PRODUCTS AFFECTED

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

DEFINITIONS:

**Barrier**: Any issue that may be an obstacle to the member receiving or participating in a care management plan or self-management plan.

**Care Coordinator/Case Manager Qualifications**: MSHO/MSC+: Care Coordination must be provided by an individual that is a Registered Nurse, a Licensed Social Worker, County Social Worker evaluated under the Minnesota Merit System, Physician Assistant, Nurse Practitioner or Physician.

**Care Coordination for MSHO MSC+ Enrollees**: The assessment, care planning, providing support, and coordination of needed services between members, involved health professionals, and care settings

**Care Management for all Enrollees** means the overall method of providing on-going health care in which Medica manages the provision of primary health care services with additional appropriate services provided to an Enrollee.

**Care Plan**: Medica does not require the use of a specific Care Plan. Medica strongly encourages use of the Collaborative Care Plan. However, any Care Plan that meets the DHS EW and or Non-EW Audit Protocol requirements and all of the elements of the Community Support Plan (CSP) DHS e-doc form #2925 may be used. Delegates must obtain prior approval from Medica to utilize an alternative Care Plan form.

**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), Instrumental Activities of Daily Living (IADL’s), or other supports may indicate the change in condition. 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.

**Essential Services:** Services that must remain uninterrupted to ensure the life, health, and/or safety of the enrollee

**Legal Guardian:** Authority to make decisions on behalf of the person, limited by court-issued documents which state the roles and responsibilities of the guardian. Whenever possible the guardian should support the choices of the person. Unless specifically stated in the guardianship documents, the person retains decision making authority.

**LTCC – Department of Human Services (DHS) Form 3428 Long-term Care Consultation Services (LTCC).** The LTCC is an evidence-based Health Risk Assessment (HRA) tool which meets DHS and CMS requirements. This form can be used for the Initial Health Risk Assessment (HRA). Use of other forms must be approved by Medica.

**Personal Health Information (PHI):** Information that directly identifies an individual or from which there is reasonable basis to believe an individual could be identified. PHI relates to either past, present or future physical or mental health condition of the individual; or (1) the treatment provision, coordination, or management of health care to the individual; or (2) the payment the provision, coordination, or management of health care to the individual; or (3) is obtained through an insurance transaction that permits judgments to be made about an individual’s character, habits, finances, credit, health or any other personal characteristics. PHI includes oral information and information records in any form or medium. PHI does not include data that is de-identified or aggregated information.

**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. This includes: (1) Treating each person with dignity, respect, and trust; (2) Building on his or her strengths and talents; (3) Helping him or her connect with his or her community and developing relationships; (4) Listening to and acting on his or her communication to you; (5) Making a sincere effort overall to understand him or her as a unique person realizing that quality of life is different for each individual; (6) Understanding and demonstrating how to balance preferences and health and safety; (7) Honoring the person’s ability to express choice and preferences; (8) Promoting and establishing a shared vision between the person and his or her team.

**Person-Centered Service Plan:** The services and supports that are important to the individual to meet the needs identified through an assessment of functional need as well as what is important to the individual with regard to preferences for the delivery of such services and supports.

**Self-Management Interventions:** Interventions that are carried out by the enrollee to take responsibility for all or part of their medical and/or social needs.

**PURPOSE:**
To clarify the role of Care Coordination/Care Management services that are designed to ensure access and integrate the delivery of all Medicare and Medicaid preventive, primary, acute, post-acute, rehabilitation, and long term care services, including State Plan Home Care Services, and Elderly Waiver (EW) services to MSHO/MSC+ Enrollees. Care Coordinators serve as member advocates; they are instrumental in identification and coordination of person centered principles and practices to ensure members needs are met in a culturally appropriate and equitable manner, promote appropriate utilization and self-management and keep members in the least segregated settings.

POLICY:
Every Medica MSHO/MSC+ member is assigned a Care Coordinator (CC). Medica will assign a CC based on the members identified Primary Care Provider (PCP). CC’s will perform the duties of Care Coordination and care management as described in DHS and Centers for Medicare & Medicaid Services (CMS) contracts as well as performs other duties assigned by Medica. The Care Coordinator serves as the primary contact for member needs.

PROCEDURE:
1. Care Coordinators (CC) will perform the duties of CC’s listed in the DHS contract, CMS contract, and Medica policies & procedures.

2. CC’s will be informed of basic member protection requirements, including data privacy.

3. CC’s will provide the name and telephone number of the CC to the member within ten (10) days of new assignment or change of CC.

4. CC’s will conduct the initial HRA, using the LTCC, 3428H, or other Medica approved HRA tool within thirty (30) days of enrollment for MSHO members and MSC+ EW members and within sixty (60) days of enrollment for MSC+ Non-EW members. (See Assessment Schedule Policy (MSHO/MSC+) and Telephonic Assessment Policy (MSC+) to determine if face to face or telephonic assessment is required)
   a. Members have a right to make choices about assessments, contacts, and transition planning. If the member declines services, CC’s should reach out annually and upon notification of high risk via the Enhanced Care Coordination/Impact Report or hospitalization to readdress if the member wants care coordination services. Best practice is to reach out quarterly as appropriate to engage member in Care Coordination services.
   b. If the member is unable to be reached or refuses assessment and/or Care Coordination, documentation of attempted contact is required in the member notes (See Unable to reach/refusing Member Policy). Note: Members receiving Elderly Waiver (EW) services must receive a face to face assessment annually in order to maintain eligibility for waiver services.
c. Use of alternate assessments and alternate forms of assessment contact type must be approved by Medica. Medica will accept tribal assessments by Tribal Assessors.

5. CC’s will conduct periodic reassessments, at least annually, within three hundred and sixty five (365) days of the previous assessment, and as necessary with change in member condition.

6. CC’s will enter the required information collected through the health risk assessment into Medicaid Management Information System (MMIS), for all members excluding institutional members.

7. CC’s will facilitate Advance Directive discussions annually with the member and/or authorized family members or legal guardians, if culturally appropriate.

8. CC’s 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.

   a. The Care Plan will include risks and needs identified through the HRA prioritizing members, authorized family members, legal guardians, and caregiver’s, goals, preferences, desired level of involvement, and self-management plans.
   b. The Care Plan will incorporate the individual member’s unique strengths, assets, interests, wishes, expectations, hopes, strengths, resources, cultures, goals, and need for support.
   c. The Care Plan will identify person-centered goals, target dates, supports needed, notes monitoring progress/goal revision, and outcome or goal achievement dates.
   d. In addition to the prioritized goals listed above, those risk findings related to member identified safety should be among the highest priority.
   e. Members have a right to decline goals. When a member declines a goal, if safety is involved a Risk Plan needs to be completed.
   f. CC should discuss member’s safety concerns with each member and, if applicable document member’s risk plan on their care plan.
   g. Only person-centered prioritized goals belong on the Care Plan. Documentation on the HRA or in the member’s notes should indicate why an identified goal is not included on the member’s care plan.
   h. The Care Plan should attempt to increase quality of life, not simply maintain it. CC’s will evaluate, identify, & coordinate available medical and non-medical supports and services identified in the HRA.
   i. The Care Plan should incorporate unique primary care, acute care, long-term care, mental health, and social service needs that the member identifies.
   j. The Care Plan should incorporate covered Medicare services, Medicaid services, and services available through the formal, informal, and quasi
formal Health and Home Based Community Services (HCBS) as identified on the HRA.

k. Analysis and discussion with the member and/or authorized family members, legal guardians, or other people of members choosing will occur prior to finalizing the Care Plan. The member must approve the plan.

l. The member maintains control of the Care Plan and information included. The member drives the planning process and formulating the plan, to the level he or she chooses. The member determines how Care Plan information is shared, who will receive it, and which sections of the Care Plan will be shared. The CC supports the person, as necessary. At a minimum, for members receiving EW services (excluding Specialized Supplies & Equipment & Personal Emergency Response System), CC’s must attempt to obtain agreement from providers of the EW services and supports in the Care Plan and their agreement to deliver them as outlined. This must be updated with changes to the Care Plan that affect how EW services are provided. Changes may include:
   i. Change in hours/units
   ii. Change in provider
   iii. Addition of new provider

m. The member can request a change in the Care Plan at any time. Plans should be revised to address changes in the member’s life and changes in the member’s choices re: services, supports, and providers. Any changes in services and supports require CC to send a copy of the revised care plan to the member.

9. CC’s will assist the member and/or authorized family members or legal guardians to maximize informed choices of services and control over services and supports based on information and experience, unrestricted by current resources or services.

10. CC’s will schedule follow-up contacts and communication with the member and/or authorized family members or legal guardians based on member request, identified risk, needs, and fragility.

11. CC’s will monitor the progress toward achieving the member’s and/or authorized family members or legal guardians prioritized goal outcomes in order to evaluate and adjust the timeliness and adequacy of services in the Care Plan.

   a. If Self-Management interventions are in place, the CC will clarify with the member and/or authorized family members or legal guardians that the interventions are acceptable and doable.
   
   b. Underlying barriers to meeting outcomes and complying with the plan will be identified. Revision and enhancement of the Care Plan may be completed through written or verbal communication with the member and/or authorized family members or legal guardians.
c. Assessment of member’s Care Plan outcome goal achievement progress may be completed during telephonic follow-up, during home visits, during change in member condition.

d. Documentation of the goal outcomes will be completed at a minimum annually. It should include the date the goal has been achieved or revised and if it will be carried forward to the updated Care Plan.

12. CC’s must verify the member has been offered a choice of supports and services, also that the member agrees with the Care Plan, and agrees with services and providers authorized by the CC. Verify that services are being provided in accordance with the member’s wishes, and that services are provided in a culturally appropriate and equitable manner. Follow up on any concerns with provider and notify Medica Clinical Liaison of any provider concerns.

13. CC’s will educate the member and/or authorized family members or legal guardians about good health practices, the importance of wellness and preventative health care, ways to avoid emergency room use, and ways to prevent hospital admissions/readmissions. CC’s will promote self-management activities, when applicable.

14. CC’s will facilitate annual physician visits for primary and preventive care. CC’s may assist the member and/or authorized family members or legal guardians in scheduling annual visits.

15. CC’s will collaborate with the Interdisciplinary Care Team (ICT) based on members assessed physical, emotional, and service needs. ICT team members will be listed in the member’s chart.

16. CC’s will collaborate with Local Agency case managers, financial workers and other staff, as necessary, including use of the DHS form "Case Managers/Financial Worker Communication," Form # 5181 as provided by the State.

17. CC’s will collaborate with lead agencies, waiver workers, or county case managers on the authorization of medical assistance home care services to prevent duplication of services and to coordinate services in the most seamless way possible for the member using the DHS form “Managed Care Organization/Lead Agency Communication Form - Recommendation for Authorization of MA Home Care Services State Plan Home Care Services, DHS-5841 as provided by the State. It is expected that a response will occur within 10 (ten) business days of submission for this form. This response time is required by both the CC’s and with lead agencies, waiver workers, or county case managers.

18. CC’s will collaborate and communicate with providers and members anytime there is a change in services and supports to ensure that that everyone included in the Care Plan is aware of the members plan and their roles in supporting the person’s goals and preferences.
19. CC’s will collaborate with other providers for members identified as having special needs requiring additional intensive Case Management. Care Coordinators will collaborate with other Care Management and risk assessment functions conducted by appropriate professionals, including Long Term Care Consultation and other screenings to identify special needs. Medica CC’s will share with other providers the results of its identification and assessment of that member’s needs to prevent duplication of those activities.

20. Medica has been advised by DHS that CC’s and waiver workers are permitted to share enrollee information without a release of information. Medica expects that information will be the minimum amount necessary to perform the required activity.

21. CC’s will include cover sheets, not including Protected Health Information (PHI) that incorporates a confidentiality statement for all fax transmissions.

22. CC’s will utilize secure email for all email communications containing PHI.

23. CC’s will collaborate with Residential Services Living Providers when indicated.

24. Intensive Case Management may be provided within the Care System or County or externally by another provider.

   a. Case Management for serious and persistent mental illness
   b. Case Management for pre-petition screening
   c. Court ordered treatment, developmental disabilities, assessment of medical barriers to employment.
   d. A State medical review team or social security disability determination
   e. Services offered through social service staff or county attorney staff for enrollees who are visits or perpetrators in criminal cases.

25. CC’s will collaborate with social service staff and other community resources such as Area Agencies on Aging (AAA). Coordination with Local Agency social service staff is required when a member 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
   g. Chemical Dependency Treatment Fund; or
   h. Adult Protection.
   i. The Managed Care Organization (MCO) shall coordinate with Local Human Service Agencies for assessment and evaluation related to judicial proceedings.
26. CC’s will collaborate with services and supports provided by the Veterans Administration (VA) for Enrollees eligible for VA services.

27. CC’s will make referrals to specialists and sub-specialists including those with geriatric expertise when appropriate.

28. CC’s will inform, educate, and assist the member and/or authorized family members or guardians with health plan related issues & accessing needed resources and services beyond the limitations of the Medicaid and Medicare benefit sets; including identifying available benefits, services, providers, resolving claims or cost sharing inquiries, rights to pursue grievances and appeals under the Medicaid program or Medicare program.

29. CC’s will provide information regarding services including procedures for promoting rehabilitation of members following acute events, and for ensuring smooth transitions and coordination of information between acute, sub-acute, rehabilitation, Nursing Facilities, and Home and Community Based Services (HCBS) settings.

30. CC’s will provide access to an adequate range of Elderly Waiver and Nursing Facility Services and for providing appropriate choices among Nursing Facilities and/or Elderly Waiver services to meet the individual needs of members who are found to require a Nursing Facility Level of Care. These 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 members whose needs could be met as well or better in non-Institutional settings and methods for meeting those needs, and assisting the Institutionalized members in leaving the Nursing Facility.

31. CC’s will collaborate with the Senior Linkage Line and other social service staff to ensure that the Pre Admission Screening (PAS) process is completed.

32. CC’s will ensure that planned and unplanned transitions between settings of care are well managed and smooth with a consistent person supporting the member and/or authorized family members or guardians.

33. CC’s will participate in Performance Improvement Projects (PIP) and Quality Improvement Projects (QIP) as requested by Medica.

34. CC’s will assist and support members during transition periods between programs, care systems, agencies, counties, and health plans to ensure that timely, effective, and efficient communication occurs in order to maintain continuity of services and avoid unnecessary disruption that may negatively impact the member. CC’s should use the DHS form “HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form”. DHS 6037 as provided and directed by the State.
35. CC’s will ensure that members are living in the most integrated setting that is the preferred option, unless the person is opposed to moving. (See DHS Person-Centered, Informed Choice, and Transition Protocol and My Move Plan Summary DHS 3936). My Move Plan is required to be completed when an EW member is moving from his or her home.
   a. All moves for EW members (whether short term changes or long term changes) need to be monitored to determine if a new My Move Plan or changes in the My Move Plan are warranted.
   b. For emergency transitions where there isn’t time for planning, the CC must go back to the My Move Plan once the crisis stabilizes and ensure that the My Move Plan created for the member supports his or her individual goals and quality of life.
   c. Documentation should include coordination between those doing the planning and those providing supports and services to ensure that the My Move Plan and Care Plan results is person-centered services.

A member that knows what they want and has the skills to put it together with minimal planning has the right to opt out of extensive planning and follow-up.

36. Annually, CC’s will share the process for filing a grievance, reporting dissatisfaction with services received from their CC, or how members can request a different CC.

37. In the event of large transfers of new enrollees into Medica with the same enrollment date, and if Medica determines that meeting the DHS timelines indicated in this section cannot be met, Medica may submit a transition plan to DHS indicating the timeline in which they expect to be able to conduct the initial assessment. Medica will notify the Care Systems, Agencies, and Counties affected if an extension has been granted by DHS.

Cross References:
DHS Person-Centered, Informed Choice, and Transition Protocol and My Move Plan Summary DHS 3936
MSHO/MSC+ DHS Contract
Medica Assessment Schedule Policy (MSHO MSC+)
Medica Telephonic Assessment Policy (SNBC MSC+)
Medica Interdisciplinary Care Team Policy
Medica Member Transfer Responsibilities Policy
Medica Unable to Reach/Refusing Members Policy
Medica Transitions of Care Policy
DUAL Solution Model of Care

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