following month.

Nursing facilities need to submit DHS Form 1503 to counties to change a member’s living arrangement to “institutional”. If the nursing facility has not done this, the county financial worker may need to be contacted by the CC.

Drug co-pay is tied to living setting. Institutional members do not have drug co-pays. Until living setting is changed by the financial worker, co-pay is member liability.

MSC+ EW, Non-EW & Institutional

MSC+ members do not have “rate cell” categories as MSHO members do. MSC+ members are MSC+ community (non-EW), MSC+ EW and MSC+ institutional. MSC+ group numbers help identify whether a member is coded as “Institutional” or not. The group number, [Care Coordination Product Group Numbers for Special Needs Plans and MSC+](https://www.medica.com/providers/administrative-resources/product-information) also identifies if a MSC+ member has Medicare or does not have Medicare.

Note: If you have any providers who are wondering where they can get more information on MSHO or MSC+, there are short provider fact sheets located on Medica.com [https://www.medica.com/providers/administrative-resources/product-information](https://www.medica.com/providers/administrative-resources/product-information)

Assessment

Per contract, care coordinators will conduct an assessment of each member’s health needs within 30 calendar days of the enrollment date for MSHO and MSC+ EW and within 60 days for MSC+ Non-EW. The assessment should address medical, social, environmental and mental health factors. See the [Assessment Schedule Policy](https://www.medica.com/providers/administrative-resources/product-information) (MSHO, MSC+) and [Care Coordination Accountability](https://www.medica.com/providers/administrative-resources/product-information) (MSHO, MSC+) policy for more information.

**MSHO Rate cell A and B:** MSHO requires face to face visits annually and as
needed. Medica utilizes the LTCC or Health Risk Assessment for MSC+ and MSHO (used for members on other waivers) for assessing all community members. The data should be entered into MMIS. **Care Coordinators must enter the assessment into MMIS on or before the cut-off date.**

**MSC+ Telephonic Option:** All MSC+ EW members must be seen face to face annually and as needed. MSC+ non EW members without PCA may be assessed telephonically.

If you do complete an assessment telephonically for a MSC+ non-EW member:

- Complete DHS 3427 (LTCC short form).
- Benefits: telephonic assessments take less time to complete, no drive time, members who refuse a home visit may be more likely to agree to complete.
- A signature sheet is sent to member along with member letter and emergency plan. Include a self-addressed stamped envelope, and ask for member to return it to you. Document in your case notes that you sent this to the member and when you receive this back from member.
- If a member requests an LTCC be completed, CC must complete a face to face visit within 20 calendar days.

**Institutional:** If a member you do care coordination for is admitted to a nursing facility, and during that time is due for their annual assessment, you can complete the Institutional Assessment found on the Medica.com care coordinator site. If the member is in the process of discharging to the community, you will want to complete the LTCC assessment.

**Care Systems ONLY - Institutional:** Members are to be assessed annually at a minimum and with changes in condition. CC to communicate with PCP annually at a minimum.

The MMIS health plan code for Medica is **MED.**

**Community Non-EW Waiver:** Members on a non-EW Waiver (Community Alternatives for Disabled Individuals (CADI), Brain Injury (BI), Developmental Disability (DD) can be enrolled in both MSHO or MSC+. Care coordinators should use the [Health Risk Assessment for MSC+ and MSHO](#) (used for members on other waivers) annually and as needed. This does not get entered into MMIS. CC needs to communicate and share information including the care plan with the member’s county case manager.

Here are some key points in providing care coordination for these members:

- A CC would be able to see in MN-ITS if the MSHO member is on another waiver.
- The responsible party must be contacted and invited to be present at the assessment, if applicable. He or she can decline to be present, and that would need to be documented. The responsible party also would be the one to sign any paperwork.
If the member lives in a group home setting, the CC must communicate with and will want to meet with the group home provider.

- Same assessment timelines and care plan timelines apply.
- Same follow-up contact schedules apply.
- The waiver worker is seen as the member primary case manager as most of the member’s needs are being met by utilizing services provided under the disability waiver.
- The CC does not need to complete a LTCC as the county waiver worker is the one who enters a screening document into the Medicaid Management Information System (MMIS).
- The CC would complete the Health Risk Assessment for MSC+ and MSHO (used for members on other waivers or equivalent) annually and with significant change of condition and keep in their records.
- The CC will want to request a copy of the waiver workers care plan and refer to that when completing the MSHO/MSC+ care plan.
- The CC will complete a care plan, and can indicate on this care plan when items are being managed by the county waiver worker and refer to the waiver care plan if received. If received, include in records with care plan. CC will need to complete sections of the care plan not addressed by the waiver worker including by not limited to: advanced directives, preventative areas, PIP related areas, etc.
- The CC will continue to communicate with the waiver worker (DHS MCO/County/Tribal Agency Communication form # 5841) throughout the year when necessary, and see if the waiver worker will include them in their annual assessment of the member. The CC will also want to provide the waiver worker with a copy of the completed care plan as a way to create a collaborative, integrated care plan.
- It is recommended that the CC coordinate the Health Risk Assessment (HRA) completion along with the PCA assessment if applicable. This will keep the waiver assessment span and PCA authorization span in sync. Currently, if the PCA assessment is completed as a stand-alone assessment it must be completed by a PHN, so it is strongly encouraged that the CC completes both assessments simultaneously.

**Care Planning-**

- A comprehensive care plan will be written and maintained for each member
on MSHO and MSC+. The only members who do not require a care plan are MSHO and MSC+ members who live long term in a nursing home.

- Care Coordinators will develop, monitor, and update the member’s care plan based on the HRA and 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, mental health and social service needs of each enrollee with coordination and communication across all providers. For community members, communication with primary care (see PCP letter template), attending appointments as needed and involving family in care planning process and visits. For nursing home members this includes review of the nursing home chart, involvement in care conferences, and staff input.

2. **Preventative Focus** - for community members this may include immunizations, tobacco cessation, alcohol use, fall risk, medications and nutrition. For nursing facility members - This includes immunization status and health risks, skin integrity, nutrition and activities to improve functioning.

3. **Disease Management** - adoption of protocols and best practices are encouraged. See the Health Improvement Programs section under tools and forms on the CC webpage for more information.

4. **Back up for emergency situation** - The CC should 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 failed or refused services. This would be documented on an emergency plan.

5. **Personal Risk Management Planning** - This type of document is to be completed when a member refuses an assessment or if a member refuses a recommended service. This plan will outline the members plan since they are choosing not to follow the recommendation of the care coordinator.

6. **Advance Directive Planning** - All Medica MSHO and MSC+ members receive an advance directive document in their enrollment materials. These materials are also available in Hmong, Somali, Spanish and Russian from Medica (contact your operations associate for copies). Care coordinators should review health care directives annually and document on the care plan.
This includes documentation of refusals.

7. **Annual Comprehensive Primary Care Visit**—Care planning should document efforts to ensure all members have had an annual comprehensive PCP visit.

8. **Care plans** must include identified goals and member specific interventions. Monitoring and evaluation of goal outcomes must include dates. The date to evaluate outcomes will often be the next scheduled reassessment date, but could be the date of the next follow-up contact. 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. Completion of a schedule for a follow-up plan and communication.

**Primary Care Communication**-

Care coordinators must communicate annually and with change of condition with member’s primary care provider. Medica encourages the use of the PCP letter template. The annual communication should be documented in the care plan.

**Disease Management**-

MSHO and MSC+ care coordinators are required by the health plan/DHS contract to make available a disease management program for members.

- Refer to the Institute for Clinical Systems Improvement (ICSI) guidelines and other disease management materials.
- All disease management interventions should be recorded on the member care plan.

Medica also has a disease management program for the following specific conditions:

- Asthma
- Diabetes
- Cardiac

Members are identified for the program via predictive modeling identification process. Members can receive resources regarding 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 also refer members to the Disease Management program at Medica by completing the referral form that can be found on the CC webpage on medica.com.

**HOSPICE Benefit**-

MSHO—Once the member elects hospice those benefits are administered through traditional Medicare. Care coordinators continue to stay involved, and communicate with hospice provider.
MSC+-If the member has Medicare (not through Medica) hospice is covered through that Medicare provider. The care coordinator continues to stay involved and communicate with the hospice provider.
If the member does not have Medicare, hospice will be provided under the member’s Medical Assistant (MA) benefit and DHS gets notified by the provider.

Initiating the Benefit

Hospice Election: Signed by the member or party acting on behalf of the member. There is both a Medicare and MA election for dual eligible members. The agency describes the coverage benefits to the member at time of signing.

- Medicare Election: Sent by agency to Centers for Medicare and MA Services (CMS)
- MA Election: Sent by agency to DHS

NOTE: A member may choose to dis-enroll from hospice at any time after their election. “Regular” Medicare benefits are resumed at that time. The member may re-enroll at any time beginning with the next hospice benefit period.

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.

Hospice certification: The hospice program must have physician certification that the member has a terminal condition with a prognosis of 6 months or less (assuming that the clinical disease process follows its normal course). Patients can be “recertified” if necessary.

NOTE: Hospice is suitable for individuals with end stage chronic conditions as well as cancer diagnoses. So persons with end stage COPD, CHF, renal disease, dementia, failure-to-thrive, etc., are also eligible.

Hospice and waiver Services: Per DHS, the primary diagnosis for waiver services should be different than the hospice diagnosis. When a member does enroll in hospice it is essential to revise the service plan to prevent duplication of services.

Medicare hospice benefit periods: Two 90-day and unlimited 60-day benefit periods. The physician must certify at each benefit period that the individual continues to meet criteria for hospice and has a terminal prognosis.

Location for care: May be whatever residence the member considers to be his/her home and can include a nursing care facility.

Medicare Hospice Benefit

- All hospitalizations, home care and respite services for the care of the person’s terminal condition.
NOTE: 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.

NOTE: 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. Then, the CC must communicate with their operations 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.

NOTE: 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, occupational therapy, speech therapy, home health aide.

NOTE: There may be a place for PCA hours to support care of a member. Coordination with the hospice program to maximize that benefit first will be necessary.

**Medical Assistance Benefit**

- Hospice should bill DHS directly for expenses not covered under the Medicare hospice benefit. This may include any co-pays the hospice may charge to the member.
- If the member’s residence is a nursing care facility the hospice bills DHS directly to cover room and board.

**Care Coordinator Role**

- Access EW or MA supports as needed to supplement Medicare and MA covered hospice.
- Continue to facilitate communication. Hospice will have regular care coordination conferences. Consider asking to join for case discussion.

Note: Hospice agencies can be found on Find-A-Doctor on Medica.com under
Clinic/Other Medical Facility.

Palliative Care

- 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.

Social Service Needs-

According to the DHS contract the responsibility of the MSHO and MSC+ care coordinator is to coordinate with the local agency (county) social service staff for any if the applicable following services:

- Pre-petition screening
- OBRA level II screenings
- Spousal impoverish assessments
- GRH
- Targeted Mental Health Care Management
- Adult Protection

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

Provision of Services-

The following is a non-exhaustive list of benefits covered under the care coordination products. Care coordinators use these formal benefits when developing the plan of care for a member in addition to informal and quasi-formal services. Care coordinator should also consider in formal and quasi formal services and document on care plan.

See the Certificate of Coverage/Summary of Benefits for each specific care coordination product for more information.

Reminder: For MSHO and MSC+, the waiver is the payer of last resort, and the care coordinator is responsible for seeking out informal and quasi-formal services prior to accessing waivered services.

Medical Services-

- MSHO enrollees are entitled to all services covered under Medicare, Medical Assistance and elderly waiver (if eligible for and open to EW).

- For MSC+ members who do not have Medicare, providers will bill Medica.

- For MSC+ members who have Medicare, providers will bill Medicare first; Medica will coordinate benefits (referred to coordination of benefits) with
Medicare.

- 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. Medica Care System utilizes the Medica Choice network for specialty care, which includes over 95% of providers in our service area.

- Prior Authorizations (PA)-Medica does have 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 will be determined by Medica Health Management.

**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 can make these requests using the [Benefit Exception Inquiry (BEI)](link) form. Documentation of the need should be submitted with the form. BEI forms are reviewed, and the care coordinator will be informed of the decision. Depending on the determination, the referral request may be entered, or the request will proceed to a Denial, Termination, and Reduction (DTR) if preferred by the member.

- All requests for care outside of the network should be submitted to Health Management by the PCP or other referring physician. Documentation from a PCP or other medical professional regarding the medical necessity to access care outside of the network is required.

- When sending in BEI’s, be sure to fax them separately. This will allow the operations staff to easily identify them.

- Please 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 provider information. “Provider” would be the provider of the item or service you are requesting, and you will then note whether they are in-network or out-of-network providers with Medica.

- When submitting a BEI for an air conditioner, please be sure to have the MD form accompanied with the BEI (or a similar MD statement). Please note: Air conditioners are a covered benefit for EW members with a documented health related need, ability to care plan need, as well as room in their case mix cap.

BEI’s have a 14 day turn-around time. They must be submitted timely. Therefore, the CC
needs to submit the BEI form as soon as possible after the member has made the inquiry.

- **Approvals:** After the inquiry has been reviewed and if it has been approved, a Medica staff person will enter a referral into Medica’s system and alert the CC. The member, member’s PCP, as well as the provider will receive a letter showing the approval. Note: it is very important that the care coordinator document on the form who the provider of the item/service will be so an accurate referral can be entered.

- **Denials:** If the inquiry is denied, the CC will be informed of the decision and directed to talk with the member about the inquiry denial. If the member is satisfied with the actions that have been taken, then the CC would document that contact with the member and not proceed to DTR. If the member is not satisfied with the denial, then the care coordinator would complete the DTR form immediately, and send into Medica using the DTR fax cover sheet. The date on the DTR form would be the date the care coordinator communicated the inquiry decision to the member.

Also, if an item has been approved through a BEI, and the member continues to have the need past the approval timeline, it is the care coordinators responsibility to submit the new/updated BEI request prior to the ending of the current authorization. Ex. If nutritional supplements are approved through the BEI for 1/1/17-6/30/17, we ask that the CC submit a new BEI with updates to justify the continued use. This may mean submitting additional supporting information such as notes from the members PCP, a dietician, OT/PT evaluation, etc.

**Denial/Termination/Reductions (also known as DTR’s):**
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 and submit it to Medica.

All DTR’s must be completed within 10 days of the date of request. Medica will review, and assign a date which the DTR will be effective. The care coordinator will be alerted to the final decision. DTR’s are a contract requirement by DHS. Link to the MSHO/MSC+ care coordination tools and forms page under operations can be found here.

**24-hour nursing hotline:**
Because our member’s health care needs do not always follow regular business hours, Medica 24 hour nurse hotline is an easy-to-use phone service staffed by registered nurses 24 hours per day, seven days per week. Medica’s 24 hour nurse hotline is a valuable health information resource, 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’s 24 hour nurse hotline – 1-866-715-0915. Hearing impaired members, call the
National Relay Service at 1-800-855-2880 and request Medica 24 hour nurse hotline at 1-866-715-0915. These numbers are available 24 hours per day, seven days per week.

**Chiropractic Care**-

MSHO and MSC+ cover standard MA covered chiropractic benefits which include;
- manual manipulation of the spine for subluxation only
- X-rays when needed to get a diagnosis of subluxation of the spine.

Providers **must** be in the network.
Providers should be referred directly to provider services for all coverage and claims issues.

**Residential Services**

Residential services are a service covered under MSHO and MSC+ for members on the elderly waiver. DHS has created a Residential Services (RS) rate tool which is used to determine a monthly rate based on the member’s needs.

As a note: All RS completed rate tools must be uploaded to DHS within 30 days of their completion through the MN-ITS system. Each contracted care coordination entity is responsible to do this function. Medica will receive reports from DHS which shows the numbers of uploads for each entity. If you are having trouble with this upload process, please refer to the MMIS upload guide put out by DHS or contact the DHS helpdesk.

CC’s are strongly encouraged to stay current to all residential services related issues by attending DHS videoconferences as able. **Always use the most current tool by accessing it from the DHS website.**

**Dental Services**-

- MSHO and MSC+ follow the Medical Assistance benefit set. Medica utilizes Delta Dental network.
- If a member is requesting a dental procedure or item outside of the dental benefit set, CC’s are to refer members to Delta Dental customer service for this request.
- If the CC is unable to locate a participating dental provider Delta Dental will assist in the process. Delta has created a phone number specifically for care coordinators to use to find dental care for their members. (For care coordinator use only. Do not distribute to members! The number is 651-994-5198 or 866-303-8138)
**Elderly Waiver Services**

MSHO and MSC+ use the same list of EW services and criteria for eligibility provided by traditional EW. See the DHS Minnesota Health Care Programs (MHCP) manual for list of EW services.

See complete listing of what requires a referral on Medica.com

- Homemaker services (referral needed)
- Respite Care
  - LTC facilities are paid MA RUGs rate.
- Adult Day Care (referral needed)
- Adult Day care bath (referral needed)
- Adult Companion Services
- Extended Medical Supplies and Equipment (if billed under T2029 code, referral needed for anything $30 and greater)
- Extended Home Health Aide (referral needed)
- Extended Personal Care Services (referral needed)
  - See PCA information under referral section
- Family and Care Giver Training and Education
- Home Delivered Meals
- Residential Care Services
- Residential Services (referral needed)
- Adult Foster Care (referral needed)
- Environmental Modifications and Adaptations (referral needed)
- CDCS (referral needed)
- Transportation

**Home Care Services-All State Plan Services**

- MSHO and MSC+ include all state plan homecare services. **Services must be obtained through a Medica contracted vendor.** All services should be coordinated with the agency. You can contact customer service for the most recent list of PCA providers or view on the care coordination website.
- Home health aide, extended home health aide, home care nursing (HCN – formerly private duty nursing or PDN) and homemaker services require a referral in our system.

**Interpreter Services**

- MSHO and MSC+ members are eligible for sign and spoken language interpreter services that assist the member in obtaining covered services. The health plan is not required to provide an interpreter for activities of daily living (ADL’s) in residential facilities.
Medica has contracted providers for interpreter services and the use of non-participating vendors is not permitted.

Telephonic translation services are available for care coordinators to use when contacting members who speak a different language. TransPerfect Language Line is the vendor resource used for telephonic translation services. CC’s can obtain the access codes via the Clinical Liaisons.

**Medication Therapy Management (MTM)**

Coverage Note:
- MTM is a benefit available to MSHO members who meet specific target criteria.
- For MSC+ members WITH Medicare, this benefit is provided through their Medicare provider.
- For MSC+ members WITHOUT Medicare, this benefit is provided through their Medica plan.

Medication Therapy Management (MTM) is provided by a pharmacist. This service is designed to help the member get the most benefit from their medication and avoid problems and can often result in reduced costs for medications as well. 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.

- How and when to take their prescriptions and over-the-counter medicines
- How their medicines work
- What they should do if they think a medicine isn’t helping them.

How it works:

- The member brings their Medica ID card along with all of their medications, including OTC’s and herbals
- The pharmacist sits down with the member to review the medications to identify any areas of concern, duplication and cost savings for the member.

Eligible members will be sent an invitation letter for an MTM consult. Members may also receive an outreach call inviting them to participate in an MTM consult.

**Mental Health and Chemical Dependency Services**

- Medica utilizes 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 @1-800-848-8327 to coordinate care planning efforts.

- The care coordinator should coordinate with county mental health providers
for those services provided through the county.

**Nursing Facility Services**
- **MSHO**: Medica is responsible for paying a total of 180 days of nursing home room and board. If the member requires continued nursing home care beyond the 180 days, the Minnesota Department of Human Services (DHS) will pay directly for their care. If DHS is currently paying for the member’s care in the nursing home, DHS, not the health plan, will continue to pay for the care. No prior hospital stay is required.

- **MSC+**: Nursing Home Daily Rate – We are responsible for paying a total of 180 days of nursing home room and board. If the member needs continued nursing home care beyond the 180 days, the Minnesota Department of Human Services (DHS) will pay directly for the care. Upon enrollment, if DHS is currently paying for the member’s care in the nursing home, DHS, not the health plan, will continue to pay for the care. If CC is aware of admission they need to complete [Nursing Home Admission Form](#) (MSC+, SNBC) and forward it to the Operations Department.

**Pharmacy**

Please refer to the product specific evidence of coverage for detailed pharmacy information.

- **MSHO** includes Medicare Part D pharmacy coverage. MSHO also covers medications under Medical Assistance, such as over the counter medications with a prescription.

- **MSC+** includes medications covered under Medical Assistance including over-the-counter medications.
  - If a member does not have Medicare, Medica pays for all medications

- Formularies are available on [Medica.com](#), under each specific product page.

- 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 who have Medicare and reside in the community have co-pays for their Part D medications. For MSHO members, there are no co-pays for over the counter (OTC) medications. For MSC+ there may be a small copay for OTC’s. When the member has been changed to an institutional living setting in the county system the co-pays will stop.

  Note: members in nursing facilities for short stays will continue to have Part D co-pays.

Medication overrides: Occasionally a member requires a medication that is not
on the formulary or a dosage that is not approved. The member or their physician may contact Medica customer service to request the override or prior authorization. The pharmacy will work directly with the prescribing physician to gather needed information. Care coordinators should encourage the member and/or their physician to contact customer service for assistance with this process.

**Silver & Fit**

What is Silver & Fit?
- A health club membership at no additional cost available to all MSHO members.
- *Home Exercise Kits* are available for members who do not want to choose the gym/health club membership. Members can only be enrolled in one program at a time. Contact Silver & Fit customer service for more information (877-427-4788).
- Transportation is covered for MSHO members to get to the nearest participating gym.
- Members will receive a Silver & Fit membership card.
- The Medica.com website has copies of the Silver & Fit flyer.
- [https://www.silverandfit.com/](https://www.silverandfit.com/)

**Transportation**

If a member does not have access to a vehicle, Medica Provide-A-Ride will help schedule transportation to and from medical appointments. More information regarding transportation can be located under tools and forms - [Provide-A-Ride](#) on the CC website.

**Vision Care Services**

MSHO and MSC+: Medica follows the Medical Assistance restrictions for selection of eyeglasses. Members must be seen at contracted provider. Refer to the MSHO [Benefits and Coverage](#) for the most current MSHO evidence of coverage or the MSC+ [Benefits and Coverage](#) for the most current evidence of coverage for MSC+.

**Other**

**Benefit Guidelines:** Medica has created benefit guidelines to help guide care coordinators in service planning. These can be found [here](#).

**Impact Report:**
This report stratifies membership into four care levels: 1, 2, 3, or 4. The care levels are based off a variety of factors such as utilization, overall claims costs, number of chronic conditions, and overall risk. The purpose of this report is for care coordinators to gain a clearer clinical picture of your members and their utilization and risk factors. The report also includes a grid with recommended care coordination activities for members in each care level. This is not a change to what
you are required to do, but rather some resources and recommendations for best practices for managing at risk members in order to decrease unnecessary hospitalizations and improve their quality of care.

**Leave-Behind Care Coordinator Document:**
This is required to be left with the member annually. This document can be located here Medica Care Coordinator Leave-Behind Document under the assessment and care plan section.

**Medica Care Coordination Website:**  [https://www.medica.com/care-coordination](https://www.medica.com/care-coordination)
The website 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.
- *News* – Care Coordination Monthly Communications can be found here which provide CC’s with updates on policies, process and forms etc.
- *Performance Improvement, Transition Care & Evidenced-Based Medicine* - 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 and procedures that guide care coordination activities and operations, as well as ICSI guidelines.
- *Tools and Forms* - Commonly used tools and forms for use in your day-to-day work including assessments, care plans, key 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.

**Member Transfers:** It is very important that we provide the receiving care coordinator/care system with all of the information that will benefit them in providing care coordination for the members. Once a CC is aware of a member transfer they are to submit the DHS-6037 to Enrollment. Enrollment will confirm the transfer and then the CC can provide the additional supporting documentation to Enrollment for Enrollment to forward onto to the receiving care coordination entity. The transfer documents can be sent via SPPEnrollmentQ@medica.com or via fax 952-992-2682. See the Member Transfer Responsibilities policy for more details on this process.

**MMIS:**
MSHO, MSC+ and SNBC: MMIS must be kept current with the name of the current CC assigned to each member per DHS contract. See the Assessment Schedule Policy (MSHO, MSC+) for more information on this process.

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

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 encourage members to inform them of both planned and unplanned transitions. A planned transition is typically due to a surgical procedure, the member/responsible party is involved in the planning and timing of the admission. An unplanned admission is usually due to illness or accident.

Requirements:
- Communicate via phone or fax within one business day of admission with the receiving facility to share key elements of the care plan.
- Communicate admission phone, or fax with primary care provider (PCP) within one business day of notification unless PCP admitted the member.
- Communicate with the member/responsible party within one business day of admission (or prior to admission if a planned event) to learn about any change in health status and possible changes to the plan of care you can assist with and make sure they know who to communicate with about transitions (usually the care coordinator but may be an operational person within the care system).
- Communicate with member within one business day of notification when they move to their next care setting (home, SNF, etc.)
- Provide education and/or services, as needed, to reduce the likelihood of readmission, e.g., information about how to manage a new condition, nutritional education, medication safety, etc.

Transition Care
- Notification of Care Transition Fax
- Transition Log
- Transition Log Instructions

Note: The Transition Log is only required for MSHO members and does not need to be completed for MSC+ members. However, care coordinators should work to support and manage members during all transitions regardless of whether the log is required.
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