### PRODUCTS AFFECTED
- Medica DUAL Solution® – for Minnesota Senior Health Options (MSHO) enrollees
- Medica Choice CareSM – for Minnesota Senior Care Plus (MSC+) enrollees

### DEFINITIONS
**Care Coordinator (CC):** Individual who coordinates the provision of all Medicare and Medicaid health and long-term care services for Enrollee’s and who coordinates services to Enrollee’s among different health and social services professionals and across settings of care.

**Change of Condition:** Any change in the health of the member that triggers an increase or decrease in the need for services. Changes in activities of daily living (ADL’s), independent activities of daily living (IADL’s), or other supports may indicate the change in condition. It is up to the professional judgment of the CC to determine if a change in member condition merits a face-to-face reassessment. In addition, the Member’s condition may have changed due to a major health event, an emerging need or risk, worsening health condition, or cases where the current services do not meet the client’s needs.

**CMS:** Centers for Medicare and Medicaid Services under the U.S. Department of Health and Human Services.

**DHS:** Minnesota Department of Human Services

**Elderly Waiver Program (EW):** A Medical Assistance program that funds home and community-based services for people 65 and older who required the level of care
provided in a nursing facility, and who choose to reside in the community.

**Health Risk Assessment (HRA):** Medica requires the use of the DHS form 3428 Minnesota Long Term Care Consultation Services Assessment Form (LTCC) or DHS form 3428H LTC Screening Document (for MSC+ non-Elderly Waiver (EW) without Personal Care Assistance (PCA) or for members on another waiver), or the Medica Intuitional Assessment for members residing in a nursing facility. Medica will require use of the MnCHOICES Assessment tool using the DHS required roll out schedule. The assessment of members, pursuant to Minnesota Statutes, § 256B.0911, is for the purpose of preventing or delaying Nursing Facility placements to offer cost-effective alternatives that are appropriate for the member’s needs, and to assure appropriate admissions to a Nursing Facility. LTCC assessments shall be completed by a qualified professional, defined for the purposes of the LTCC as a social worker, public health nurse, registered nurse, physician assistant, nurse practitioner, or physician. The qualified professional shall use the form designated by the STATE to determine eligibility for Nursing Facility placement or Home & Community Based Services (HCBS).

**HRA and Assessment Tools for MSHO/MSC+**

NOTE: Medica owned tools can be found on the Medica Care Coordination website under Tools and Forms. All DHS tools please refer to the DHS Edocs site for current versions.

- DHS form 3428 Minnesota Long Term Care Consultation Services Assessment Form (LTCC) – used for all MSHO non-institutional members, MSC+ EW members, and MSC+ non- EW members with PCA services.

- DHS Form 3428H LTC Screening Document – allowed for MSC+ non-EW members without PCA services and for MSHO/MSC+ members on other waivers (used for members on Community Access for Disability (CADI), Brain Injury (BI), or Developmental Disability (DD) waivers).

- Institutional Member Assessment

- Personal Care Assistance (PCA) assessment completed when assessing for PCA services. The Supplemental Waiver PCA Assessment (DHS form 3428D) is used when completing the LTCC/HRA (DHS 3428).

- Transfer Member Health Risk Assessment - for MSHO/MSC+ members that have transferred into Medica or transferred between MSHO and MSC+ and have had an LTCC/HRA/MnCHOICES assessment within the past 365 days. Can only be used if CC is able to obtain a copy of the full assessment previously completed with the member. NOTE: NOT to be used when a member transfers to MSHO/MSC+ from SNBC.

**MMIS:** Medicaid Management Information System. A complex, highly integrated claims payment, information management and retrieval system implemented by the
State of Minnesota Department of Human Services to manage Medicaid enrollee data.

**MSHO Rate Cell A:** Community Non-Elderly Waiver Enrollees who, at capitation for MSHO, are coded in MMIS to be in a community living arrangement and are not enrolled in the Elderly Waiver for the first of the following month. These members are not ‘nursing home certifiable’ or not receiving at least one EW service.

**MSHO Rate Cell B:** Community Elderly Waiver Enrollees who, at capitation for MSHO are coded in MMIS to be in a community living arrangement and are enrolled in the Elderly Waiver for the first of the following month. These members are ‘nursing home certifiable’ and are receiving at least one EW service.

**MSHO Rate Cell D:** MSHO member who has been a resident of a nursing home for more than 30 days.

**MSHO Rate Cell E:** Community Non-Elderly Wavier Enrollees who, at capitation for MSHO are coded in MMIS to be in a community living arrangement and are not enrolled in the Elderly Waiver for the first of the following month. These members are not “nursing home certifiable or not receiving at least one EW service. These members are receiving Hospice benefits.

**MSHO Rate Cell F:** Community Elderly Waiver Enrollees who, at capitation for MSHO are coded in MMIS to be in a community living arrangement and are enrolled in the Elderly Waiver for the first of the following month. These members are “nursing home certifiable or not receiving at least one EW service. These members are receiving Hospice benefits.

**MSC+ Non-EW:** Community Non-Elderly Waiver Enrollees who, at capitation for MSC+, are coded in MMIS to be in a community living arrangement and are not enrolled in the Elderly Waiver for the first of the following month. These members are not “Nursing Home Certifiable” or not receiving at least one EW service.

**MSC+ EW:** Community Elderly Waiver Enrollees who, at capitation for MSC+ are coded in MMIS to be in a community living arrangement and are enrolled in the Elderly Waiver for the first of the following month. These members are “Nursing Home Certifiable” and are receiving at least one EW service.

**MSHO/MSC+ Institutional:** MSHO/MSC+ member who has been a resident of a nursing home for more than 30 days.

**NF Level of Care:** Standard to allow entry to nursing facilities and the home and community-based waivers for individuals demonstrating one or more of the following characteristics: a high need for assistance in four or more activities of daily living (ADL); a high need for assistance in one ADL that requires 24 hour staff availability; a
need for daily clinical monitoring; significant difficulty with cognition or behavior; qualifying nursing facility stay of 90 days; or living alone and risk factors are present.

**Screening Document Type “H”:** All HRAs for the following member types: Non-EW, Rate Cell A without PCA services, and members who have refused or are unable to be located will need to be entered in MMIS as a screening document type “H”.

**Screening Document Type “L”:** For MSHO & MSC+ members on EW or who are receiving PCA services, the assessment should continue to be entered as a screening document “L”. Assessments conducted using the LTCC assessment tool due to a member’s request and/or need to determine eligibility for services can also be entered a screening document “L” even if the member is not opened to elderly waiver. This includes case management or document changes using activity type 05 and assessment result 98.

**Transfer Member:** A member that has transferred from County Fee For Service or from another Managed Care Organization to Medica for Care Coordination; has changed from one Medica product to another (i.e.: MSC+ to MSHO or MSHO to MSC+), or has changed from one Medica Care Coordination Delegate to another.

**PURPOSE**
To ensure all Medica member assessments are completed in a timely manner using the appropriate tools in accordance with DHS, CMS, and Medica requirements.

**POLICY**
Counties, Agencies, and Care Systems that provide services for Medica members must complete assessments and reassessments with members in accordance with the DHS, CMS, and Medica requirements. Assessment and reassessment dates will be audited items as part of the care plan audit.

All members are required to have a face-to-face assessment offered to them upon enrollment with Medica, and at least annually thereafter. This includes members who have transferred to MSHO/MSC+ from SNBC. Care Coordinators (CC) are also required to complete a face to face assessment upon member request or as indicated following a change of condition. For all transfer members, please see the scenarios at the end of this policy for further guidance. Members are able to decline the face-to-face assessment HRA (note: to continue Elderly Waiver and PCA services, members must receive a face-to-face assessment by their annual assessment due date). If the face-to-face assessment is declined, telephonic assessments may be offered for MSC+ non-EW members without PCA services. See Telephonic Assessment Policy.

**MEMBERS WHO LOSE ELIGIBILITY**

For members who lose eligibility, but are due for an annual reassessment within 90 days of their MA term, per DHS and CMS guidance, CC’s are to complete the HRA by the due date. If the member is reinstated without a lapse in coverage, this HRA can then
be entered into Medicaid Management Information System (MMIS) using the appropriate activity date. If the member is not reinstated within 60 days, send the DHS 6037 to the county of responsibility for communication purposes—see DHS #6037A for more information.

If a member loses eligibility but is reinstated and there is no lapse in coverage with Medica a new HRA does not need to be completed provided the CC has maintained regular scheduled contact with the member, the HRA/Care Plan is current, and there has been no change of condition or a change in the supports identified or requested. A new HRA would need to be completed if there was a change in condition or change in the supports needed or requested during that time. Documentation in case notes should include notes on efforts made to assist member with eligibility issues.

If a member loses eligibility due to a managed care enrollment exclusion such as a “spenddown” as determined by DHS or the financial worker, the care coordinator is to complete the DHS 6037 form and send to the county of residence immediately. Information related to the reason for the loss of eligibility is found on your full enrollment report from Medica each month.

PROCEDURE:

1. The County, Agency, and Care System must contact new members via phone or approved letter within 10 business days of enrollment to inform the member of the CC and provide contact information. Best practice is to set up an initial assessment during the introductory call.

2. Initial Assessments

   a. MSHO - must be conducted within the first 30 calendar days of enrollment. If the member requests a deferment or if the visit does not take place within 30 days, the CC must document all attempts to schedule the assessment visit/HRA and document why the assessment was not completed timely. At a minimum the documentation must include at least 3 phone call attempts to reach the member and documentation that a follow-up letter in its attempt to reach the member was sent.

      i. For initial assessment, if there is no open elderly waiver span, and the CC cannot schedule an assessment, a screening document type “H” should be entered in MMIS by the last business day of enrollment month

      ii. When the CC is able to complete an assessment, MMIS should be updated.

      iii. Medica will honor any previous PCA authorizations. The CC will not complete a PCA assessment due to a transition. The CC will only complete a PCA Assessment at the time of the initial HRA if the CC is unable to obtain the most recent PCA Assessment or authorization, there is a change in condition or supports, the
member requests a new PCA Assessment, or the PCA authorization will end within 30 days of the HRA date.

b. MSC+ - must be conducted within the first 60 calendar days of enrollment. If the member requests a deferment or if the visit does not take place within 60 days, the CC must document all attempts to schedule the assessment visit/ HRA and document why the assessment was not completed timely. At a minimum the documentation must include at least 3 phone call attempts to reach the member and documentation that a follow-up letter in its attempt to reach the member was sent.
   i. For initial assessment, if there is no open elderly waiver span, and the CC cannot schedule an assessment, a screening document type “H” should be entered in MMIS by the last business day within 60 days of the enrollment month
   ii. When the CC is able to complete the assessment, MMIS should be updated.

c. Institutional-- must be conducted within the first 30 calendar days for MSHO and 60 days for MSC+ of enrollment. If the member requests a deferment or if the visit does not take place timely the CC must document all attempts to schedule the assessment visit/ HRA and document why the assessment was not completed timely. At a minimum the documentation must include at least 3 phone call attempts to reach the member and documentation that a follow-up letter in its attempt to reach the member was sent.
   i. When the CC is able to complete the assessment, the members file should be updated.

3. The CC will complete the LTCC/HRA/Transfer HRA at the first assessment for all MSHO and MSC+ members.

4. Upon completion of assessment, CC will determine appropriate Rate Cell/EW eligibility/NF level of care status based on outcome of assessment. If member is appropriate for Elderly Waiver, CC will need to complete the DHS 3428, LTCC to determine rate cell and open Elderly Waiver. Members who request PCA or Elderly Waiver services must have an LTCC completed to determine eligibility.

5. Upon completion of assessment, CC will place member in the following contact schedules. Follow up, frequency and purpose will be noted on the care plan. Frequency of contact should be based on professional judgment and member input as well as Rate Cell/EW eligibility/NF level of care status. CC should consider member’s care level on Medica’s Enhanced Care
Coordination/Impact Report when setting contact schedule. Refer to the Care Coordination Assessment and Follow up Activities Grid at the end of this policy. These are the minimum required contacts.

a. MSHO/MSC+ Community Based Members (MSC+ EW or Non EW Community Based members or MSHO Rate Cell A, B, E, F):
   i. Annual face to face visits using approved assessment tool.
   ii. MSC+ Non EW, Non PCA may complete a telephonic visit using approved HRA.
   iii. Minimum contact every 6 months (additional contacts per CC judgement)
   iv. Contacts related to member transitions

b. MSHO/MSC+ Institutional Members (MSHO Rate Cell D):
   i. Annual face to face visits using approved assessment tool
   ii. Participation in care conferences
   iii. Minimum contact every 6 months (additional contacts per CC judgement)
   iv. Contacts related to member transitions

c. MSHO/MSC+ members who have been determined eligible for another waiver (DD, BI, CADI):
   i. Annual face to face visits using approved assessment tool
   ii. Minimum contact every 6 months (additional contacts per CC judgement)
   iii. Contacts related to member transitions
   iv. Annual and PRN contact with county case manager

d. MSHO/MSC+ Institutional or Members residing in an ICF-DD:
   i. Annual face to face visits using approved assessment tool
   ii. MSC+ Non EW, Non PCA may complete a telephonic visit using approved HRA.
   iii. Minimum contact every 6 months (additional contacts per CC judgement)
   iv. Participation in care conferences
   v. Contacts related to member transitions

6. CC will document all work related to care coordination, for example, attempted member contacts, contacts with the member, family, providers, county social services, and case management systems.

7. A new assessment must take place as soon as reasonable if the member has a change of condition or change of living setting (ex. move to CL). If member has PCA services and recently had a change of condition, CC to complete PCA assessment along with DHS 3428 during face-to-face visit.
8. When a member requests an assessment this must be completed within 20 calendar days of request.

9. Annual reassessments must be completed within 365 days of previous assessment. Note: if the CC completed the initial assessment using the Transfer HRA, the 365 days should be calculated from the date on the full, completed LTCC/HRA. If the member requests a deferment or if the visit does not take place within 365 days, the CC must document all attempts to schedule the assessment / HRA and document why the assessment was not completed timely. At a minimum the documentation must include at least 3 phone call attempts to reach the member and documentation that a follow-up letter in its attempt to reach the member was sent. A screening document type "H" should be entered in MMIS within 30 days of member refusal or member unable to be located.

10. Refer to grid at the end of this policy to determine what actions are required to be completed.

**MMIS ENTRY PROCESS**

Below are the Activity types to be used for Members enrolled with a Health Plan

**Activity Type 01: Telephone Screen**
- Used for Health Risk Assessments conducted by telephone for MSC+.
- Used for nursing facility Pre-Admission Screening (PAS) process using DHS 3427T

**Activity type 02: Face to Face Assessment**
- MSHO Rate Cell A: Use for initial and reassessments. Assessment result is 35
- MSHO Rate Cell B: Use only for initial opening to EW
- MSC+ Non EW: If not using Activity Type 01, Use for initial and reassessments, assessment result is 35
- MSC+ EW: Use only for initial opening to EW

**Activity Type 05: Document Change**

To be used for:
- Updating the Care Coordinator name in MMIS:
  - for transfers from another Care System, County or Agency
  - a member that has been internally transferred from one Care Coordinator to another
  - When a member has changed from one product to another but the health plan remains the same and transfer HRA has been completed. (i.e. MSC+ to MSHO)
- Making a change to the Activity Date; use date that assessment and care plan reviewed with the member
- Activity Date can be the same as the assessment result date
- Assessment Result should be 98
- Health Plan: change to MED if needed
- Assessment team: change to 02 if needed

Note: 05 cannot be used to open a waiver span
**Activity Type 06: Reassessment**
- To be used only for MSHO Rate Cell B (EW) and MSC+ EW members to continue waiver eligibility.
- Note: Activity Type 06 is not to be used for MSHO rate cell A reassessments or for MSC+ non-EW reassessments.

**Activity Type 07: Case Management/Administrative Activity**
- For use when a member has refused the Health Risk Assessment: Assessment result is 39.
- For use when a member is unable to find or is “not located”: Assessment result is 50
- To exit EW members due to SNF admission, Death, or no longer using EW services.
- Updating MMIS for members who are already on EW but choosing to start CDCS.

**Activity Type 09: Eligibility Update**
- Only used when additional eligibility determination(s) unrelated to the assessment have not been completed by the county within the 60 day window.
- See bulletin #17-25-11
- Allows the earliest effective date of eligibility to be the date of the face-to-face assessment, if the eligibility update occurs within 90 days of the face-to-face assessment and all other eligibility requirements are met

Note: If the member has an opened elderly waiver span – Do Not enter a refusal document into MMIS as this will close the waiver.
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<tr>
<th>Scenario</th>
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<tbody>
<tr>
<td>Member Newly enrolled in Managed Care Organization (No previous Care Coordinator, No previous FFS)</td>
<td>- Complete new assessment and paperwork per CC assessment and follow-up activities grid below.</td>
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</tbody>
</table>
| Transfer from Fee-for service (FFS) - Able to obtain current assessment, member signature page, and care plan for the transferred member. | - **Review received paperwork** including, but not limited to DHS-6037-ENG Home and Community- Based Services Case Management Transfer Form, copy of current assessment (MnCHOICES assessment counts), care plan, member signature sheet, and PCA assessment, if indicated. **Note:** If you are unable to obtain the required paperwork from the previous Case Manager, member must be reassessed and all assessment paperwork will need to be completed.

- **Health Risk Assessment (HRA)** - CC will conduct initial assessment with member/responsible party within 30 days for MSHO/60 days for MSC+ of transfer/enrollment OR review previous assessment telephonically or in person with member. CC will document that review occurred on the Transfer Member HRA, including the date and if there are any updates or changes. If it is determined by the CC that a change of condition has occurred or change in living setting has occurred CC will proceed with new assessment (see change of condition or change of living setting scenario below).

- **Update MMIS** - (See above instructions) CC will document date MMIS Document Change occurred on Transfer Member HRA.

- **Care Plan** - CC will review previous care plan telephonically or in person with member. CC will document that review occurred on the Transfer Member HRA, including the date and if there are any updates or changes. CC will create a new care plan within 30 days of date of review of assessment or update health related goals section of Transfer Member HRA if there are updates needed. CC will address remaining elements on Transfer Member HRA if they are not addressed on the current Community Support Plan (CSP)/Collaborative Care Plan (CCP).
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| These elements will include at a minimum: Preventive Care & Advance Directive discussion. | - **Update Financial Worker:** CC will document date notification of change in CC occurred on Transfer Member HRA  
  - **Update Primary Care Physician:** CC will document date notification of change in CC occurred on Transfer Member HRA.  
  - **Member Signature Sheet:** must be included in the transfer paperwork received or CC should review elements with member and obtain new signature sheet.  
  - **Review received paperwork** copy of current assessment, care plan, member signature sheet, and PCA assessment if indicated.  
  - **Transfer HRA not required when internal transfer.** Review member documents and document in member case notes.  
  - **If you are unable to obtain the required paperwork from the previous Medica CC,** member must be reassessed and all assessment paperwork will need to be completed.  
  - **Send member Medica Change of CC letter OR contact member, introduce self.**  
  - **Update all necessary parties as needed** (county waiver worker, financial worker, primary care physician, etc.)  
  - **Update MMIS –** (see above instructions)  
  - **Review received paperwork** including, but not limited to [DHS-6037-ENG](#): Home and Community-Based Services Case Management Transfer Form, copy of current assessment, care plan, member signature sheet, and PCA assessment, if indicated. **Institutional members will only have of copy of the current assessment.** **Note:** If you are unable to obtain the required paperwork from the previous Medica CC, member must be reassessed and all assessment paperwork will need to be completed.  
  - **Recent Assessment (HRA)** - CC will conduct initial assessment with member/responsible party within 30 days of transfer/enrollment **OR** review |
### Scenario

- Does NOT include internal Care System/County/Agency transfers within your own agency, see Internal Agency Transfer above

### Action

- Previous assessment telephonically or in person with member. CC will document that review occurred on the Transfer Member HRA, including the date and if there are any updates or changes. If it is determined by the CC that a change of condition has occurred or change in living setting has occurred CC will proceed with new assessment (see change of condition or change of living setting scenario below).

- **Update MMIS** - (see above instructions). CC will document date MMIS. Document Change occurred on Transfer Member HRA.

- **Care Plan** - CC will review previous care plan telephonically or in person with member. CC will document that review occurred on the Transfer Member HRA, including the date and if there are any updates or changes. CC will create a new care plan within 30 days of date of review of assessment or update health related goals section of Transfer Member HRA if there are updates needed. CC will address remaining elements on Transfer Member HRA if they are not addressed on the current CSP/CPP. These elements will include at a minimum: Preventive Care & Advance Directive discussion. *NA for Institutional members.*

- **Update Financial Worker:** CC will document date notification of change in CC occurred on Transfer Member HRA.

- **Update Primary Care Physician:** CC will document date notification of change in CC occurred on Transfer Member HRA.

- **Member Signature Sheet:** must be included in the transfer paperwork received or CC should review elements with member and obtain new signature sheet. *NA for Institutional members.*

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<tr>
<td>**Transfer (FFS, External, Internal)-**No current assessment. (Member not assessed within the last 365 days)</td>
<td>Complete new assessment and paperwork per CC assessment and follow-up activities grid below.</td>
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<tr>
<td>**Transfer- (FFS, External, Internal)-**Unable to obtain assessment, member signature page or care plan for the transferred member within timeframe.</td>
<td>Complete new assessment and paperwork per CC assessment and follow-up activities grid below.</td>
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<tr>
<td>**Transfer (FFS, External, Internal)-**Inconsistent documentation:</td>
<td>Complete new assessment and paperwork per CC assessment and follow-up activities grid below</td>
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| ▪ Health Risk Assessment not aligned with member needs  
▪ Care plan findings not consistent with HRA review. |  |
| **Change in Product (even if CC did not change)**-  
▪ MSC+ to MSHO  
▪ MSHO to MSC+ | ▪ **Review paperwork** including, but not limited to [DHS-6037-ENG](#) Home and Community-Based Services Case Management Transfer Form (if member was transferred to a new CC), copy of current assessment, care plan, member signature sheet, and PCA assessment, if indicated. *Institutional members will only have of copy of the current assessment, others NA.* **Note:** If you are unable to obtain the required paperwork from the previous Medica CC, member must be reassessed and all assessment paperwork will need to be completed.  
▪ **Recent Assessment (HRA)** - CC will conduct initial assessment with member/responsible party within 30 days of transfer/enrollment OR review previous assessment telephonically or in person **with member.** CC will document that review occurred on the Transfer Member HRA, including the date and if there are any updates or changes. If it is determined by the CC that a change of condition has occurred or change in living setting has occurred CC will proceed with new assessment (see change of condition or change of living setting scenario below).  
▪ **Update MMIS** - (see above instructions). CC will document date MMIS Document Change occurred on Transfer Member Health Risk Assessment  
▪ **Care Plan**- CC will review previous care plan telephonically or in person with member. CC will document that review occurred on the Transfer Member HRA, including the date and if there are any updates or changes. CC will create a new care plan within 30 days of date of review of assessment or update health related goals section of Transfer Member HRA if there are updates needed. CC will address remaining elements on Transfer Member HRA if they are not addressed on the current CSP/CCP. These elements will include at a minimum: Preventive Care & Advance Directive discussion. **NA for Institutional members.** |
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<td><strong>Update Financial Worker:</strong> CC will document date notification of change in CC occurred on Transfer Member HRA.</td>
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<tr>
<td><strong>Update Primary Care Physician:</strong> CC will document date notification of change in CC occurred on Transfer Member HRA.</td>
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<tr>
<td><strong>Member Signature Sheet:</strong> Must be included in the transfer paperwork received or CC should review elements with members and obtain new signature sheet. <em>NA for Institutional members.</em></td>
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<tr>
<td><strong>Change in Program (even if CC did not change):</strong> SNBC to MSHO/MSC+</td>
<td><strong>Complete new assessment</strong> and paperwork per CC assessment and follow-up activities grid below.</td>
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<tr>
<td><strong>Change in Program - With PCA (even if CC did not change):</strong> SNBC to MSHO/MSC</td>
<td><strong>Review received paperwork</strong> including, but not limited to DHS-6037 Home and Community Based Services Case Management Transfer Form.</td>
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<td><strong>Complete new HRA/LTCC assessment</strong> and paperwork per CC assessment and follow-up activities grid below</td>
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<td><strong>PCA Authorization:</strong> Obtain the most recent PCA Assessment (PCA Legacy Assessment or MnCHOICES Assessment) from the PCA Provider, member or the county. Contact the PCA agency by phone or by using the Flexible Verification Form to receive the number of units remaining in the authorization using the MSHO/MSC+ enrollment date and the end date on the current authorization. If the PCA provider is an out of network provider, the CC will assist the member in transitioning to an in network provider as soon as possible. The authorization for an out of network provider cannot extend beyond 120 days.</td>
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<td><strong>PCA Assessment:</strong> The CC will <em>not</em> complete a new PCA Assessment at the time of the initial HRA. The CC will only complete a new PCA assessment at the time of this HRA if:</td>
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| o The CC is unable to obtain the most recent PCA Assessment or authorization  
  o There is a change in condition or a change in member supports  
  o Member requests a new PCA Assessment  
  o The PCA Authorization will end within 30 days of the HRA date | **Missing Member or Refusing Member** - The CC will complete the referral for PCA services through the initial authorization period. The member will require an HRA and PCA Assessment completed before the end of the authorization. If the CC is unable to complete an HRA and PCA assessment during the required time period, the member will be considered Unable to reach/Refusing and the CC will need to enter a screening document type “H” and complete a DTR for the PCA services.  
  **Waiver managed by the county**: If the member is on a waiver managed by the county (ex: CADI), the CC will obtain the most recent PCA Assessment or MnCHOICES assessment from the county waiver Case Manager and utilize the DHS 5841 to communicate the authorization.  
  **Note**: Because in most cases the HRA and PCA Assessment will not be aligned, it will require the CC to do an additional visit to complete another HRA and a PCA Assessment prior to the end of the initial PCA authorization. This will align the assessments going forward. |
<p>| Change of Condition or change in living setting | <strong>Complete new assessment and paperwork per CC assessment and follow-up activities grid below. If member has PCA and recently had a change of condition, CC to do PCA assessment during face-to-face visit.</strong> |</p>
<table>
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<tr>
<th></th>
<th>MSHO/MSC+EW</th>
<th>MSHO/MSC+ NON EW</th>
<th>MSHO/MSC+ INSTITUTIONAL</th>
<th>MSHO/MSC+ NON EW WAIVER (BI, CADI, DD)</th>
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<tbody>
<tr>
<td><strong>ASSESSMENT &amp; MMIS ENTRY</strong></td>
<td>Initial, including OBRA Level 1, within 30 days of enrollment</td>
<td>MSHO: Initial, including OBRA Level 1, within 30 days of enrollment</td>
<td>MSHO/MSC+: Institutional Assessment within 30 days of admission</td>
<td>MSHO: Initial, including OBRA Level 1, within 30 days of enrollment</td>
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<td>MSC+: Initial, including OBRA Level 1 within 60 days of enrollment</td>
<td>For both MSHO/MSC+: Institutional Assessment Annually (every 365 days)</td>
<td>MSC+: Initial, including OBRA Level 1 within 60 days of enrollment</td>
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<td></td>
<td>For both MSHO/MSC+: LTCC/HRA Annually (every 365 days)</td>
<td>For both MSHO/MSC+: Institutional Assessment Annually (every 365 days)</td>
<td>For both MSHO/MSC+: HRA Annually (every 365 days)</td>
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<td></td>
<td>For LTCC’s completed: Screening document type “L” in MMIS by last business day of the month</td>
<td>For LTCC’s completed: Screening document type “L” in MMIS by last business day of the month</td>
<td>Enter in MMIS using screening document type “H” by last business day of the month or within 30 days of determination of refusal/unable to reach</td>
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<td>For HRA’s completed: Screening document type “H” in MMIS by last business day of month or within 30 days of determination of refusal/unable to reach</td>
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<tr>
<td><strong>CARE PLAN</strong></td>
<td>Collaborative Care Plan within 30 days of assessment</td>
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<td>Review institutional care plan and document review</td>
<td>Collaborative Care Plan within 30 days of assessment</td>
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<td>Member Signature Sheet</td>
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<tr>
<td>MEMBER DOCUMENTS MADE AVAILABLE AFTER ASSESSMENT</td>
<td>MSHO/MSC+EW</td>
<td>MSHO/MSC+ NON EW</td>
<td>MSHO/MSC+ INSTITUTIONAL</td>
<td>MSHO/MSC+ NON EW WAIVER (BI, CADI, DD)</td>
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<tr>
<td>• Entire Care Plan</td>
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<td>• Nursing Facility Chart Coverage Guide provided to Nursing Facility for member chart</td>
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</tr>
<tr>
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<td>• Medica Leave Behind Document • Medica Post Visit Member Letter</td>
<td>• Annual face-to-face assessment within 365 days of previous assessment • MSC+ Members who are non EW, Non PCA may have their assessment completed telephonically. Note: All MSHO members require face to face HRA’s. • Annual contact with PCP • Contact every 6 mo minimum or PRN; or as indicated from ECC/Impact Report • Follow-up with each notice of transition</td>
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**FOLLOW-UP**

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**CROSS REFERENCES**
DHS Contract for MSHO/MSC+