PRODUCTS AFFECTED
Medica Choice – 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-Integrated) enrollees

DEFINITIONS
Care Coordinator (CC): A person, who assesses the member, develops a care plan, coordinates, and supports delivery of services identified in the care plan, also referred to as a navigator.

DHS: Minnesota Department of Human Services

HRA: Health Risk Assessment

Special Needs Basic Care (SNBC): 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). SNBC includes one hundred (100) days of Nursing Facility care for Enrollees who qualify.

Minnesota Senior Care Plus (MSC+): The mandatory Prepaid Medical Assistance Program (PMAP) program for Enrollees age sixty five (65) and over. MSC+ uses § 1915(b) waiver authority for State Plan services, and § 1915(c) waiver authority for Home and Community-Based Services (HCBS). MSC+ includes Elderly Waiver services for Enrollees who qualify, and one hundred and eighty (180) days of Nursing Facility care

HRA Assessment Tools
- DHS form 3427H Health Risk Assessment Screening Document
- DHS form 3428H Minnesota Health Risk Assessment Form
- DHS form 3426 OBRA Level I Criteria – Screening for Developmental Disabilities or Mental Illness (OBRA)
PURPOSE
Face-to-face Health Risk Assessment (HRA) with members is best practice. Based on the member’s needs, health conditions, and service status there may be instances when specific SNBC and MSC+ member’s HRA may be completed telephonically. To ensure that all Care Systems, Agencies, and Counties that provide care coordination for Medica members and are conducting telephonic HRA’s are aware of the identification process for “red flags” that will prompt a CC to offer the member a face-to-face HRA or visit with a member/responsible party.

POLICY
CC must assess and reassess members in accordance with DHS and Medica requirements. In the event that the HRA is completed telephonically, Medica has established the following criteria which include the procedures, identification process, schedules and timelines for face-to-face visits for all members based on the member’s needs and health conditions.

MEMBERS THAT MAY BE CONSIDERED FOR TELEPHONIC HRA
- SNBC members not permanently residing in a skilled nursing facility
- MSC+ members not on Elderly Waiver (EW)
- MSC+ members not receiving Personal Care Assistance (PCA)

FACE-TO-FACE ASSESSMENT OFFERING REQUIRED
- If the member/responsible party is requesting a face-to-face HRA or visit by a CC
- If at least one of the following “red flags” has been identified:
  - 3 or more emergency room (ER) visits during the last 12 months.
  - 1 or more hospital admissions during the last 3 months.
  - Diagnosis of Schizophrenia
  - At risk pregnancy
  - Skin breakdown
  - Infections/Urinary Tract Infections (UTI)
  - Activities of Daily Living (ADL) rating of 4 or more dependencies

PROCEDURE:
1. The CC will complete the following telephonically (applicable to MSC+ and SNBC members)
   - DHS 3428H
   - DHS 3427H
   - DHS 3426 (OBRA)

2. If any of the face-to-face "red flags" are identified or if the member/responsible party requests a face-to-face visit, the CC will proceed with offering the face-to-face HRA or face-to-face visit with the member/responsible party within 20 calendar days. If the member/responsible party request a deferment, the CC will document all
attempts to schedule the visit and will proceed with completing the assessment telephonically if the member is willing to do so.

3. When the HRA is completed telephonically, the CC will attempt to address all elements of the assessment with the member.

   - If all elements cannot be addressed, additional telephonic contact with the member may be warranted upon member agreement.
   - If the CC is unable to obtain all elements of the assessment, an explanation will be documented.

4. Upon completion of assessment, the CC will place the member in the following visit/contact schedule and note the follow-up frequency on the care plan.
   - Annual HRA
   - Minimum contact every 6 months (additional contacts per CC judgement)
   - Contacts related to member transitions, if applicable

5. The CC will document all member contacts in the member’s record or chart.

6. If CC becomes aware through notification from a county, health care provider, family member, the member or others, of a member’s change of condition or recent change of living setting due to an increase in service needs (for example, move to customized living setting or group home), CC will contact member within 1 business day and schedule an assessment.

7. Annual reassessments must be completed within 365 days of previous assessment.

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.

Activity Type 05: Document Change
- 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.
  - a member has changed from Medica’s MSHO product to MSC+ 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 07: Case Management/Administrative Activity**
- For use when a member has refused the Health Risk Assessment or CC is unable to find/contact. Assessment result should be 39

If the member’s HRA is being completed face-to-face, refer to the Assessment Schedule Policy for more information. If the member is considered a missing member or has refused an assessment, refer to the Missing Member/Refusing Member Policy for more information.

**Care Coordinator Assessment and Follow up Activities**

| Assessment/HRA                                      | SNBC: DHS 3428H, 3427H and DHS 3426 OBRA Level 1 within 30 days of enrollment.  
|                                                   | MSC+: DHS 3438H, 3427H and DHS 3426 OBRA Level 1 within 60 days of enrollment.  
|                                                   | Completed annually, within 365 days from previous assessment.  
| Care Plan                                         | SNBC: AccessAbility Solution Care Plan  
|                                                   | MSC+: Collaborative Care Plan.  
|                                                   | Completed annually, within 30 days of HRA.  
| Member documents made available to member after assessment | SNBC: At a minimum, service plan portion of Care Plan  
|                                                   | MSC+: Entire Care Plan  
|                                                   | Medica Post-Visit Member Letter  
|                                                   | Medica Care Coordinator Leave-Behind Document  
|                                                   | Any additional follow up or educational items based on member discussion/HRA.  

**CROSS REFERENCES:**