PRODUCTS AFFECTED:

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

Continuity of Care: The members experience of a continuous caring relationship with an identified health care professional. Service provided through integration, coordination and the sharing of information between different providers.

Future End Date: Future end dates indicate members who have lost their Medicaid eligibility and Medica is covering services for 90 days. This information is located on the enrollment report sent to each care system, agency, and county lead.

Home and Community Based Services Case Management Transfer and Communication Form (DHS form 6037A or 6037B): Universal form used 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 when a member moves from one Care Coordination entity to another Care Coordination entity.

Care Coordination Entity: an entity that Medica contracts with and delegates some portion of its Care Management to (e.g. Care Systems, Agencies, and Counties)

Transfer: A member moving from a product, a County, a Care System, an Agency, or a Health Plan to another product, County, Care System, Agency, or Health Plan.

Transfer Documents: To include but not limited to: Home and Community Based Services Case Management Transfer and Communication Form (DHS form 6037), HRA
Member Transfer Responsibilities

Relationship Development Responsibilities

PURPOSE:
This policy will help guide Care Systems, Agencies, and Counties to ensure continuity of care for members during the time the member is transferred from one Care Coordination Entity to another Care Coordination Entity.

POLICY:
Care Coordinators will assist in maintaining member continuity of care during transition periods. Care Coordinators will complete assessments and other required documentation, to ensure that Medicaid Management Information System (MMIS) requirements, Department of Human Services (DHS) contract requirements, Center for Medicare and Medicaid Services (CMS) contract requirements, and Medica operational requirements are met.

PROCEDURE:
1. REQUESTING TO TRANSFER A MEMBER TO A PARTNER CARE COORDINATION ENTITY (CARE SYSTEM/AGENCY/COUNTY)

   Care System Staff Accountabilities:
   1. The sending entity will contact the receiving entity and obtain confirmation of the receiving entities ability to accept the member prior to notification of Medica Enrollment Staff.
   2. Transfer requests must be submitted to Medica by the 24th of the month prior to transfer effective date barring any enrollment issues from Department of Human Services (DHS)/ Center for Medicare & Medicaid Services (CMS).
   3. The current Care System’s Operation Staff will complete the Primary Care Clinic (PCC) Change Grid and submit it to Medica via ShareFile or secure email to SPPEnrollmentQ@medica.com.
   4. The current Care Coordinator will complete the Home and Community Based Services Case Management Transfer and Communication Form (DHS form 6037) and send it to the receiving entity.
   5. Members who have a future end date cannot be transferred.
   6. Medica will notify the sending entity if a transfer request is not approved.
   7. The sending entity is responsible for ongoing Care Coordination until the transfer effective date.
   8. Once the sending entity has been notified the transfer is approved, the sending entity will supply supporting transfer documents to the receiving entity. This should not be completed until approval of the transfer has been finalized by Medica.
   9. Medica sends Enrollment Reports to the Care Systems, Counties, and Agencies twice each month.
a. A New Member Enrollment Report is sent at the beginning of each month.
b. The Full Membership Enrollment is sent after the 10th of each month.  
The Medica Enrollment Team will highlight transferred members under  
the ‘Adds’ tab on the Full Enrollment report sent after the 10th of each  
month for the entity who received the member as a transfer.  For the  
entity that transferred the member, they will see the member on the terms  
tab of the Full enrollment report.

Agency/County Staff Accountabilities:
1. The sending entity will complete the Primary Care Clinic (PCC) Change Grid and  
submit it via ShareFile or secure email to SPPEnrollmentQ@medica.com.  
2. Transfer requests must be submitted to Medica by the 24th of the month prior to  
transfer effective date barring any enrollment issues from Department of Human  
Services (DHS)/ Center for Medicare & Medicaid Services (CMS).  
3. Members who have a future end date cannot be transferred.  
4. Medica will notify the sending entity if a transfer request is not approved.  
5. The sending entity will receive a communication from the Medica Enrollment  
Team that the transfer has been approved including the name of the receiving  
entity, and the date the transfer is effective.  
6. The sending entity is responsible for ongoing Care Coordination until the transfer  
effective date.  
7. Once the sending entity has been notified the transfer is approved, the sending  
entity will submit any additional supporting transfer documents via ShareFile or  
secure email to SPPEnrollmentQ@medica.com.  Once Medica verifies the  
transfer is finalized, Medica will forward the submitted supporting transfer  
documents to the receiving entity.  
8. Medica sends Enrollment Reports to the Care Systems, Counties, and Agencies  
twice each month.  
   a. A New Member Enrollment Report is sent at the beginning of each month  
   b. The Full Membership Enrollment is sent after the 10th of each month.  
The Medica Enrollment Team will highlight transferred members under  
the ‘Adds’ tab on the Full Enrollment report sent after the 10th of each  
month for the entity who received the member as a transfer.  For the  
entity that transferred the member, they will see the member on the terms  
tab of the Full enrollment report.

2. SENDING TRANSFERS BETWEEN HEALTH PLANS

   Care System/Agency/County Staff Accountabilities:  
1. The Care Coordinator may learn that a member has changed to another Health  
Plan via a member call, from the Medica Enrollment Report, or through a call  
from the new Health Plan.  
2. The Care Coordinator should check Mn-ITS to verify the new Health Plan. The  
Care Coordinator will complete a Home and Community Based Services Case  
Management Transfer and Communication Form (DHS form 6037) including any  
supporting transfer documents.
3. The Care Coordinator will supply the transfer documentation directly to the contact at the new Health Plan. This information should not be submitted to Medica.

3. LARGE GROUP ENROLLMENT TRANSFERS
   Care System/Agency/County Staff Accountabilities:
   1. In the event of a large group transfer resulting from a delegate change, product change, etc., Medica will work with the delegates to formulate a plan for the transfer of information.
   2. For large group transfers of enrollees with the same initial enrollment date Medica will determine if the assessment schedule timelines can be met and may choose to submit a transition plan to DHS, for review and approval, indicating the timeline in which they expect to be able to conduct this initial assessment required for new enrollees. Care Systems, Agencies, and Counties will be notified if an exception is being made to the Assessment Schedule Policy.

4. RECEIVING A MEMBER TRANSFER
   Care System/Agency/County Staff Accountabilities:
   1. The receiving entity is informed of a transferred member via the Medica Enrollment report sent after the 10th of each month.
   2. The receiving entity must contact new members via phone or approved letter within 10 business days of enrollment to inform the member of the Care Coordinator and provide contact information.
   3. Receiving Care Coordinator must review previous assessment and care plan telephonically with the member within 30 days of transfer.
   4. Refer to Medica Assessment Schedule Policy to determine required assessment activity and updates required in MMIS.
   5. The receiving Care Coordinator will communicate their contact information to the financial worker using DHS 5181.
   6. The receiving Care Coordinator will communicate case management information (including authorization for State plan home care services) with current County Case Managers, using DHS 5841, when applicable.

Cross References:
MSHO/MSC+ DHS Contract
SNBC DHS Contract
Medica Assessment Schedule Policy MSHO MSC+
Medica Assessment Schedule Policy SNBC SNBC Enhanced
Home and Community Based Services Case Management Transfer and Communication Form & Scenarios (DHS Form 6037 and scenario documents 6037A or 6037B)

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