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Member Eligibility

To enroll in Medica DUAL Solution (MSHO) a member must:

- Be age 65+
- Be eligible for Medical Assistance (Medicaid)
- Have Medicare Part A and Part B
- Reside in the Medica DUAL Solution service area

To enroll in Medica Choice Care MSC+ (MSC+) a member must:

- Be age 65+
- Be eligible for Medical Assistance (Medicaid)
- Reside in the Medica Choice Care MSC+ service area

MSC+ members may or may not have Medicare covered through another plan or Medicare

For the remainder of this document we refer to these two Medica products by their state program names:

- MSHO for Medica DUAL Solution
- MSC+ for Medica Choice Care MSC+

As a representative of Medica, the Care Coordinator (CC) manages benefits provided by state plan home care services, as well as Elderly Waiver (EW) services and Personal Care Assistance (PCA) for members who qualify. The MSHO program integrates the members Medicare and Medicaid benefits. Although the MSC+ program does not include Medicare benefits, it is the responsibility of the care coordinator to coordinate services with Medicare as applicable.

CCs have the unique responsibility of assisting the member across all settings of care, transitions, and stages of the aging process. The CC is the member’s primary contact for accessing all benefits under MSHO or MSC+.
1. Upon receiving the enrollment information, within ten (10) days contact the member to:
   
   • Introduce yourself to the member
   • Provide contact information
   • Answer any questions about the plan the member has

   Medica provides the member a letter containing the general contact information for the entity or partner providing their CC along with Medica Member Services numbers.

2. Conduct a **Health Risk Assessment (HRA)** of each member’s health needs within the first thirty (30) calendar days of enrollment for all MSHO members and MSC+ EW members and within the first 60 calendar days of enrollment for MSC+ non EW members. After the initial HRA, CCs conduct assessments annually (within 365 days) thereafter and with any significant change of condition. Complete a face-to-face assessment with all members annually using the appropriate HRA document for all members:
   
   • MSHO
   • MSC+ with EW
   • MSC+ with personal care attendant (PCA)
   • Medica approved HRA for long term care (nursing home) members

   MSC+ non-EW members without PCA may have the HRA conducted either face to face or telephonically.

   See the Assessment Schedule Policy found on the [Medica Care Coordinator](https://www.medica.com) site for information related to timelines.

   The assessment addresses medical, social and environmental and mental health factors, including the physical, psychosocial, and functional needs of the member. The member’s HRA must identify person-centered principles and practices: assurance that members have the opportunity for meaningful choice and self-determination, and that their civil and legal rights are affirmed and respected.

   LTCC assessments and reassessments are used to determine eligibility for home and community based services and/or home care services performed as part of this assessment process. Upon completion of the assessment, the CC is required to enter specified information into MMIS for all community members.
Note: Upon implementation of MnCHOICES with a Medica MSHO or MSC+ member CCs are required to use the state’s MnCHOICES tool.

3. 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 in partnership with:

- The member and/or authorized family members or alternative authorized decision makers
- The primary care provider in consultation with any specialists caring for the member

The Care Plan should 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. CC should incorporate the individual member’s unique strengths, assets, interests, wishes, expectations, hopes, strengths, resources, cultures, goals, and need for support in the care plan.

4. Follow Medica’s policies/protocols for facilitating annual physician visits for primary and preventive care, and assist in removing any barriers member is facing related to obtaining this care.

5. Assist members in locating and accessing specialists and sub-specialists including those with experience in working with seniors.

6. Arrange and coordinate supports and services identified through the assessment and care planning process.

7. Assist the member and/or authorized family members or alternative authorized decision makers, if any, to maximize informed choice of services and control over services and supports.

8. Monitor and record outcomes in order to evaluate the adequacy of services and interventions.

9. Assist the member with health plan related issues as needed. This could include referring the member, family or provider to the appropriate contact point within Medica. CCs are not the primary contact for billing issues for providers. For billing issues refer providers to Medica Provider Services.

10. Coordinate with primary care, including assisting a member locate appropriate providers if needed.

11. Educate member about good health practices, including wellness and preventative activities. Obtain and distribute self-management materials and education to members regarding aging related conditions.

12. Participate in Performance Improvement Projects (PIPS) or Chronic Care Improvement Projects (CCIPS) for applicable members.

13. Assist members in accessing resources and services beyond the Medical Assistance and Medicare benefit set including informal and formal supports.

14. CCs may need to complete a referral for some services that require an authorization in our system.

- The Referral Request Form can be found on the Care Coordination website under Tools and Forms.
• Refer to Claims Referral Guidelines for MSC+, MSHO, and SNBC for a list of services that require a service authorization. The guide can be found on the Care Coordination website under Tools and Forms.

15. Ensure smooth transitions and coordination of information between acute, sub-acute, rehabilitation and nursing facilities and home and community based settings. A transition log is required for MSHO members, highly recommended for MSC+ as all transition tasks remain the same.

16. Stay up to date with changes that relate to Medical Assistance benefits and program changes. Attend trainings put on by Medica, DHS, PIP collaborative and other entities as needed.

17. Have experience working with people who are aging, people with disabilities, primary care, nursing, behavioral health, social services and/or community based services.

18. Complete all necessary activities surrounding nursing home placements including but not limited to DHS-3427T LTC Screening Document - Telephone Screening per the DHS pre-admission screening process (PAS). The document is found on the DHS eDocs site by clicking here and searching for 3427T.

19. Conduct DHS-3426 OBRA Level 1 Criteria - Screening for Developmental Disabilities or Mental Illness and convey any information obtained during the screening to the Local Agency and send copy to nursing facility (NF). The document is found on the DHS eDocs site by clicking here and searching for 3426. Follow the OBRA Level II process if indicated. More information on this process can be found later in this training manual.

20. Be familiar with the Medica twenty four (24)-hour, seven (7)-day-per-week nurse line members can access. CCs are to direct members to the nurse line phone numbers on their member ID cards for use by the member when needed and educate members on the importance of this resource. More information is found in the NurseLine by HealthAdvocate section of this document.

21. Communication and Coordination with Counties, Tribes and Providers:

• Communicate with county social service agencies, community agencies, nursing homes, residential and home care providers involved in providing care under fee for service to MSHO and MSC+ members. Communication includes HIPAA compliant electronic communication vehicles.

• Coordinate with local agency/county as necessary, including use of the DHS-5181 Lead Agency Assessor/Case Manager/Worker LTC Communication Form with any new CC assignment, change of address, change of living setting, etc. The document is found on the DHS eDocs site by clicking here and searching for 5181.

• Communicate with lead agencies (counties/tribes) for members on waivers such as BI, CADI, DD related to the members need for state plan home care services using the DHS-5841 Managed Care Organization, County and Tribal Agency Communication Form - Recommendation for State Plan Home Care Services. The document is found on the DHS eDocs site by clicking here and searching for 5841.
• Communicate with the receiving health plan if the member has changed health plans or with the lead agency (county/tribe) if the member has dis-enrolled and is receiving services which may need to be paid for Fee-For-Service. This communication is done using the DHS-6037 Home and Community-Based Services Case Management Transfer Form. The document is found on the DHS eDocs site by clicking here and searching for 6037. See the instructions for this form related to communications that are required.

• Coordinate and communicate with tribal assessors and case managers. CCs accept the results of home care assessments, reassessments and the resulting service plans developed by tribal assessors for Tribal Community Members as determined by the tribe. Referrals to non-tribal providers for home care services resulting from the assessments must be made to providers within the Medica network. This applies to home care services requested by Tribal Community Members residing on or off the reservation.

22. CCs must be aware of services that include 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.

23. **Range of Choices**

Work with members to ensure access to an adequate range of elderly waiver and nursing facility services and provide 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 procedures 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 member in leaving the nursing facility. For purposes of this section, the word “assisting” includes, but is not limited to, discharge planning and care management responsibilities.

24. **Coordination with Social Service Needs**

Referrals and/or coordination with county social service staff are required when the member is in need of or receiving the following services (as outlined in the DHS contract):

- Pre-petition Screening;
- OBRA Level II referral for Mental Health and Developmental Disability;
- Spousal Impoverishment Assessments;
- Adult Foster Care;
- Group Residential Housing Room and Board Payments;
- Substance Use Disorder room and board services covered by the Consolidated Chemical Dependency Treatment Fund; or
- Adult Protection.
- The MCO shall coordinate with Local Human Service Agencies for assessment and evaluation related to judicial proceedings.
- Case Management for Serious and Persistent Mental Illness;
- Case Management for pre-petition screening;

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• Court ordered treatment, developmental disabilities, assessment of medical barriers to employment; or
• A State medical review team (SMRT) or social security disability determination.
• Services offered through social service staff or county attorney staff, for Enrollees who are the victims or perpetrators in criminal cases.

25. **Identification of Special Needs & Screening information**
CCs implement and coordinate with other care management and risk assessment functions conducted by appropriate professionals when indicated, including Long Term Care Consultation (LTCC) and other screenings to identify special needs such as but not limited to:

- Common geriatric 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
- Language or comprehension barriers

This information is shared with the new health plan in the event that the member chooses to transfer to that health plan.

26. Make reasonable efforts to coordinate with services and supports provided by the Veteran’s Administration (VA) for members eligible for VA services.

27. Inform members of resources available for advance directive planning based on individual member needs and cultural considerations. Members receive an advance directive document annually in their Member Resource Guide.
**MHSO Rate Cells/MSC+ Classifications**

**MHSO rate cells**

MHSO members are assigned to a rate cell by DHS. This categorization determines the monthly capitation payment paid by the state and CMS to the health plan. The information entered in the Medicaid Management Information System (MMIS) by the CC and MAXIS by the county financial worker determines this assignment. The principle determinants are living arrangement, Nursing Home Certifiability and Elderly Waiver Status. The criteria for nursing home certification are on the *Nursing Facility Level of Care Criteria* document. The document is found on the DHS eDocs site by clicking [here](#) and searching for 7028.

A change in rate cells is an automated process through the state’s data system. The new rate cell will be assigned to members if the data is entered by the CC by the capitation date for the following month.

Nursing facilities need to submit DHS Form 1503 to counties to change a member’s living arrangement to “institutional”. If the nursing facility has not done this, the county financial worker may need to be contacted by the CC.

Drug copays are tied to living setting. Institutional members do not have drug copays. Until living setting is changed by the financial worker, the copay is member liability.

**MSC+ classifications**

MSC+ members do not have rate cell categories as MSHO members do. MSC+ members are placed in the following 3 classifications based on where they live and waiver status:

- MSC+ community (non-EW)
- MSC+ EW
- MSC+ institutional

MSC+ group numbers help identify whether a member is coded as institutional or not. The group number identifies if a MSC+ member has Medicare or does not have Medicare. The [Care Coordination Product Group Numbers for Medica Special Needs Plans (SNP) and Minnesota Senior Care Plus (MSC+) document](#) on the Medica Care Coordination page shows these differences.

**NOTE:** If providers working with Medica members are wondering where they can get more information on MSHO or MSC+ there are provider fact sheets that overview the Medica products located on [Medica.com Providers → Administrative Resources → Product Information](#).
Assessments

Per DHS requirements, CCs must conduct a health risk assessment of each member’s health needs within thirty (30) calendar days of the enrollment date for MSHO and MSC+ EW and within sixty (60) days for MSC+ non-EW. The assessment addresses medical, social, environmental and mental health factors. See the Assessment Schedule (MSHO, MSC+) and Care Coordination Accountability (MSHO, MSC+) policies for more information.

Assessment requirements

MSHO Community Based members (Rate cells A and B):

Assessments are required for MSHO members within 30 days of enrollment and every 365 days thereafter, and must be completed face to face. Medica utilizes the LTCC (DHS form 3428) for MSHO members on EW or receiving PCA services. For community based MSHO members not on EW or PCA, the HRA form used is the DHS form 3428H. **CCs must enter the assessment into MMIS on or before the capitation cut-off date, as instructed in the MMIS section of this manual**

MSC+:

All MSC+ members on the Elderly Waiver as well as all MSC+ members receiving PCA services must be assessed face to face within 60 days of enrollment. All MSC+ members not on elderly waiver and not receiving PCA services must be assessed within 60 days either face to face or telephonically. If during a telephonic assessment, if it appears the member may require EW services or PCA, a face to face assessment would then be required to be completed. Medica considers face to face assessments to be best practice.

Medica utilizes the LTCC (DHS form 3428) for MSC+ members on EW or receiving PCA services. For community based MSC+ members not on EW or receiving PCA, the HRA form used is the DHS form 3428H. The document is found on the DHS eDocs site by clicking here and searching for 3428.

MSC+ Telephonic Option:

If you complete an assessment telephonically for an MSC+ member:

- Complete the DHS-3427T LTC Screening Document - Telephone Screening
  The document is found on the DHS eDocs site by clicking here and searching for 3427T.

- A signature sheet is sent to member along with member letter and emergency plan
Include a self-addressed stamped envelope, and ask for member to return the signed sheet to you.

Document in your case notes that you sent this to the member and when you receive this back from member.

Best practice is a minimum of two (2) documented attempts to obtain members signature.

If a member requests a LTCC be completed, CC must complete a face to face visit within twenty (20) calendar days.

NOTE: Upon implementation of the MnCHOICES assessment for members CCs are required to use the HRA component of the state’s MnCHOICES tool which will then meet the requirements of this section.

Community Members on a waiver other than Elderly Waiver:

Members on Community Alternatives for Disabled Individuals (CADI), Brain Injury (BI), or Developmental Disability (DD) waivers can be enrolled in MSHO or MSC+. CCs use the Minnesota Health Risk Assessment (DHS form 3428H) within 30 days of enrollment for MSHO or within 60 days of enrollment for MSC+ and at least annually thereafter. The document is found on the DHS eDocs site by clicking here and searching for 3428H. This data gets entered into MMIS as “H” screening documents. CC is required to communicate and coordinate with the members waiver case manager including but not limited to sharing of information including the care plan and joint visits with the member.

Key points and best practices for providing care coordination for members on other waivers:

- A CC can see in MN-ITs if the MSHO or MSC+ member is on another waiver.

- If the member has a legal guardian they must be contacted and invited to be present at the assessment. The legal guardian can decline to be present; if they do that must be documented. If present, the legal guardian signs any paperwork; if not present paperwork needs to be sent to the legal guardian for review and signature.

- If the member lives in a group home setting, the CC must communicate with and meet with the group home provider to let them know that we are involved and create a relationship for team work on the member’s behalf.

- Assessment timelines, care plan timelines and, follow-up contact schedules apply.

- The waiver worker is seen as the member primary case manager (lead agency) as most of the member’s Activities of Daily Living (ADL)/Instrumental Activities of Daily Living (IADL) needs are being met by the disability waiver services.

- The CC does not need to complete a LTCC (DHS 3428). The county waiver worker enters a screening document into MMIS.
• The CC completes the Minnesota Health Risk Assessment (3428H) annually and with significant change of condition and keeps it in their records. The document is found on the DHS eDocs site by clicking here and searching for 3428H.

• Request a copy of the waiver workers care plan and refer to that when completing the MSHO/MSC+ care plan.
  
  o The CC completes a care plan, and indicates on this care plan when items are being managed by the county waiver worker and refer to the waiver care plan if received. Include copy of the county care plan in the member’s records. CC completes sections of the care plan not addressed by the waiver worker including by not limited to: advanced directives, preventative areas, PIP related areas, etc.

• The CC communicates with the waiver worker (DHS MCO/County/Tribal Agency Communication form # 5841) throughout the year when necessary, and request that the waiver worker includes them in their annual assessment of the member. The CC also provides the waiver worker with a copy of the completed care plan as a way to create a collaborative, integrated care plan.

For members on waiver programs other than EW, the county case manager is responsible for completing the PCA assessment through MnChoices. Once completed, the CC reviews the assessment and submits a Referral Request Form to have authorization entered. The form is found on the Medica Care Coordinator site under Tools and Forms CC is responsible to communicate with waiver case manager to be sure annual PCA reassessment (MnChoices or legacy document depending on county) is completed so that there is no gap in the member’s service/authorization.

Institutional members

If a member assigned to you is admitted to a nursing facility, and during that time is due for their annual assessment, you can complete the Institutional Assessment found on the Medica Care Coordinator site. If the member is in the process of discharging to the community, complete the LTCC assessment. Be sure to follow the pre-admission screening process, also known as PAS when needed. See the Partner Nursing Home Checklist for more information.

Institutional members are to be assessed within 30 days of enrollment for MSHO and within 60 days of enrollment for MSC+ and annually (every 365 days) at a minimum and with changes in condition. Communicate with PCP annually at a minimum.

Preadmission Screening and OBRA requirements

CCs play an important part of the PAS process which includes the work done to ensure members are appropriate for that level of care, referred to as Nursing Facility level of care (NF LOC), completion of the OBRA paperwork when indicated, and when indicated to complete the required work in MMIS which informs DHS as to what members are in the nursing home, as well as allows providers to be paid properly.

The below outlines specific tasks related to PAS and CCs based on the members situation including waiver status. This list does not include all tasks that a CC must complete when someone enters a SNF, NF or Swing Bed, but just
those tasks related to PAS found in DHS bulletin 19-25-02. This bulletin includes detailed information (attachment A, pages 18-20) related to the duties of the Health Plan CC compared to the others (FFS, county/tribe waiver workers). Always refer to the DHS webpage for the current bulletins.

The OBRA Level II is done by the County so if your member is in need of NH placement and requires a Level II you will contact the county to complete that assessment. When a member is planning to enter a SNF/NF/Swing bed and based on the OBRA Level I, the member is in need of a Level II, per the bulletin the following applies:

- OBRA Level II referrals for mental health conditions are sent to the county of hospital or clinic location.
- OBRA Level II referrals for developmental disability or related conditions are sent to the county of financial responsibility.

Note: This is a very important process for the care coordinator to be aware of and follow, refer to the bulletin for more information and to the Medica Clinical Liaison with any questions.

- DHS-3426 OBRA Level 1 Criteria - Screening for Developmental Disabilities or Mental Illness
The document can be found on the DHS eDocs site by clicking here and searching for 5020A

MSHO/MSC+ (not open to EW)

- For MSHO/MSC+ members not open to EW:
  - The CC completes the OBRA level 1 (DHS #3426) form annually and with change of condition reassessments and keeps this in the member’s record.

- For members entering a SNF/NF/Swing Bed:
  - The Senior Linkage Line (SLL) sends to Medica the Pre-Admission Screening (PAS) document which is forwarded to the CC.
  - The CC completes the MMIS entry using DHS Form # 3427T (also known as telephone screen document).
  - The CC sends the PAS and current OBRA level 1 form to the SNF, NF, Swing Bed facility.
  - If the member triggers for an OBRA level II screening to be done, the CC is to notify the appropriate county and send them the OBRA level 1.
  - The CC will be involved in discharge planning activities.

- For members who are planning to enter a SNF/NF and level of care cannot be established (see note on PAS under Level of Care Result):
  - CC is to complete a face to face assessment with the member using DHS Form 3427, and enters this into MMIS prior to the admission

MSHO/MSC+ on EW

- For MSHO/MSC+ members open to the EW:
  - The CC completes the OBRA level 1 (DHS #3426) form annually and with change of condition reassessments and keeps this in the member’s record.

- For member entering a SNF/NF/Swing Bed:
  - The SLL sends to Medica the PAS document which is forwarded to the CC.
  - The CC sends the PAS and current OBRA form to the SNF, NF,
Swing Bed facility
- If the member triggered for an OBRA level II screening to be done, the CC is to notify the appropriate county and send them the OBRA level 1.
  - The CC closes the waiver through the MMIS waiver exit process done when members exit the waiver based on nursing facility placement by the 30th day of placement.
  - Note: A 3427T screening document is not necessary for members on the Elderly Waiver (EW) as level of care had already been established.
- The CC will be involved in discharge planning activities.

**MSHO/MSC+ on CAC, CADI, BI waivers**

- For members on CAC, CADI and BI waivers:
  - For members on CAC, CADI and BI, the CC does not complete the OBRA level 1 form annually, this is done by the lead agency/waiver worker.
- For member entering a SNF/NF/Swing Bed:
  - The SLL forwards the PAS to Medica for notification purposes only and to the county of financial responsibility for CAC, CADI, and BI waiver participants who will conduct PAS duties.
  - CC is to be aware of the admission, and work collaboratively with the waiver case manager and be involved in discharge planning.
  - The county/lead agency/waiver worker is responsible to establish NF LOC, complete the OBRA and send to the facility and enter the DHS 3427T into MMIS.

**MSHO/MSC+ on DD waiver**

- For members on the DD waiver:
  - For members on the DD waiver, the CC completes the OBRA level 1 (DHS# 3426) annually and with change of condition reassessments.
- For member entering a SNF/NF/Swing Bed:
  - The SLL forwards the PAS to Medica and to the county of financial responsibility for DD waiver participants
  - The CC sends the PAS and current OBRA form to the SNF/NF/Swing Bed facility
  - The CC completes the MMIS entry using DHS Form # 3427T.
  - CC is to work collaboratively with the DD waiver case manager and be involved in discharge planning.
  - Note: The waiver worker will complete additional entry into MMIS related to the OBRA Level II and DD screening document.

- MMIS entry of the Preadmission Screening activities (PAS) is to be done by day 30 of placement. Activity type would be 01 Telephone Screen.

- Communication of the nursing facility admission is made to the financial worker using the DHS-5181 Lead Agency Assessor/Case Manager/Worker LTC Communication Form and the OBRA activities completed. The document is found on the DHS eDocs site by clicking here and searching for 5181.

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• Allowing the EW to “naturally” close is **not** appropriate. For example, no action in MMIS-to-DHS, no activity in MMIS appears as though the MCO has missed completing their annual assessment with the member.

• For members who are no longer eligible for EW, and for members who have entered a nursing home for 30 days the waiver needs to be closed. You **must** take action in MMIS to close the waiver. Without this, DHS does not have what they need to:
  
  a) Pay Medica appropriately for members on EW and those not on EW
  
  b) Pay nursing home providers after Medica’s liability is complete (payment period where we pay for the nursing home care)

  **Medica is subject to financial penalties when waivers are not managed correctly.**

**Medicaid Management Information System (MMIS)**

**The DHS MMIS Training series** provides instruction on how to use the MMIS for the LTC and HRA screening documents. Session 1 is mandatory. New staff working with the MMIS should review sessions 2 – 5. Other sessions that includes the HRA screening are 7, 7a, 8b, 12, and 13. These sessions are located on TrainLink. See Session 8b of the MMIS Training Series for instruction on entering the HRA into MMIS. Each delegated care coordination entity bears responsibility for keeping staff up to date with MMIS changes related to MSHO and MSC+.

Per the contract with DHS, MMIS entry is required for all MSHO and MSC+ members who are not in a nursing home/institution, even if the member has refused to participate in an assessment, or is unable to be located. MMIS entry must be completed timely, completely and accurately. DHS provides Medica some reporting which identifies when entry has been missed or entered late and you will be contacted if you have a member on this list. Contact the Medica Clinical Liaison if you have any questions related to timelines related to required MMIS entry.

Per DHS MMIS entry manual for MSHO/MSC+ specific to members on the Elderly Waiver (DHS edoc #4669): For rate cell B, the EW eligibility span includes the following month for the capitation run in the current month. If the eligibility span ended the last day of the current month and the document entered prior to the current month’s capitation date, the rate cell will change to A for the following month. To avoid changing the rate cell from B to A, enter the annual reassessment visit that is due in the twelfth month of the eligibility span into MMIS prior to the capitation date of that month. The document is found on the DHS eDocs site by clicking [here](#) and searching for 4669.

**Missing members and refusing members**

If a member refused an assessment or is unable to be located, MMIS entry is required by DHS. A best practice is to complete the MMIS entry prior to the capitation date, also referred to as the cut-off date. See the Assessment Schedule Policy (MSHO, MSC+) and Unable to Reach/Refusing Member policy on the Medica Care Coordinator site for more information related to the MMIS specifics.

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DHS resources related to MMIS entry:

- **DHS-3428  Minnesota Long Term Care Consultation Services Assessment Form**
  The document is found on the DHS eDocs site by clicking [here](#) and searching for 3428.

- **DHS-3428H Minnesota Health Risk Assessment Form**
  The document is found on the DHS eDocs site by clicking [here](#) and searching for 3428H.

- **DHS-3427 LTC Screening Document - AC, BI, CAC, CADI, ECS, EW, MHM, MSC+, MSHO, SNBC**
  The document is found on the DHS eDocs site by clicking [here](#) and searching for 3427.

- **DHS-3427T LTC Screening Document - Telephone Screening**
  The document is found on the DHS eDocs site by clicking [here](#) and searching for 3427T.

- **DHS-4669 Instructions for Completing and Entering the LTCC Screening Document into the MMIS for the MSHO and MSC+ Programs**
  The document is found on the DHS eDocs site by clicking [here](#) and searching for 4669.

- **PreAdmission Screening Bulletin #19 25 02**

The MMIS health plan code for Medica is **MED**.

MMIS must be kept current with the name of the current CC assigned to each member per DHS contract. See the [Assessment Schedule Policy](#) (MSHO, MSC+) for more information on this process.
Care Planning

Care planning is an essential and required task completed by the CC with the member and/or their responsible party. Information obtained during the HRA is incorporated into an Individualized Care Plan (ICP) that is individualized to the member and reflective of their health care needs, goals, wishes and values. The ICP centers on the member goals and priorities as well as input received from the member’s interdisciplinary care team (ICT) with the goal to improve or maintain their health and functioning. A comprehensive care plan is written and maintained for each member except for MSHO and MSC+ members who live long term in a nursing home; they do not require a care plan.

Medica recommends use of the) Collaborative Care Plan found on the Medica Care Coordinator site. Medica allows use of an alternative care plan tool, however the tool must be provided to Medica for approval prior to use. Care Coordination delegates who use an alternative tool must ensure that all updates to the Collaborative Care Plan are incorporated into their tool, and provide a copy to Medica annually for review and approval. Alternate care plan tools must be approved by Medica prior to their use in order to ensure it contains necessary elements.

1. A comprehensive care plan is written and maintained for each member on MSHO and MSC+. For community based members, the recommended care plan tool is the Collaborative Care Plan. For members who are living long term in the nursing home, the care plan elements are included on the institutional HRA tool, so a separate care plan is not required.

2. 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.

3. Care Plans must include the following components:

   a. **Interdisciplinary/Holistic Focus** - The care plan should incorporate the primary, acute, long term care, mental health and social service needs and wishes of each member with coordination and communication across all providers.

      • For community members, communication with primary care (see PCP letter template), attending appointments as needed and involving family in care planning process and visits.

      • For nursing facility members- this includes review of the nursing home chart, involvement in care conferences, and staff input, which is documented in the institutional assessment form.

   b. **Preventive Focus**

      • For community members this may include immunizations, tobacco cessation, alcohol use, fall risk, medications and nutrition.
• For nursing facility members this includes immunization status and health risks, skin integrity, nutrition and activities to improve functioning, which is documented in the institutional assessment form.

c. **Disease Management**- adoption of protocols and best practices are encouraged. CCs are to provide education to members as needed. See the Health Improvement Programs section under tools and forms on the Medica Care Coordinator site for more information.

d. **Back up for emergency situation**- assist the member/responsible party in planning for emergency situations, such as sudden illness, accident, worsening of chronic conditions. This planning should also include back up plans for failed or refused services. This is documented on an emergency plan.

e. **Safety Plan**- this is completed when there is a safety concern or risk identified with the member. If there are identified health and safety risks, document how these will be addressed with services or the members plan for managing risk in the applicable portion of the care plan. If the member doesn’t have a plan because member doesn’t have the risks identified or doesn’t believe they have any risks, note this on the applicable section of the care plan. If the CC offers a service that is critical to the member’s health and safety that is not accepted by the member, this should be noted.

f. **Advance Directive Planning**- review health care directives annually and with changes in care needs. These reviews are documented on the care plan. This includes documentation of refusals. All Medica MSHO and MSC+ members receive an Honoring Choices health directives packet in their enrollment materials. These materials are also available in several other languages from the Honoring Choices website: [www.honorinchoices.org](http://www.honorinchoices.org)

g. **Annual Comprehensive primary care provider (PCP) Visit**- care planning should document efforts to ensure all members have had an annual comprehensive PCP visit.

h. **Care plans must include:**

   • Identified goals and member specific interventions; including who is responsible for each intervention (for example: “member will....”; “care coordinator will....”)

   o Monitoring and evaluation of goal outcomes must include dates; the date to evaluate outcomes will often be the next scheduled reassessment date, but could be the date of the next follow-up contact.

   • Identify possible barriers, such as lack of transportation, language, cognition, and design interventions that address these barriers so goals can be achieved

   • A schedule for a follow-up plan and communication

Note: Unable to locate or refusal MSHO members require an Unable to Contact/Refusal Care Plan found under tools and forms on the Medica Care Coordinator site.
Monitoring and managing transitions, whether they are planned (ex. scheduled knee surgery) or unplanned (emergency admission due to an acute episode) are an important function of the CC. Not only does CC involvement make the transitions more seamless, it also is a requirement from the Centers for Medicare and Medicaid Services (CMS). While MSC+ is not a product that includes Medicare, Medica requires that transitions still be managed per the current Transitions Process. MSHO is a Medicare product and must be managed per the current Transition Process and documented on the Transition Log. Though the transition log is not required for MSC+ members its use is a best practice. All transition activities need to be documented in the member’s chart.

Transition of Care is defined as the movement of a member from one care setting to another as the member’s health status changes. This includes outpatient procedures that may impact the ability of the member/responsible party to manage usual activities of daily living. Remind members to inform you of both planned and unplanned transitions. A planned transition is typically due to a surgical procedure, where the member/responsible party is involved in the planning and timing of the admission. An unplanned admission is usually due to illness or accident.

**Transition requirements**

**Within one business day of notification of admission:**

- Communicate with the receiving facility to share key elements of the care plan. This may include but is not limited to:
  - Current services
  - Informal supports
  - Advance directives
  - Medication regimen
  - CC contact information

- Communicate admission with primary care provider (PCP) within one business day of notification unless PCP was the admitting physician

- Communicate with the member and/or authorized family members or alternative authorized decision makers within one business day of admission (or prior to admission if a planned event) to learn about any changes in health status and/or care needs. Explain the transition process and provide CC contact information for additional support.
As needed after notification of admission:

- Start a new note if there are additional transitions that occur before return to the usual care setting.
- Update the member’s plan of care.

Upon discharge to the member’s usual or “new” usual care setting:

- Communicate with member/responsible party about:
  - The care transition process
  - Changes to the member’s health status; does the member have any needs that require a change to their services/supports?
  - Plan of care updates; review care plan to ensure that member’s plan continues to meet their needs
  - Educating member/responsible party about transitions and how to prevent unplanned transitions/readmissions. Education should include but is not limited to:
    - The importance of keeping appointments
    - Addressing potential barriers
    - Medication self-management
    - Knowledge of warning signs
    - Benefits of maintaining a personal health record; does member know what red flags would indicate a call back to their physician?
    - Benefits of maintaining a personal health record (PHR)

Transition care resources

- Notification of Care Transition Fax
- Transition Log
- Transition Log instructions

The Transition Log is only required for MSHO members and does not need to be completed for MSC+ members. However, CCs should work to support and manage members during all transitions regardless of
whether the log is required. If log is not used for MSC+, it is expected that the CC will document transition management activities.
Primary Care Provider (PCP) communication

Communicate with the member’s primary care provider at least annually, as well as with changes of a member’s condition and member transitions. Medica encourages the use of the PCP letter template. The annual communication is documented in the care plan. Best practice includes accompanying your member on their PCP visit if that level of support is needed by that member.

Communication with waiver program worker/Targeted Case Manager

For MSHO/MSC+ members on waivers other than EW such as BI, CADI, and DD, the CC has the responsibility of communicating and collaborating with that waiver worker to be sure the members needs are being met, that the waiver worker is part of the interdisciplinary care team, and that there are not duplicative services occurring. The DHS-5841 Managed Care Organization, County and Tribal Agency Communication Form - Recommendation for State Plan Home Care Services form could serve as the communication tool as well as other methods such as phone calls. The document is found on the DHS eDocs site by clicking here and searching for 5841. All communication is documented in the member’s case notes.

A listing of county contacts, as well as county managed care advocate at each county is located on the DHS website.
Member Transfers

When members transfer between CCs (change of care system, member relocated, etc.), the exchange of the transfer paperwork is not only a requirement, but is important to the receiving CC. It allows them to continue the work done by the previous CC without always requiring the member to go through the assessment and care planning process again.

**With all transfer requests** transfer paperwork must accompany the request. At a minimum this includes:

- The DHS-6037 *Home and Community-Based Services Case Management Transfer Form*. The document is found on the DHS eDocs site by clicking [here](#) and searching for 6037.
- A copy of the current assessment
- A copy of the current care plan.

**Note:** The only exception to this is if the member is a missing member or has refused an assessment, the minimum amount of information we require are notes related to your attempts to reach or engage the member.

If there are additional documents you are still completing and plan to send at a later date, indicate that with the transfer request so the receiving CC knows when to expect it. Once Medica has confirmed the transfer, the transfer documents are to be sent directly the receiving care coordination entity. For further details, see the Member Transfer Responsibilities Policy.

The Member Transfer Responsibilities policy is found on the Medica Care Coordinator site under Policies and Guidelines → Policies.

**Minnesota Senior Health Options (MSHO)/Minnesota Senior Care Plus (MSC+) Transfer Member Health Risk Assessment**

Completion of the Minnesota Senior Health Options (MSHO)/Minnesota Senior Care Plus (MSC+) Transfer Member Health Risk Assessment meets the requirements for a Health Risk Assessment (HRA) and a supplement to the existing care plan for members with a product change who have had a Health Risk Assessment (HRA) within the past 365 days. This form is completed within 30 days of transfer for MSHO and MSC+ members. It must be attached to the most recent Health Risk Assessment and Care Plan. A new Health Risk Assessment and Care Plan must be completed if there is not an assessment completed within the previous 365 days or if CC is unable to obtain a copy of the Health Risk Assessment or care plan to review and update. Please refer to Assessment Schedule Policy for details.
Medica offers a Disease Management Program for members per our contract with DHS. CCs help support members in the following ways:

- Refer to leading organizations materials when providing education to members such as American Cancer Society, National Alliance of Mental Illness (NAMI), etc.
- Refer to websites such as Medline Plus, Center for Disease Control (CDC), etc.
- Refer to materials on the Medica Care Coordinator site under Tools and Forms → Evidenced-Based Medicine.
- Record all disease management intervention and education on the member’s care plan.

Medica has a disease management program for the following conditions:

- Asthma
- Diabetes
- Cardiac

Members with these above diagnoses are identified for the program via a predictive modeling identification process and are contacted by Medica to be part of the disease management program. Members in the program can receive resources for their condition; an online “digital coaching” program or telephonic disease management with a nurse based on their risk factors and severity of their illness.

CCs can also refer members to the Disease Management program and the Tobacco Cessation program at Medica by completing the Health Support Referral Form found on the Medica Care Coordinator site under Tools and Forms.
Following is an incomplete list of benefits. CCs use these formal benefits when developing the plan of care for a member in addition to informal and quasi-formal services. MSHO members have access to supplemental benefits through Medica that may change each calendar year. To learn more about these supplemental benefits see the *MSHO Supplemental Benefits* document found on the Medica Care Coordinator site Policies and Guidelines → Benefits Guidelines.

See the following for detailed information regarding benefits:

- MSHO Member Handbook
- MSC+ Member Handbook
- DHS MHCP & CBSM manuals

Reminder: For MSHO and MSC+, the waiver is the payer of last resort, and the CC is responsible for seeking out informal services and supports prior to accessing waivered services.

CCs cannot authorize an out of network provider. Request to use an out of network provider is submitted by a provider and reviewed by Medica Utilization Management (UM). UM will make a determination and will notify the provider. Additional information can be found on Medica.com. Providers should always be referred to Medica Provider Service Center (PSC) if they have questions.

Please note, if a member is a new member with Medica and currently receiving services from an out of network provider, the member can continue to receive services from that provider for up to 120 days. Providers can contact PSC or the member or CC can contact Medica Customer Service to speak with someone about this. The member will need to transition to an in network provider within 120 days unless otherwise approved by Medica UM.

**Medical services**

- MSHO members are entitled to all services covered under Medicare, Medical Assistance and Elderly Waiver (if eligible for and open to EW).

- MSC+ members who do not have Medicare; Medica is the only payer.

- MSC+ members who have Medicare; Medicare is the primary payer; Medica will coordinate benefits (referred to coordination of benefits or COB) with Medicare.

- The role of the CC is not to make medical determinations. The CC often times will receive requests for approval of medical services. Providers are to call Medica Provider Service for verification of benefits and
to inquire whether prior authorizations through care management are required. Care systems may choose to direct members to in-network care. Refer to the provider search tool.

Medica has a list of procedures which require prior authorization in order to pay claims. Medica’s Health Services department reviews these requests.

**Dental services**

- MSHO and MSC+ follow the Medical Assistance benefit.
- Medica uses Delta Dental of Minnesota’s Minnesota Select Dental network. Medica uses Delta Dental to manage the dental benefit and dental network.
- If a member is requesting a dental procedure or item outside of the dental benefit set, CC’s are to refer members to Delta Dental customer service for this request.
- If the CC is unable to locate a participating dental provider Delta Dental assists in the process. Delta Dental has a phone number specifically for CCs to use to find dental care for their members.

These number are for CCs only and must not be shared with members: 651-994-5198 or 866-303-8138.

**Elderly Waiver (EW) Services**

- MSHO and MSC+ use the same list of EW services and criteria for eligibility provided by traditional EW. See DHS MHCP Manual for list of EW services.
- See the complete listing of what requires a referral on Medica.com Claims Referral Guidelines for MSC+, MSHO and SNBC
- All recipients receiving EW services must first access Medical Assistance (MA) home care services to the highest extent before adding Elderly Waiver (EW) services to the community support plan. If a member’s assessment indicates personal care needs that can be met by an MA home care services such as Personal Care Assistance (PCA) or Home Health Aide (HHA), the CC is responsible for the approval and provision of the home care service. For member’s eligible/open to the Elderly waiver, the addition of an EW service, such as homemaking, can be added when the MA home care service does not meet all the member’s assessed needs or the member does not qualify for the MA home care service. The EW service is not to replace a home care service that the member is eligible to receive.
- Elderly Waiver service providers registered with DHS can be found by searching under “waiver providers” on www.Mnhelp.info
Home care services - state plan services

- MSHO and MSC+ include all state plan homecare services. **Services must be obtained through a Medica contracted provider.** All services are coordinated with the agency.

- Home health aide (HHA), extended home health aide, home care nursing (HCN – formerly private duty nursing or PDN), and PCA services require a referral in our system.

- Always refer to the Medica.com CC site for the current list of what requires a referral in our system.

Interpreter services

- MSHO and MSC+ members are eligible for sign and spoken language interpreter services that assist the member in obtaining covered medical services. The health plan is not required to provide an interpreter for activities of daily living (ADL’s) in residential facilities, or that are related to waivered or non-medical services.

- Medica has contracted providers for interpreter services and the use of non-par vendors is not permitted.

- Telephonic translation services are available for CC’s to use when contacting members who speak a different language. TransPerfect is the vendor resource used for telephonic translation services. **CCs can obtain the access details via the Clinical Liaison.** See the Other Resources for Care Coordinators section of this document for contact information.

Mental/behavioral health and substance use disorder treatment

Medica uses the Medica Behavioral Health (MBH) network. Mental Health Providers contact MBH directly for authorizations.

- MBH assigns a “care advocate” to all inpatient mental health stays. Please contact MBH to coordinate care planning efforts.

- The CC coordinates with county mental health providers for those services provided through the county.

- MBH is available for case consultation by contacting MBH customer service and speaking with a care advocate at 1-800-848-8327

**NurseLine by HealthAdvocate℠**
Our member’s health care needs do not always follow regular business hours so NurseLine by HealthAdvocate is an easy-to-use phone service staffed by registered nurses twenty-four (24) hours per day, seven (7) days per week. NurseLine by HealthAdvocate offers valuable health information resources that can help our members get the medical care they need quickly. With one call, the nurses can instruct the members on the care of minor illnesses and injuries at home, as well as help them find a doctor near their home.

Medica 24 hour nurse line: 1-866-715-0915, TTY (711).

**Nursing facility Services for MSHO and MSC+**

- **MSHO:** Medica is responsible for paying a total of 180 days of nursing home room and board. If the member requires continued nursing home care beyond the 180 days, the Minnesota Department of Human Services (DHS) will pay directly for the care. Upon enrollment, if DHS is currently paying for the member’s care in the nursing home, DHS, not the health plan, will continue to pay for the care. No prior hospital stay is required. Facilities are responsible to contact Medica related to admissions.

- **MSC+:** Medica is responsible for paying a total of 180 days of nursing home room and board. If the member needs continued nursing home care beyond the 180 days, the Minnesota Department of Human Services (DHS) will pay directly for the care. Upon enrollment, if DHS is currently paying for the member’s care in the nursing home, DHS, not the health plan, will continue to pay for the care. Facilities are responsible to contact Medica related to admissions.

**Personal Care Assistance for MSHO and MSC+**

The CC is responsible to complete the PCA assessment using the DHS 3428D Supplemental Waiver PCA Assessment and Service Plan. The document is found on the DHS eDocs site by clicking here and searching for 3428D. The PCA assessment is a supplement to the HRA, and must be completed along with the LTCC assessment.

Medica requires that all CCs view the DHS Legacy PCA training video series. Contact the Clinical Liaison for information on how to access this training. See the Other Resources for Care Coordinators section of this document for contact information.

PCA requires an authorization in Medica’s system. Authorizations may not exceed 365 days in length. PCA assessments are completed at least annually.

If an MSHO or MSC+ members is new to Medica and is already receiving PCA services, Medica will honor the current authorization and no new PCA assessment is required. The CC may need to complete more than one HRA in the first year in order to align the LTCC/HRA with the PCA assessment. See Assessment Schedule Policy MSHO/MSC+ for more information on this topic.

PCA reassessments are to be completed annually and with change of condition/supports.
If a member new to Medica already receiving PCA services from a provider that is not in the Medica network, Medica will authorize PCA services with that out-of-network provider for up to 120 days. In that time the CC must work with the member to find an in-network PCA provider. The CC will complete the Referral Request Form, indicating on the form that services are being received temporarily from an out of network provider. The Referral Request Form can be found on the Medica Care Coordinator site under Tools and Forms.

Following a PCA reassessment, if there is a denial, termination, or reduction (DTR) related to a service change the CC must follow DTR process. The DTR Form and Instructions are found on the Medica Care Coordinator site under Tools and Forms.

Please note PCA assessments must be completed in conjunction with the DHS 3428 by all CCs.

**Pharmacy services**

Please refer to the Member Handbooks for detailed pharmacy information:

- **MSHO Member Handbook**
- **MSC+ Member Handbook**
  - MSHO includes Medicare Part D pharmacy coverage. MSHO also covers medications under Medical Assistance, such as over-the-counter medications with a prescription.
  - MSC+ includes medications covered under Medical Assistance including over-the-counter medications.
    - If an MSC+ member does not have Medicare, Medica pays for all covered medications.
  - Helpful information about the pharmacy benefit, list of covered drugs (formularies), and covered pharmacies are available on Medica.com, under each specific product page.
    - MSHO Pharmacies and Prescriptions
    - MSC+ Pharmacies and Prescriptions
  - Medications must be obtained at a Medica contracted pharmacy.
  - Members can download the CVS app to help manage their medications (see Medica.com for more information).
  - Medica customer service can be very helpful in terms of pharmacy questions for members and/or CCs.
• Co-pays for prescriptions:
  o Members who have Medicare and reside in the community (MSHO and MSC+) have co-pays for their Part D medications.
  o MSHO members do not have co-pays for over the counter (OTC) medications.
  o MSC+ members may be charged a low co-pay for OTC’s.
  o When the member has been changed to an institutional living setting in the county system the co-pays will stop.
  o Members in nursing facilities for short stays will continue to have Part D co-pays.

Medication Overrides and Prior Authorizations

Occasionally a member requires a medication that is not on the formulary or a dosage that requires prior authorization.

Medication overrides

• The best option is to have the pharmacist contact the Pharmacy Help Desk to request an override on the member’s behalf. The pharmacist will work directly with the prescribing healthcare provider to gather needed information.

• The member may call Medica Customer Service to request an override.

Prior Authorizations

• The best option is to have the member’s healthcare provider submit a prior authorization request using the provider resources on medica.com or contact the CVS Pharmacy Help Desk.

• Members may contact Medica Customer Service to have a Health Plan Specialist complete a prior authorization on the member’s behalf.

Residential Services

Residential services are a service covered under MSHO and MSC+ for members on the Elderly Waiver. DHS has created a Residential Services (RS) rate tool which is used to determine a monthly rate based on the member’s needs for members in Customized Living settings and in Adult Foster Care.

All RS completed rate tools must be uploaded to DHS within thirty (30) days of their completion through the MN-ITS system. Each contracted care coordination entity is responsible to do this.
function. Medica receives reports from DHS which show the numbers of uploads for each entity. If you are having trouble with this upload process, please refer to the MMIS upload guide put out by DHS or contact the DHS helpdesk.

CCs are strongly encouraged to stay current to all residential services related issues by attending DHS videoconferences as able. Always use the most current tool by accessing it from the DHS website.

**Tobacco Cessation**

SNBC SNP and SNBC members can self-refer to the Medica Tobacco Cessation program by calling Medica, or a referral can be made by the Care Coordinator using the *Health Support Referral Form* which can be found on the [Medica Care Coordinator](#) site under *Tools and Forms*.

**Transportation**

If a member does not have access to their own transportation, Medica Provide-A-Ride℠ helps schedule transportation to and from covered health care visits. More information regarding transportation is found on the [Medica Care Coordinator](#) site under *Tools and Forms → Provide-A-Ride*.

If a member has access to a working vehicle and use that vehicle for medical appointments; refer members to their county of residence to seek mileage reimbursement.

Provide-A-Ride also arranges non-medical transportation authorized through a member’s Elderly Wavier plan.

**Vision care services**

- Medica follows the Medical Assistance restrictions for selection of eyeglasses.
- A member can choose their eyeglass frames from the catalogs provided on Medica.com under the MSHO or MSC+ product page:
  - [MSHO Benefits and Coverage](#)
  - [MSC+ Benefits and Coverage](#)
- Members must be seen at a contracted provider:
  - [MSHO Physicians and Facilities](#)
  - [MSC+ Physicians and Facilities](#)
- Refer to the Member Handbooks for more detailed benefit information
- MSHO Member Handbook
- MSC+ Member Handbook
The Benefit Exception Inquiry process is a way for CCs to ask Medica if a member can receive something outside of the benefit set.

- The CC may be asked by a member to authorize benefits outside the standard benefit set. CCs make these requests using the Benefit Exception Inquiry (BEI) form found on the Medica Care Coordinator site under Tools and Forms.
  
  o Supportive documentation of the need must be submitted with the form.
  
  o BEI forms are reviewed, and the CC is informed of the decision.
  
  o Depending on the determination, a referral may be entered, or the CC may need to follow the Denial, Termination, and Reduction (DTR) process

- When sending in multiple BEI’s be sure to send them separately. This allows the operations staff to easily identify them and process them accordingly.

- Include the cost of the item or service that you are requesting.

- On the BEI form, there is a section for the member’s PCP information, as well as service provider information. “Service Provider” is the provider of the item or service you are requesting; note whether they are in network or out of network providers with Medica.

To begin the BEI process, the CC submits the BEI form as soon as possible after the member has made the inquiry. BEI’s have a fourteen (14) day turn-around time once received.

- **Approvals:** After the inquiry is reviewed and if it has been approved, a Medica staff person enters a referral and alerts the CC. The member and service provider will receive an approval letter.

  **Note:** it is very important that the CC documents on the form the provider of the item/service so an accurate referral is entered.

- **Denials:** If the inquiry is denied, the CC is informed of the decision and directed to talk with the member about the inquiry denial. If the member is satisfied with the action taken, the CC documents that contact in the member’s chart. If the member is not satisfied with the denial, the CC completes the DTR form immediately and submits it to Medica. The date on the DTR form is the date the CC communicated the inquiry decision to the member.

If an item has been approved through BEI, and the member continues to have the need past the approval timeline it is the CC’s responsibility to submit the new/updated BEI request prior to the end of the current authorization.
E.g. If nutritional supplements are approved through the BEI for 1/1/YYYY-6/30/YYYY, the CC submits a new BEI with updates to justify the continued use past 6/30/YYYY. This may mean submitting additional supporting information such as notes from the members PCP, a dietician, OT/PT evaluation, etc.

Note: Requests for care with an out-of-network provider are not processed through a BEI. Those requests must be submitted to Medica Utilization Management by an in-network referring provider. Documentation of the medical necessity is required. The form that the provider would complete can be found on medica.com.
Denial, Termination, or Reduction (DTR)

Medica’s DTR policy is found on the Medica Care Coordinator site under Policies and Guidelines. If a service is being denied (based on lack of need), terminated (based on member’s request or other reason) or reduced (based on member’s request or other reason) a CC must complete a DTR form found on the Medica Care Coordinator site under Tools and Forms.

Medica reviews, and assigns a date which the denial, termination or reduction is effective. The CC is alerted to the final decision. This process takes the CC out of the position to make the final decision, and leaves the final decision with Medica, helping the CC to maintain the positive relationship with the member. DTR’s and the timelines around them are a contract requirement by DHS.
Benefit guidelines:

Medica has created benefit guidelines to help guide CCs in service planning. These are found on the Medica Care Coordinator site under Policies and Guidelines → Benefit Guidelines.

Impact report/enhanced care coordination (ECC):

This report stratifies membership into four care levels: 1, 2, 3, or 4. The care levels are based off a variety of factors such as utilization, overall claims costs, number of chronic conditions, and overall risk. The purpose of this report is for CCs to gain a clearer clinical picture of their members, their utilization, and risk factors.

The report also includes a grid with recommended care coordination activities for members in each care level. This does not change what a CC must do, but rather points to resources and recommendations for best practices of managing at risk members in order to decrease unnecessary hospitalizations and improve quality of care.

CC Leave-behind document:

This is required to be given to the member annually. This Medica Care Coordinator Leave-Behind Document is found on the Medica Care Coordinator site under Tools and Forms.

Medica Member Product Page:

The member webpage is a helpful resource to see what your members can see about the benefits and services available to them under their coverage and offers easy access to many member facing materials.

- MSHO Benefits and Coverage
- MSC+ Benefits and Coverage

Medica Care Coordinator website:

The Medica Care Coordinator website (medica.com/care-coordination) is the main hub where most all care coordination resources can be found.

- Letter Templates - Prepared letters to correspond with Medica members and primary care providers. These are the letters that are to be used for member correspondence as they have gone through the appropriate approval process.
• News - Care Coordination Monthly Communications are found here which provide CC’s with updates on policies, process and forms etc.

• Performance Improvement, Transition Care & Evidenced-Based Medicine - CC toolkits, fliers, and other information related to current performance improvement projects as well as transitions process details.

• Policies and Guidelines - This section has current policies, procedures and guidelines that guide care coordination activities and operations.

• Tools and Forms - Commonly used tools and forms for use in day-to-day work including assessments, care plans, contact information, health improvement, program flyers, and much more.

• Training Materials - The Medica Care Coordinator Training Manuals are provided to assist you with your job duties. The training manuals describe the CC role and responsibilities, member classifications, provision of services, and benefit guidelines.

When and Where to Get Care:

This helpful member resource can be reviewed and left with members to help them understand the different levels of care available to them. This is an especially helpful resource for members who may be frequenting the emergency room for non-emergent conditions. This can be found on the Medica Care Coordinator site under Tools and Forms → Performance Improvement.

Medica Clinical Liaison:

Medica has a Clinical Liaison devoted to assisting our CCs by developing trainings, communicating updates, and offering support.

• The Medica Clinical Liaison facilitates trainings to CCs in a variety of areas including but not limited to:
  
  o New processes
  
  o DHS policy changes
  
  o Form updates
  
  o Use of reports
  
  o Working collaboratively with county/tribes
  
  o Use and referral process for home care and mental health services covered by Medica
  
  o Relevant linkages to Fee for Service (FFS)
• Medica has clinical consultation services available to identify the health care needs of the member and
develop a care plan that appropriately addresses the individual’s health care needs. This is met and/or
coordinated through our Medica Clinical Liaisons who are available to all CCs

• The Medica Clinical Liaison reaches out to assigned CCs related to member inquiries, service plans, etc.

• CCs can reach out to the Medica Clinical Liaison via phone or via email

• Special training requests or training topic requests can be sent to the Clinical Liaison

**Restricted Recipient Program:**

The Restricted Recipient Program (RRP) is for members who have been determined by Medica, or a previous
health plan to have received or is still receiving prescription drugs in a quantity or manner that might be
harmful to their health. Members who only have Medical Assistance and not a primary insurance such as
Medicare, are eligible for RRP. Members in the RRP program are restricted to using only one in-network
physician to prescribe all of their medications at one in-network pharmacy. The members remain on this
program for 24 months, where they are reevaluated to determine if they are eligible to be released from the
program.

Each member in the RRP is assigned a nurse from the Medica Special Investigative Unit (SIU). The member is
given the nurse’s first name and contact information. The CC redirects members with questions about the RRP
to their assigned SIU nurse at Medica. A CC can see the member’s assigned PCP and pharmacy by looking up
the member in MN-ITS. If a CC wants to locate a member’s RRP nurse call 1-888-906-0970.

Additional information on the RRP and referrals is found on Medica.com and the Provider Administrative
Manual.
## Resources:

### Medica Care Coordinated Products Member Services

<table>
<thead>
<tr>
<th>Service</th>
<th>MSHO</th>
<th>MSC+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toll free</td>
<td>8 a.m. to 8 p.m. Central, seven days a week. Access to a representative is limited evenings, weekends and holidays during certain times of the year.</td>
<td>8 a.m. to 8 p.m. Central, Monday-Thursday 9 a.m. to 8 p.m. Central, Friday</td>
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</table>

### Provide-A-Ride and Interpreter Services

<table>
<thead>
<tr>
<th>Service</th>
<th>MSHO</th>
<th>MSC+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toll free</td>
<td>8 a.m. to 8 p.m. Central, seven days a week. Access to a representative is limited evenings, weekends and holidays during certain times of the year.</td>
<td>8 a.m. to 6 p.m. Central, Monday-Thursday 9 a.m. to 6 p.m. Central, Friday</td>
</tr>
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</table>

### Medica Behavioral Health

<table>
<thead>
<tr>
<th>Service</th>
<th>Toll free: 800-848-8327 (TTY: 711) 8 a.m. to 5 p.m. Central, Monday-Friday</th>
<th>Behavioral health crisis services 24 hours a day, seven days a week</th>
</tr>
</thead>
</table>

### Delta Dental

- **Member Services**
  
  Toll free: 800-459-8574 (TTY: 711) 7 a.m. to 7 p.m. Central, Monday-Friday

- **Care Coordinators only**
  
  Toll free: 866-303-8138 (TTY: 711) 8 a.m. to 4:30 p.m. Central, Monday-Friday

### Member Pages

- **DUAL Solution**: medica.com/dual
- **MSC+**: medica.com/msc
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Contact Information</th>
<th>Operating Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HealthAdvocate Services</strong></td>
<td></td>
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<tr>
<td>NurseLine by Health Advocate</td>
<td>Toll free: 866-715-0915 (TTY: 711)</td>
<td>24 hours a day, seven days a week</td>
</tr>
<tr>
<td>Personal HealthAdvocate</td>
<td>Toll free: 866-715-0915 (TTY: 711)</td>
<td>24 hours a day, seven days a week</td>
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<tr>
<td><a href="http://healthadvocate.com/medicaid">healthadvocate.com/medicaid</a></td>
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<tr>
<td><strong>Care Coordination Support (Clinical Liaison)</strong></td>
<td>Toll free: 888-906-0971 (TTY: 711)</td>
<td></td>
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<td></td>
<td>Email: <a href="mailto:MedicaCCsupport@medica.com">MedicaCCsupport@medica.com</a></td>
<td></td>
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<tr>
<td><strong>Care Coordination website</strong></td>
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<tr>
<td></td>
<td><a href="http://medica.com/care-coordination">medica.com/care-coordination</a></td>
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<tr>
<td><strong>SilverSneakers</strong></td>
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<tr>
<td>MSHO only</td>
<td>Toll Free: 1-877-871-7053 (TTY: 711)</td>
<td>7 a.m. to 7 p.m. Central, Monday-Friday</td>
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<tr>
<td></td>
<td><a href="http://SilverSneakers.com">SilverSneakers.com</a></td>
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<td><strong>Medline Plus</strong></td>
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<td><a href="http://medlineplus.gov">medlineplus.gov</a></td>
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<td><strong>Tobacco Cessation Program</strong></td>
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<td></td>
<td>Toll free: 866-905-7430 (TTY: 711)</td>
<td>8 a.m. to 5 p.m. Central, Monday-Friday</td>
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<tr>
<td><strong>Transplant Program</strong></td>
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<tr>
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<td>Toll free: 888-906-0958 (TTY: 711)</td>
<td>8 a.m. to 5 p.m. Central, Monday-Friday</td>
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<td></td>
<td>Email: <a href="mailto:caresupport@medica.com">caresupport@medica.com</a></td>
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<tr>
<td><strong>Restricted Recipient Program</strong></td>
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<tr>
<td></td>
<td>Toll free: 888-906-0970 (TTY: 711)</td>
<td>8 a.m. to 5 p.m. Central, Monday-Friday</td>
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