PRODUCTS AFFECTED
Medica AccessAbility Solution® – for Special Needs Basic Care (SNBC) enrollees
Medica AccessAbility Solution® Enhanced - for Special Needs Basic Care (SNBC) enrollees who are dually eligible

DEFINITIONS
Care Coordinator (CC): Individual who coordinates the provision of 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

Health Risk Assessment (HRA): Medica requires the use of the DHS form 3428H for all SNBC members.

HRA Assessment Tool for SNBC
One assessment tool is used for all new SNBC members regardless of waiver status or living setting. This is the DHS 3428H. For all DHS tools, please refer to
the DHS Edocs site for current versions.

- DHS Form 3428H LTC Screening Document
- Transfer Member Health Risk Assessment (HRA)-for members who go from Medica’s AccessAbility Solution plan to Medica AccessAbility Solution Enhanced plan. This can also be used for members who go from Medica’s AccessAbility Solution Enhanced plan to Medica’s AccessAbility Solution plan. In order to complete a Transfer HRA the previous HRA must have been completed in the past 365 days and the care coordinator has a copy of that previously completed HRA and care plan. NOTE: NOT to be used when a member is a new Member to Medica

**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.

**SNBC Community:** SNBC member who is residing in a community living arrangement or may be experiencing a short term rehabilitation stay.

**SNBC Institutional:** SNBC member who is permanently residing in a skilled nursing facility

**Screening Document Type “H”:** This should be used for all SNBC members regardless of waiver status or living setting. This also includes members who have refused an HRA or are unable to be located as well as members residing in an institution.

**Transfer Member:** A member that has transferred from another Managed Care Organization to Medica for Care Coordination; has changed from one Medica product to another (i.e.: SNBC to SNBC Enhanced or SNBC Enhanced to SNBC) or has changed from one Medica Care Coordination Delegate to another.

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

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

**HRA/ASSESSMENT REQUIRED**
All members are required to have an assessment offered to them upon enrollment with Medica, and at least annually (365 calendar days) thereafter. Members who are not currently on a waiver program are required to have a face to face assessment offered annually and with reassessment. If this face to face assessment offered to them is declined, a telephonic assessment is to be offered. See Telephonic Assessment Policy.

**Members with loss of eligibility**
For members who lose eligibility, but are 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 identified or requested during that time. Documentation in case notes should include notes on efforts made to assist member with eligibility issues.

**PROCEDURE:**
1. The County, Agency, and Care System must contact new members via phone or approved letter within 10 calendar 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. The initial assessment for SNBC must be conducted within the first 30 calendar days of enrollment. If the member requests a deferment or if the assessment does not take place within 30 days, the CC must document all attempts to schedule the 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. If the CC cannot schedule an assessment, a refusal assessment/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.

3. The CC will complete the HRA for all SNBC members new to Medica.

4. For members who are going from Medica’s AccessAbility Solution product to AccessAbility Solution Enhanced product, a care coordinator may complete a Transfer HRA if they choose.

5. The CC will complete MMIS entry following all HRA’s and Transfer HRA’s

6. Upon completion of assessment, CC will set up a follow-up contact schedule with the member. Follow up frequency will be noted on the plan of care. Frequency
of contact should be based on professional judgment and member input. 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.

i. SNBC (AccessAbility Solution and AccessAbility Solution Enhanced)
   1. Annual HRA using 3428H
   2. Minimum contact every 6 months (additional contacts per CC judgement)
   3. Contacts related to member transitions

ii. SNBC Institutional
   1. Annual face to face using 3428H
   2. Participation in care conferences
   3. Minimum contact every 6 months (additional contacts per CC judgement)
   4. Contact related to member transitions

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

8. A new assessment must take place as soon as reasonable if the member has a change of condition or a change in the supports needed or requested such as a change of living setting

9. When a change occurs or a member requests an assessment this must be completed within 20 calendar days of request.

10. 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 assessment does not take place within 365 days, the CC must document all attempts to schedule the HRA and document why the assessment was not completed timely. A screening document type “H” should be entered in MMIS within 30 days of completion.

11. Refer to grid below to determine actions, required to be completed.
<table>
<thead>
<tr>
<th>Scenario</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Newly enrolled in Medica’s AccessAbility Solution or AccessAbility Solution Enhanced products</td>
<td>▪ Complete new assessment and paperwork per care coordinator assessment and follow-up activities grid below</td>
</tr>
</tbody>
</table>
| Internal Transfer- New Care Coordinator assigned within your Care System, County, or Agency | ▪ **Review received paperwork** copy of current assessment, care plan, member signature sheet, document your review of member's file in case notes. *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.*  
▪ Send member Medica Change of CC letter OR contact member, introduce self.  
▪ Update all necessary parties as needed (county waiver worker, financial worker, etc.)  
▪ Update MMIS                                                                 |
| Transfer (External, Internal)-No current assessment. (Member not assessed within the last 365 days) | ▪ Complete new assessment and paperwork per care coordinator assessment and follow-up activities grid below                              |
| Transfer (External, Internal)-Inconsistent documentation upon review Care plan findings not consistent with HRA review. | ▪ Complete new assessment and paperwork per care coordinator assessment and follow-up activities grid below                              |
| Change of Condition or change in living setting                         | ▪ Complete new assessment and paperwork per care coordinator assessment and follow-up activities grid below                              |
### External Transfer: SNBC Member Transfer with current assessment
- Medica Care System/County/Agency to another Medica Care System/County/Agency
- Note: Does NOT include internal Care System/County/Agency transfers within your own agency, see Internal Agency Transfer above

- **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. **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.**

- **Health Risk Assessment (HRA)** - CC will conduct initial assessment with member/responsible party within 30 days of transfer/enrollment OR review previous assessment telephonically 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).

- **Care Plan** - CC will review previous care plan telephonically with member. CC will document that review occurred on the Transfer 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 if there are updates needed. **NA for Institutional members.**

- **Update Financial Worker, Primary Care Physician, Waiver Worker** - 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.**

- **Update MMIS**
<table>
<thead>
<tr>
<th><strong>Transfer (External, Internal)</strong></th>
<th>Unable to obtain assessment, member signature page or care plan for the transferred member within timeframe.</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Complete new assessment and paperwork per care coordinator assessment and follow-up activities grid below</td>
<td></td>
</tr>
</tbody>
</table>
### Care Coordinator Assessment and Follow up Activities-SNBC

<table>
<thead>
<tr>
<th>SNBC (all except for institutional members)</th>
<th>Institutional</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSESSMENT &amp; MMIS Entry</strong></td>
<td></td>
</tr>
<tr>
<td>• DHS 3428H HRA including OBRA Level 1 within 30 days of enrollment</td>
<td>• DHS 3428 HRA within 30 days of enrollment</td>
</tr>
<tr>
<td>• HRA annually, within 365 days</td>
<td>• HRA annually, within 365 days</td>
</tr>
<tr>
<td>• Screening document type “H” in MMIS by last business day of enrollment month or within 30 days of completion of HRA or determination of refusal of assessment</td>
<td>• Screening document type “H” in MMIS by last business day of enrollment month or within 30 days of completion of HRA</td>
</tr>
</tbody>
</table>

| **CARE PLAN** | |
|---------------||
| • Medica AccessAbility Solution (SNBC)/AccessAbility Solution Enhanced Care Plan or other Medica approved care plan to be completed within 30 days of assessment | • Review of institutional care plan and documentation of recommendations provided on member’s assessment. |
| • Member Signature Sheet | |

<table>
<thead>
<tr>
<th><strong>MEMBER DOCUMENTS MADE AVAILABLE AFTER ASSESSMENT</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Care Plan</td>
<td>• Nursing Facility Chart Coverage Guide provided to Nursing Facility for member chart</td>
</tr>
<tr>
<td>• Emergency plan</td>
<td></td>
</tr>
<tr>
<td>• Medica Leave Behind Document</td>
<td></td>
</tr>
<tr>
<td>• Medica Post Visit Member Letter</td>
<td></td>
</tr>
</tbody>
</table>

| **FOLLOW-UP** | |
|---------------||
| • Annual assessment within 365 days of previous assessment | • Annual face-to-face assessment within 365 days of previous assessment |
| • Annual contact with PCP                                | • Contact every 6 mo. minimum or PRN; or as indicated from ECC/Impact Report |
| • Contact every 6 mo. minimum or PRN; or as indicated from ECC/Impact Report | • Follow-up with each notice of transition |
| • Follow-up with each notice of transition               | • If applicable: Transfer to Medica Care System after 100 days in NF |
MMIS ENTRY PROCESS

Below are the Activity types to be used for SNBC members

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

Activity type 02: Face to Face Assessment
- Use for initial and reassessments, assessment results is 35.
- For members residing in a nursing home,
  - Current Living Arrangement is 04 – living in a congregate setting
  - Current Housing Type is 02 – institution ICF/DD, or 11 Institution NF/certified boarding care
- 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; or
    - a member that has been internally transferred from one Care Coordinator to another
    - a member has changed from Medica’s AccessAbility Solution to Medica’s AccessAbility Solution Enhanced product and the transfer HRA has been completed.
  - 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 is 98
  - Health Plan: change to MED if needed

Activity Type 06: Reassessment
- Does not apply to SNBC, do not use. See Activity types 01, 02 or 07.

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

CROSS REFERENCES
DHS contract for SNBC
Medica.com Care Coordination site
DHS Bulletin #17-25-08
DHS edoc 5020A