Policy Title:	**Assessment Schedule SNBC/I-SNBC**
Department:	**Markets Growth & Retention**
Business Unit:	**Medicaid and Special Needs Plan**
Approved By:	**Director, Medicaid & SNP Member Solutions and Innovations**
Approved Date:	**4/22/2013**
Original Effective Date:	**5/1/2013**
Review Date(s) (no changes	
Revision Dates:	**12/23/2015, 12/12/2016, 3/23/2017, 11/10/2017, 1/22/2018, 12/13/2018, 6/5/2019, 11/14/2019, 3/11/2020, 9/8/2020, 1/4/2021, 3/29/2021, 12/13/2021, 8/8/2022, 12/1/2023**

PRODUCTS AFFECTED

- Special Needs BasicCare (SNBC) – Medica AccessAbility Solution®
- Integrated Special Needs BasicCare (I-SNBC) – Medica AccessAbility Solution Enhanced®

DEFINITIONS

Care Coordinator (CC): A person who assesses the member, creates a person centered care plan/support plan, and then coordinates the provision of services and supports for those members among different health and social services professionals and across settings of care.

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), independent activities of daily living (IADL's), or other supports may indicate the change in condition. 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. It is up to the professional judgment of the CC to determine if a change in member condition merits a reassessment.

CMS: Centers for Medicare and Medicaid Services under the U.S. Department of Health and Human Services

DHS: Minnesota Department of Human Services

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. Future end dates only apply to I-SNBC members who meet criteria.

HRA and Assessment Tool for SNBC/I-SNBC
Medica owned tools can be found on the Medica Care Coordination Hub under Tools and Forms. All Legacy tools can be found the DHS Edocs site.

- DHS form 3426 OBRA Level I Criteria – Screening for Developmental Disabilities or Mental Illness (OBRA)- if using Legacy tools. This is built into the MnCHOICES assessments.
- DHS form 3428H Health Risk Assessment/MnCHOICES HRA- used for all SNBC members regardless of product, waiver status, or living setting.
- Medica Transfer Member Health Risk Assessment/MnCHOICES Transitional HRA- used for SNBC/I-SNBC members that have transferred to Medica or transferred between SNBC and I-SNBC and have had a 3428H assessment/MnCHOICES HRA within the past 365 days. Can only be used if CC is able to obtain a copy of the full assessment previously completed with the member. This does NOT represent a full assessment. At this time, you must complete both the Medica Transfer Member Health Risk Assessment & the MnCHOICES Transitional HRA for all transfers

In-Person Assessment- An assessment conducted in-person with the member or member's legal representative. The in-person assessment could be conducted in the person's residence or other setting. For purposes of this definition "assessment" includes both legacy and MnCHOICES forms (e.g., MnCHOICES Assessment, MnCHOICES HRA, LTCC and DHS 3428H).

MMIS: Medicaid Management Information System. A complex, highly integrated claims payment, information management, and retrieval system implemented by the State of Minnesota Department of Human Services to manage Medicaid enrollee data.

MnCHOICES: A single, comprehensive, web-based application that integrates assessment and support planning.

Remote Assessment- Assessment conducted by HIPAA secure interactive video or telephone in place of an in-person assessment. For purposes of this definition "assessment" includes both legacy and MnCHOICES forms (e.g., MnCHOICES Assessment, MnCHOICES HRA, LTCC and DHS 3428H). As outlined in this policy, for certain members, a Remote Assessment must be completed via HIPAA Secure interactive video; for others, a Remote Assessment may be completed via HIPAA Secure interactive video or telephone.

Screening Document Type "H": All Health Risk Assessments that were completed using Legacy tools regardless of product, waiver status, or living setting will need to be entered in MMIS as a screening document type "H". This also includes members who have refused an HRA or are unable to be located.

SNBC/I-SNBC Community: SNBC/I-SNBC member who is residing in a community living arrangement or may be experiencing a short term rehabilitation stay.

SNBC/I-SNBC Institutional: SNBC/I-SNBC member who is permanently residing in a nursing facility or

identified institutional living setting. Members considered to be "institutional" are shown on the full enrollment report to be in DHS designated living settings 41 and 43.

Transfer/Transitional Member: A member that has transferred/transitioned from another Managed Care Organization to Medica for Care Coordination; has changed from one Medica product to another (i.e.: SNBC to I-SNBC or I-SNBC to SNBC) or has changed from one Medica Care Coordination Delegate to another Medica Care Coordination Delegate.

PURPOSE
To ensure all Medica members are assessed in a timely manner using the appropriate tools & mode in accordance with the DHS, CMS, and Medica requirements.

POLICY
Counties, Agencies, Care Systems, and internal Medica staff that provide services for Medica members must complete assessments and reassessments with members in accordance with the DHS, CMS, and Medica requirements. Assessments and reassessment timeliness will be audited items as part of the care plan audit.

HRA REQUIRED
Care Coordinators must offer all SNBC/I-SNBC members an in-person HRA upon enrollment with Medica, and at least annually (within 365 calendar days) thereafter. If a member declines to complete an in-person assessment, a remote assessment may be completed via HIPAA secure interactive video or telephone in certain circumstances, as detailed in Initial & Annual Assessment Guide at the end of this policy. The following member types are <u>required</u> to have in-person assessment and do not have a remote assessment option available:

- SNBC/I-SNBC Institutional: Both initial and annual HRAs must be in-person.
- All members that request an in-person HRA

See the Initial & Annual Assessment Guide at the end of this policy and the Remote Assessment Policy for additional detail regarding remote assessments. If a member declines/refuses a required in-person or remote (when allowed) HRA, proceed with the Refusal process.

If the CC determines a member's needs have changed, they will use their professional judgment to determine if the support plan can be updated or if a full reassessment is necessary. If it is determined the member requires a full reassessment, the CC will refer to the Initial & Annual Assessment Guide to determine the mode of assessment (in-person or remote) that is required. Transfer/Transitional HRA's can be completed via remote interview with the member.

MEMBERS WHO LOSE ELIGIBILITY
Care Coordinators are required to support members in understanding why they have had a loss in Medicaid eligibility and assist them in re-establishing their eligibility, if possible. It is important to note the reason for the member's loss of eligibility. The reason for the loss of eligibility is found on the full enrollment report provided by Medica each month. The CC needs to determine if the enrollment report states "eligibility", "spenddown", or "other".

For all members who lose eligibility**"** but are due for an annual reassessment within 90 days of their Medical Assistance (MA) term, per DHS and CMS guidance, CCs are to complete the HRA by the due

date. If the member is reinstated without a lapse in coverage, this HRA can then be entered into Medicaid Management Information System (MMIS)/MnCHOICES using the appropriate activity date.

If a member loses eligibility but is reinstated and there is no lapse in coverage with Medica, a new HRA does not need to be completed provided the CC has maintained regular scheduled contact with the member, the HRA and Care/Support Plan is current, and there has been no change of condition or a change in the supports identified or requested. A new HRA would need to be completed if there was a change in condition or change in the supports identified or requested during that time. Documentation in case notes should include notes on efforts made to assist the member with eligibility issues.

For I-SNBC members who lose their MA eligibility, most will remain on the program for 90 days. This future term date is called the future end date. During this time, all care coordination requirements remain in place to include any HRAs due. Also, during this time, the CC is to be assisting the member and the county related to the member's MA paperwork. CCs are to refer to their Full Enrollment report to identify if they have members with a future end date as they are to offer assistance with the Medicaid renewal process.

PROCEDURE:

1. The County, Agency, Care System or internal Medica staff must contact new members via phone or approved letter within 10 business days of enrollment to inform the member of the CC and provide contact information. Best practice is to set up an initial assessment during the introductory call.

2. The initial assessment for SNBC/I-SNBC members must be conducted within 60 calendar days of enrollment.

3. If the member requests a deferment or if the assessment does not take place within 60 calendar days, the CC must document all attempts to offer/schedule the HRA and document why it was not completed timely. At a minimum there must be documentation of at least three phone call attempts to reach the member and a follow-up letter or documentation that the member explicitly declined to participate in the HRA.
    i. If the CC cannot schedule an assessment, a refusal/unable to find screening document type "H" should be entered in MMIS if using Legacy documents or an UTR/Ref HRA should be completed in MnCHOICES to record the date of last outreach attempt or refusal conversation within 60 days of enrollment.
    ii. When the CC is able to complete an assessment, MMIS/MnCHOICES should be updated.

4. The CC will complete the appropriate MMIS/MnCHOICES entry following all HRAs .

5. Upon completion of the required HRA, the CC will set up a follow-up contact schedule with the member.

    a. Follow up frequency and purpose will be noted on the care plan/support plan. Follow up frequency for each member is based on the professional judgement of the CC and is drawn from the members HRA and identified needs, concerns and These are the minimum required contacts.
    b. CCs should consider the member's care level on Medica's Enhanced Care

Coordination/Impact report when setting the contact schedule. These are the minimum required contacts:

i. SNBC/I-SNBC Community Members
    1. Refer to Initial & Annual Assessment Guide at the end of the policy
    2. Minimum contact every 6 months (additional contacts per CC judgement and identified member needs)
    3. Contacts related to member transitions
    4. Annual & PRN contact with county case managers, if a member is on another waiver

ii. SNBC/I-SNBC Institutional Members
    1. Refer to Initial & Annual Assessment Guide at the end of the policy
    2. Minimum contact every 6 months (additional contacts per CC judgement and identified member needs)
    3. Contacts related to member transitions
    4. Annual & PRN contact with county case managers, if a member is on another waiver

6. Annual reassessments must be completed within 365 calendar days of the previous HRA. If the member requests a deferment refer to the unable to reach refusal process under initial assessment instructions.

7. Refer to grids at the end of this policy for additional information regarding enrollment scenarios, required mode of assessment and care coordination actions to be completed.

MMIS ENTRY PROCESS (Required if completing assessment using Legacy tools, not required if completing assessment in MnCHOICES unless noted otherwise)

All entries are to be completed in H Screen.

Activity Type 01: Telephone Screen

- For use with initial and reassessment Health Risk Assessments conducted by telephone, Assessment Result 35. Program Type 28.
- For use with nursing facility admission. MCO staff complete the Pre-Admission Screening (PAS) process using DHS 3427T

Activity type 02: Face to Face Assessment

- For use with initial and reassessment Health Risk Assessments conducted through an in-person visit, Assessment Results 35. Program Type 28.
- For members residing in a nursing home,
    - Current Living Arrangement 04 – living in a congregate setting
    - Current Housing Type 02 – institution ICF/DD, or 11 Institution NF/certified boarding care

Activity Type 05: Document Change

- For use when showing a change in Care Coordinator, Care Coordination Delegate or Managed Care Organization (MCO)
    - a member that has been internally transferred and assigned to a new Care

Coordinator assigned within the same Care System, County, or Agency or to a new Medica Delegate without a change in product.

- a member that has been transferred and assigned to Medica as a new MCO

- Activity Date can be the same as the assessment result date
- Assessment Result is 98
- Health Plan: MED
- Assessment team: 02
- Program Type 28

Activity Type 06: Reassessment

- Does not apply to SNBC/I-SNBC, do not use. See Activity types 01, 02, 05 or 07.

Activity Type 07: Case Management/Administrative Activity

- For use when a HRA was not successful due to the member declining to complete Assessment Result is 39. Program Type 28.
- For use when a HRA was not successful due to the member not being located. Assessment Result is 50. Program Type 28.
- For use when a review of the last HRA occurred with the member due to a change in products (SNBC to I-SNBC or I-SNBC to SNBC). Activity date: date CC completes review. Assessment result 51. The Effective Date filed must match the Effective Date of the last Assessment Result 35 and not be more than 366 days from the current date. Program Type 28.

Scenario	Action
Newly enrolled in Managed Care Organization (No previous Care Coordinator) **OR** **Transfer (External, Internal)**-No current assessment (Member not assessed within the last 365 calendar days), **OR** unable to obtain required transfer documents for review, **OR** inconsistent documentation as listed below: • Health Risk Assessment not aligned with member needs • Collaborative Care Plan/Support Plan/CSP/CSSP goals and interventions not consistent with HRA review.	▪ **Send member Welcome letter OR contact member,** introduce self and provide updated CC contact information. If contact is other than a Welcome letter, this must be documented in member's file in case notes. ▪ **Complete new assessment and paperwork per care coordinator assessment and follow-up activities grid below** ▪ **Update MMIS**- Complete MMIS entry process outlined above for all Legacy documents completed, this may include Assessment Type 1 or Assessment Type 2. MMIS entry is not required for MnCHOICES MCO HRA assessments.

Scenario	Action
External Transfer- Able to obtain current HRA, member signature page, and care/support plan for the transferred member. This includes: ▪ Transfer to Medica from another Managed Care Organization (MCO) ▪ Transfer within Medica from Medica Care System/County/Agency to another Medica Care System/County/Agency **OR** **Change in Product (even if CC did not change)-** Able to obtain current HRA, member signature page, and care/support plan for the transferred member. ▪ SNBC to I-SNBC ▪ I-SNBC to SNBC	▪ **Send member Welcome Letter or contact member,** introduce self and provided updated CC contact information. If contact is other than a Medica Change of CC letter, this must be documented in member's file in case notes**.** ▪ **Review received paperwork,** including but not limited to DHS-6037 ENG Home and Community-Based Service Case Management Transfer Form, copy of current HRA, care plan/support Plan, member signature sheet/support plan signature sheet ▪ **Transfer Health Risk Assessment (HRA)/MnCHOICES Transitional Assessment-** CC will review the previous assessment **with member** and complete the Medica Transfer HRA Form within 60 calendar days of transfer/enrollment. CC will document the review occurred on the Medica Transfer HRA Form, including the date and if there are any updates or changes needed. If working in MnCHOICES, CC must also create a Transitional HRA to document the date of the review of the prior assessment and care/support plan with the member. ▪ If completing a new assessment and support plan because the prior assessment and care/support plan are not available for review or the member had a change of condition, do not create a Transitional HRA in MnCHOICES. Instead, follow the process for completing a new MnCHOICES Assessment or HRA and Support Plan ▪ **Care Plan/Support Plan-** CC will review previous care plan/support plan **with member.** CC will document that review occurred on the Medica Transfer HRA Form, including the date and if there are any updates or changes needed. If updates to the care/support plan are needed, CC will update the health related goals section of the Medica Transfer HRA Form, create a new care plan (if using legacy documents) or revise the current MnCHOICES Support plan, as necessary. ▪ **Member Signature Sheet/Support Plan Signature Sheet-** must be included in the transfer paperwork received or CC should review elements with the member and obtain new signature sheet. ▪ **Update MMIS-** If using Legacy documents, complete Document Change in MMIS, see MMIS Entry Process above. No MMIS entry needed if completing transitional health risk assessment activity in MnCHOICES. For the transfer members with a change in CC there would need to be a 05 document change to update the new CC in MMIS. ▪ **Update Financial Worker, Primary Care Physician, and Wavier Worker-** CC will document date notification of change in CC or that the change in product occurred on Transfer HRA.

Scenario	Action
Internal Transfer- New Care Coordinator assigned <u>within</u> your Care System, County, or Agency- Able to obtain current HRA, member signature sheet or DHS 6791, and Collaborative Care Plan/Support Plan or CSP & CSSP for the transferred member	▪ **Send member Medica Change of CC letter OR contact member**, introduce self and provide updated CC contact information. If contact is other than a Medica Change of CC letter, this must be documented in member's file in case notes. ▪ **Review received paperwork** including but not limited to copy of current HRA, care plan/support Plan, member signature sheet/support plan signature sheet. ▪ Transfer/Transitional HRA is NOT required when internal transfer occurs. CC will review member documents to ensure all documents are current, present, and representative of member's needs. This will be documented in the members case notes. ▪ **Update MMIS**- Complete Document Change in MMIS, see MMIS Entry Process above. CC will need to assign the member to themselves in MnCHOICES prior to accessing or creating health risk assessment. ▪ **Update Financial Worker, Primary Care Physician, and Waiver Worker-** CC will document date notification of change in CC or that change in product occurred in member's file in case notes.
Change of Condition or Change in Living Setting	• Complete new HRA/MnCHOICES HRA and paperwork per care coordinator assessment and follow-up activities grid below

INITIAL AND ANNUAL MODE OF ASSESSMENT GUIDE

Product/Member Type	Initial Assessment	Annual Assessment
SNBC/I-SNBC - Residing in Community	1. Offer/attempt to schedule in-person assessment 2. If member declines to complete an in-person assessment, may complete assessment remotely via HIPAA secure interactive video or telephone 3. CC must document the assessment method, including the member's refusal to complete the assessment in-person, as applicable	1. Offer/attempt to schedule in-person assessment 2. If member declines to complete an in-person assessment, may complete assessment remotely via HIPAA secure interactive video or telephone 3. CC must document the assessment method, including the member's refusal to complete the assessment in-person, as applicable
SNBC/I-SNBC - Residing in Institutional Setting	In-person	In-person

CARE COORDINATION ASSESSMENT & FOLLOW UP ACTIVITIES

CARE COORDINATION TASKS TO BE COMPLETED	**SNBC/I-SNBC (all community & institutional members)**
ASSESSMENT COMPLETION & MMIS/MnCHOICES ENTRY	• Initial, 3428H/MnCHOICES HRA including OBRA Level 1 (if using Legacy Tools) within 60 calendar days of enrollment • For initial assessment Transfer/Transitional HRA process may be used if required documentation present • 3428H/MnCHOICES HRA annually, (within 365 calendar days of prior assessment) • If using 3428H, screening document type "H" in MMIS by last business day of enrollment month or within 30calendar days of completion of HRA or determination of unable to reach/refusal of assessment • UTR, Refusal & Transfer Members: If working in MnCHOICES, create HRA to record appropriate date in the MnCHOICES system. Also, complete Medica Transfer HRA Form (SNBC and I-SNBC) or Medica Unable to Contact/Refusal Care Plan (required for I-SNBC; recommended for SNBC) and upload in MnCHOICES as an attachment.
CARE PLAN/SUPPORT PLAN	• Medica AccessAbility Solution (SNBC)/AccessAbility Solution Enhanced Care Plan/MnCHOICES Support Plan-HRA to be sent within 30 calendar days of assessment • Signed Member Signature Sheet/Support Plan Signature Sheet (must make and document a minimum of two attempts to obtain signature)

MEMBER DOCUMENTS MADE AVAILABLE AFTER ASSESSMENT	• Care Plan/MnCHOICES Support Plan (Sent to member/legal representative & providers with permission of member/legal representative within 30 days of assessment) • MnCHOICES health risk assessment—Managed care organization (HRA—MCO) (upon request) • About Me- My Care Team (upon request) • Care coordination next steps indicator report (upon request) • Medica Leave Behind Document • Medication Disposal Flyer (For I-SNBC in-person visits) • Medica Post Visit Member Letter
FOLLOW-UP	• Annual assessment within 365 calendar days of previous assessment • PCP contact annually, with changes in condition, changes in products, changes in CC, and with transitions • Minimum contact every 6 months (additional contacts per CC judgement and identified member needs) • Follow-up with each notice of transition • Participation in Care Conferences (Institutional) • Contact with waiver case manager annually and with changes in member's needs, if applicable (DHS 5841) • Contact with behavioral health providers with changes in member's behavioral health needs, if applicable

CROSS REFERENCES

DHS SNBC Contract
Instructions for Completing and Entering the Health Risk Assessment into the MMIS for the Special Needs BasicCare (SNBC) Program DHS 5020A
MnCHOICES revision assessment and support plan documents and reports

Rev.12/2023