PRODUCTS AFFECTED
Medica AccessAbility Solution® - for Special Needs Basic Care (SNBC) enrollees

DEFINITIONS:
Care Coordinator Qualifications:
SNBC Care Coordination (Same role referred to in the Department of Human Services (DHS) Contract as Case Manager/Navigator Assistant)- Medica prefers SNBC Care Coordinators be a Registered Nurse, Licensed Social Worker, County Social Worker evaluated by the Minnesota Merit System, Physician Assistant, Nurse Practitioner or Physician. At a minimum, SNBC Case Manager/Navigation Assistant must be supervised by a Licensed Social Worker, Registered Nurse, Physician Assistant, Nurse Practitioner or Physician.

In lieu of these requirements, an individual with specialized expertise working with people with disabilities may be allowed to act as a care coordinator if they have a four-year degree in a closely related field and three or more years of experience in home and community based services. The individual must also be trained on assessments and consultation for long-term care services and other training required by DHS. Medica must approve the individual’s qualifications before they can function in a Case Manager/Navigation Assistant capacity. The entity that hired these individuals must submit the initial and ongoing disability-related training plan for the staff working with the SNBC Medica members. Medica requires these staff to have at least 24 clock hours of training that is relevant to their role as a Case Manager/Navigation Assistant and/or the population served every two years. It is the responsibility of the contracted entity to ensure this training occurs and to provide Medica with documentation upon request.

Care Plan: Medica does not require the use of a specific Care Plan. Medica strongly encourages use of the Medica SNBC Care Plan. However, any Care Plan that meets the DHS EW audit protocol requirements and all of the elements of the Community
Support Plan (CSP) DHS e-doc form #2925 may be used. Prior approval must be obtained from Medica prior to using an alternative care plan.

**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 (I ADL’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.

**Health Risk Assessment (HRA):** The Medica SNBC Health Risk Assessment tool meets DHS and Medica requirements. The health risk assessment shall include questions designed to identify health risks and chronic conditions, including but not limited to: 1) activities of daily living, 2) risk of hospitalizations, 3) need for primary and preventive care, 4) mental health needs, 5) rehabilitative services, and 6) protocols for follow up to assure that physician visits, additional assessments or Case Management interventions are provided when indicated.

**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.

**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.

**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.

**Special Needs Basic Care** – The Minnesota prepaid managed care program, pursuant to Minnesota Statutes, § 256B.69, subd. 28 that provides Medicaid services and/or integrated Medicare and Medicaid services to Medicaid eligible people with disabilities who are ages eighteen (18) through sixty-four (64).

**PURPOSE:**
To clarify the role of Care Coordination/Case Management / Navigation Assistant services that are designed to ensure coordinate the delivery of all Medicare, and Medicaid preventive, primary, acute, post-acute, rehabilitation, specialty and pharmacy services, and long term care services, including State Plan Home Care Services for SNBC members. Care Coordinators serve as member advocates; they are instrumental in identification and coordination of activities that strive to keep members in the least restrictive settings, promote appropriate utilization, and self-management.

**POLICY:**
Every Medica SNBC member is assigned a Care Coordinator (CC). Medica will assign a CC based on the member demographic location and identified special needs, and/or the primary care provider (PCP). The CC will coordinate the provision of services to enrollees and must promote and assure service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, culturally appropriate care, and fiscal and professional accountability. The CC serves as the primary contact for the member’s needs.

**PROCEDURE:**
1. CC’s will perform the duties of Case Managers/Navigation Assistants listed in the DHS contract Article 6 Benefit Design and Administration and perform other duties as assigned by Medica.

2. CC’s will be informed of basic member protections 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 a Health Risk Assessment of each members health needs within the first thirty (30) calendar days of enrollment. The Health Risk Assessment may be conducted through mailed surveys, email, phone, or face-to-face contacts.
   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 located or refuses assessment, documentation of attempted contact is required in the clinical notes
   c. Use of alternate assessments and alternate forms of assessment contact type must be approved by Medica.
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 ADL information collected through the health risk assessment into Medicaid Management Information System (MMIS), for all members.

7. CC’s will coordinate the provision of all Medicaid acute and basic care services; including collaboration with Medicare services, Fee for Service services (FFS), and waiver services.

8. 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 visits.

9. CC’s will facilitate advance directive planning annually with the member and/or authorized family members or legal guardians based on individual member needs and cultural considerations.

10. CC’s will develop the member’s Care Plan based on the Health Risk Assessment (HRA) within thirty (30) days of HRA completion.

   a. The Care Plan will include risks and needs identified through the HRA including involvement from the members, authorized family members, legal guardians, caregiver’s, and primary practitioner’s goals, preferences, desired level of involvement, self-management plans, and consent to medical treatment. The plan should incorporate a holistic and preventative focus including member participation, and should accommodate specific cultural and linguistic needs and disability conditions of the member.

   b. The Care Plan should incorporate unique primary care, acute care, long-term care, mental health, and social service needs of the member per DHS guidelines. It should also incorporate both covered Medicaid services and services available through the formal, informal, and quasi formal health and Home Based Community Services as identified on the HRA.

   c. The Care Plan will address the identified goals, target dates, interventions, and will include monitoring progress towards goals through the year, and will document outcome/achievement dates.

   d. Risk findings related to safety (medical & environmental) should be among the highest priority when working with members.

   e. Members have a right to decline goals. If this occurs, documentation on the HRA, Care Plan, or in the member’s clinical notes should indicate why a goal is being declined.

   f. Analysis and discussion with the member and/or authorized family members or legal guardians will occur prior to finalizing the Care Plan. This will include written documentation that informs them of the agreed
upon Health and Home Based Community Services and supports that will be provided.

- Assessment and updating of member’s Care Plan outcome goal progress will be completed at each visit, change in member condition, or at a minimum annually. This should include dates and if the goal has been achieved or if it remains ongoing and will be carried forward for continued Case Management.

11. CC’s will provide self-management and educational materials to members with disability related conditions, as applicable.

12. CC’s will have interventions and protocols for management of disability related conditions common among members with disabilities such as skin breakdown & urinary tract infections.

13. 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 settings.

14. 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.

15. 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.

16. CC’s will make referrals to specialists and sub-specialists.

17. CC’s will work in partnership with the member and/or authorized family members or alternative decision makers, and Primary Care Physicians (PCP) in consultation with any specialists caring for the member, to develop and provide services and to assure consent to the medical treatment or service.

18. CC’s will coordinate care for American Indian members on their caseload.

19. CC’s will coordinate with Individual Education Plan (IEP), an Individual Family Service Plan (IFSP) or Individual Community Support Plan (ICSP) including services and supports.

20. CC’s will coordinate with Case Management services provided by children’s mental health collaborative, and family services collaborative and adult county mental health initiatives.
21. CC’s will coordinate with transitional care for children between the ages of eighteen (18) and twenty-one (21) who require ongoing services as they transition to adult programs covered under the DHS Contract.

22. CC’s will coordinate with county social service agencies, community agencies, nursing homes, residential and home care providers and case management systems involved in providing care for SNBC members using Health Insurance Portability and Accountability Act (HIPAA) compliant electronic communication vehicles.

   a. Referrals and/or coordination with County Social Service staff will be required when the member is in need of the following services:

      i. Pre-petition screening,
      ii. Preadmission screening for Home and Community Based Services (HCBS),
      iii. County Case Management for HCBS,
      iv. Child protection,
      v. Court ordered treatment,
      vi. Case Management and service providers for people with developmental disabilities,
      vii. Relocation service coordination,
      viii. Adult protection,
      ix. Assessment of medical barriers to employment,
      x. State medical review team or social security disability determination,
      xi. Working with Local Agency social service staff or county attorney staff for Members who are the victims or perpetrators in criminal cases.

23. CC’s will coordinate with Local Agency human service agencies for assessment and evaluation related to judicial proceedings.

24. 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.

25. 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 Care Coordinators and with lead agencies, waiver workers, or county case managers.

26. CC’s will collaborate with other providers for members identified as having special needs requiring additional Intensive Case Management, other Care Management, and risk assessments including Long Term Care Consultation and other screenings to identify special needs such as: common 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. Medica CC’s shall share with other providers serving the member with special health care needs the results of its identification and assessment of that member’s needs to prevent duplication of those activities.

27. Medica has been advised by DHS that CC 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.

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

29. CC will utilize secure email for all email communications containing PHI.

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

31. CC 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. This includes completing documentation in the members file, following specified timeframes, communication with members or responsible parties about changes to the member’s health status and plan of care, collaboration with providers of services, providing education on how to prevent unplanned transitions, and coordinating services for members at high risk for having transitions.

32. CC will make reasonable efforts to coordinate with services and supports provided by the Veteran’s Administration (VA) if applicable.

33. CC will help determine if members with HIV/AIDS and related conditions may have access to federally funded services under the Ryan White CARE Act, 42 U.S.C. § 300ff-21 to 300ff-29 and Public Law 101-381, Section 2.

34. CC will assist in coordination of Chemical Dependency Treatment Services (CD).
a. CD treatment services do not include detoxification (unless it is required for medical treatment).
b. Medica is responsible for all CD treatment services including room and board as determined necessary by the assessment.
c. Services include:
   i. Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) screening following a positive
   ii. “Screening and Brief Intervention and Referral to Treatment” (SBIRT) screen.
      1. The goal of SBIRT is to improve the effectiveness of early detection of at-risk or harmful substance abuse and to provide effective strategies for intervention prior to the need for more extensive or specialized treatment.
      2. The SBIRT may be offered in a primary care, or emergency care setting.

35. CC will assist in coordination with Intensive Case Management 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.

36. CC will notify members under the age of 21 of the availability of Child and Teen Checkup (C&TC) screenings annually.

   a. CC will provide and document all of the required screening components according to the C&TC standards and current periodicity schedule, and provide all medically necessary health care, diagnostic services, treatments and other measures, to correct or ameliorate deficits due to physical or Mental Illness conditions that are discovered during screening services, which are mandatory or optional Medical Assistance-covered services under 42 U.S.C. § 1396d (a). See 42 U.S.C. § 1396d® (5).
   b. Diagnostic services include up to three maternal depression screenings that occur during a pediatric visit for a child under age one. The STATE recommends the initial maternal screening within the first month after delivery, with a subsequent screen suggested at the four-month visit. The following C&TC components are currently required and must be performed in accordance with C&TC program standards and according to the periodicity schedule as specified in the current C&TC Chapter of the Provider Manual, which is herein incorporated by reference as applicable: (A)Assessment of physical growth, (B)Vision screening, (C) Hearing
screening, (D) Health history, (E) Developmental and behavioral assessment, (F) Physical examination, (G) Nutritional assessment,(H) Immunization and review, (I) Laboratory tests, (J) Health education and anticipatory guidance, (K) The Managed Care Organization (MCO) agrees to provide, or arrange to provide, dental services according to the C&TC dental periodicity schedule to each enrollee from age one age twenty-one (21).

37. CC will participate in Performance Improvement Projects (PIP) as requested by Medica.

38. CC 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 will use the DHS form “HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form” DHS 6037 as provided and directed by the state.

39. CC will assist members turning 65 years old in transitioning to MSC+ or MSHO per DHS requirements.

40. 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.

41. 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:
SNBC Contract
Medica Assessment Schedule Policy SNBC
Medica Member Transfer Responsibilities Policy
Medica Unable To Reach/Refusing Member Policy
SNBC Members Turning 65 Policy

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