Medica

June Quarterly Care Coordination Meeting

06/06/2023

9 am to 11 am

Agenda

- Case Management Overview - Erin Hause/Sara Dutton
- MA Renewals, address change process – Becky
- Return to FTF visits, meeting EW eligibility criteria – Becky
- EVV – Becky
- RRF - Becky
- MnCHOICES – Theresa
- Audit element overview/Trends – Jenny
- Reema – Courtney
- Chore service overview and auths/Transitional services (moving) – Joy/Shelley
- Supplemental Benefit Re-Cap – Theresa/Shelley
- SIU Reminder – Joy
- Other Updates - Becky
- Nurses Week – Theresa
- Success Story – Theresa

Medica

Medica Complex Case Management

Erin Hause, Manager, Case Management

Dana Phillips, Supervisor, Case Management

Sara Dutton, Case Manager

Complex Case Management

Medica's Complex Case Management program is an NCQA accredited program that supports members with complex health needs across the healthcare continuum.

Case Management is:

- Conducted telephonically

- A collaborative process that assesses, plans, implements, monitors, and evaluates the care options and services required to meet an individual's health needs

- Episodic in nature, targeting impactable conditions for at risk members

- Focused on specific, measurable health outcomes

Complex Case Management Interventions

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Interventions are focused on helping the member:

- Develop and achieve member identified health goals

- Better understand disease trajectory

- Identify risks and benefits of treatment decisions

- Work towards self-management of conditions and medications

- Foster healthy patient/provider relationships

- Identify and resolve barriers to care

Medica Care Management Framework

Members are identified for programs through a variety of sources including:

- Predictive modeling
- Referrals (vendor, care coordinator, self-referral, provider)

Members are engaged in Case Management programming by Engagement Coordinators

Case Management programs:

- Are **opt-in** programs available to members as a part of their benefit
- Address whole-person health including medical, psychosocial, behavioral, and cultural/spiritual needs
- Identify gaps in care, and establish health goals that align with member values and goals of care

Success Story

Member: 70 yo, female
Referral Source: Predictive Modeling

Primary Concerns:
- Medical- CHF management, ileostomy care
- BH-Anxiety, Panic Attacks, Hoarding Disorder
- SDoH- at risk of losing apartment due to hoarding; city involved

Outcomes:
- Ostomy issues resolved- new bags from supplier
- ARMHS worker set up for assisting with apartment clean-up
- Mental health being addressed and providers in place
- Better understanding of cardiac medications

Highlight: Collaboration amongst Medica CM, Delegate Care Coordinator, and Community Mental Health Provider

Referrals to Care Management

- Internal Medica Care Coordinators submit referral to CM Engagement Specialist WQ through GuidingCare

- Delegate Agency Care Coordinators complete the Care Management Referral Form for Care Coordinators and return by email to CareSupport@medica.com

- For questions or to reach a case manager: 866-905-7430

DHS Updates

MA renewals, EW eligibility, Return to FTF visits, EVV, RRFs and MnCHOICES,

MA Renewals and address change process

MA Renewals (see email dated 5/22/23)

- List of members in first cohort sent out to Cc's.
- CC's or representative from CC organization is being asked to make outreach calls to all members on their list.
- Lists will come out monthly from Medica.
- Beginning for August Cohort-expect to see less members on monthly lists as members who are able to be auto-renewed will be removed from the list. No outreach is needed to these members.
- DHS public facing online look up tool: https://www.mnrenewallookup.com/ This can be used by anyone who has the members "case number" and "member number". This will tell the member what "cohort" or renewal month they are in or if they are able to be auto renewed.
- See email for resource document with important links.

Member address change process (see email dated 5/1/23)

- Only certain people, including Medica Care Coordinators and Medica Customer Service are allowed to complete this form.
- This form is required if the member reports an address change to you. Upon completion/submission, the form will be automatically sent to the members county.
- Do not refer the member to call their county or tribe with an address change, and do not put an address change on the DHS 5181 to notify the county/tribal financial worker During this time, the DHS 8354 is the only way to report an address change to the county/tribe.

With both of these processes, let Medica know if you encounter anything unusual related to these processes, get questions from your members you cannot answer with the resources provide or have any questions that we or DHS may need to consider.

Elderly Waiver Eligibility

Waiver Eligibility and Medical Assistance (MA) financial eligibility renewals and the end of the continuous coverage period

- On April 11th, The Minnesota Department of Human Services announced timelines for restarting MA renewals that also apply to reassessments for waivers **with an effective date of July 1st, 2023** . The AASD and DSD eList announcement refers to the following bulletins; Bulletin #23-21-08: DHS Announces Key MHCP Eligibility Policies during the Unwinding Period and Bulletin #23-21-09: DHS Announces the Resumption of MHCP Annual Eligibility Renewals (PDF). Please review for more detail regarding the renewals.

- The timing of MA financial eligibility renewals does not affect the timing of annual reassessments. Elderly Waiver reassessments may occur before or after the MA eligibility renewal is completed.
  - Care Coordinators must complete annual reassessments following the Assessment Schedule Policy. All members will have their reassessment completed based on the date of their last assessment or reassessment. Care Coordinators cannot change reassessment dates simply to align with MA financial renewal dates.
  - For any annual reassessment completed **beginning in May 2023 that has an effective date of July 1, 2023, or later**, the member must meet all Elderly Wavier eligibility criteria in order to continue on the program. If the member no longer meets all Elderly Waiver at reassessment, the Care Coordinator must close the Elderly Waiver no earlier than the first day after the end of their current waiver. Care Coordinators must provide advanced notice by completing a DTR and notify the financial worker by completing the DHS 5181.

Return to Face-to-Face Visits

Case management face-to-face requirements resume Nov. 1, 2023 (DHS announcement dated 4/4/23)

Beginning Nov. 1, 2023, lead agencies (including MCO's) must meet minimum case management face-to-face requirements for people using the Elderly Waiver (EW). This applies to people whose waiver year ends on or after Nov. 1, 2023.

Members on EW and for members receiving PCA services:
The waiver case manager/care coordinator must conduct at least one face-to-face visit per 12-month period.

Recommended practices during the transition period
The temporary COVID-19 policy that previously allowed lead agencies to conduct case management visits remotely will expire at the end of the public health emergency.

DHS is providing a six-month transition period, the maximum allowed by the federal Centers for Medicare & Medicaid Services, to prioritize individual needs and choices and support lead agency capacity development.

Until requirements resume on Nov. 1, 2023, DHS encourages CC's to:
- Inform people that minimum face-to-face requirements will resume starting Nov. 1, 2023.
- Offer a choice of in-person or phone visits and honor the person's choice.
- Discuss and address the person's in-person visit needs and preferences.

Specific to SNBC/ISNBC: Medica continues to give the guidance that CC's offer to schedule assessments/reassessments face to face as that can help in developing a trusting relationship. If SNBC members are not interested in meeting face to face, a telephonic health risk assessment may occur following the current process.

Electronic Visit Verification (EVV) Update

- Provider requirement, already started for some services in FFS

- Health Plans are contracted with DHS's vendor HHaX

- Health Plans will send HHaX list of members with the below services

- First phase beginning in approx. June will be the following services: PCA, ICLS, in home respite, homemaking with personal care.

- **Care Coordinators-please be sure to send authorizations in timely and with all necessary information.**

Referral Request Forms/Service Authorizations

- **Care Coordinators-please be sure to send authorizations in timely, accurate and with all necessary information.**

- Medica applies a 10 day turn around time to entering authorizations into our system.

- Authorizations are needed in our system in order for some claims to pay. See Referral Guideline document on CC Hub for the list of services.

- When a provider bills Medica, and the authorization that is required in our system for the claim to pay is NOT THERE, a claims payment denial is generated, and the member and provider receive a notice.

- Conclusion: Timely submission of authorizations/Referral Request Forms will result in less provider and members calls.

MnCHOICES

- As part of the new "Phase 0" in the revised MnCHOICES launch, a small group of lead agency users are continuing the beta testing in the new MnCHOICES Training Zone (MTZ) and have now begun testing in the production environment as of June 1, 2023.

- All Medica delegates should now have access to the new MTZ training zone and your staff should be getting logged in and practicing as soon as possible to get familiar with functionality which more closely replicates the revised application. Mentors should have provided instructions to all MnCHOICES users to access the new MnCHOICES Training Zone platform.

  - DHS emailed the new MTZ URL link https://mnchoices-trn-carity.feisystemsh2env.com/ and the universal password to all users on 5/30/23. Continue to use your MTZ username.

- The revised MnCHOICES application will officially launch for all lead agencies (Medica delegates) on July 10th

  - Medica is suggesting that you choose your agency/care system/county "super users" to begin work in the new platform. This is at the delegate discretion based on their staffing, caseloads, and membership.

    - These individuals will begin completing member work within the new application.

    - They will be able to start using the new application and provide feedback to your other users, DHS, and Medica.

MnCHOICES

What is improved in the new MTZ?
- Updates to roles and permissions including fixing permissions for offline mode
- Additional services and updates to services
- Providers: Current provider list updates
- The following configurable forms are available
  - CFSS-to-PCA conversion worksheet
  - OBRA Level I
  - EW Customized Living and Foster Care Worksheet

- In the new MTZ Micro-learnings will not be available in the Help Center but they are available in the TrainLink course MNCH901.

Regulatory Quality

Audit Element Overview and Trends

2023 Audit Findings

1. All enrollee's assessed needs and concerns are addressed in the care plan

2. All HRA fields are completed or noted as Not Applicable or Not Needed

3. Assessments are completed timely

4. Communication with Primary Care Physician (PCP) or clinic

5. Care Plan includes measurable outcomes (SMART goals)

All enrollee's assessed needs and concerns are addressed in the care plan

- If the assessment identifies an unmet need, concern, or preference, a goal MUST be created OR there must be a statement as to why it is not included on the care plan.

- Medica requires that CCs indicate whether a goal is needed for each element in the Managing and Improving My Health section of the care plan.

F.4b Pain Screening

PAIN SCREENING	DATE 5/20/2023

Are you experiencing any pain now or in the last 2 weeks? ☑ Yes ☐ No

Has your pain affected your function or quality of life (e.g., activity level, mood, relationships, sleep or work)? ☑ Yes ☐ No

How often do you experience pain (Constantly, Daily, Once a Week or Not Often)?
Daily

At its worst, how severe is your pain (1 to 10 with 10 being the worst)?
7

LTC SD 70 I.5 Have you experienced any falls in your home or while out in the community?
00 No   01 Yes
[2]

I.5a If no, ask: Does concern about your balance or falling affect your daily activities or access to the community?   00 No   02 Yes

I.5b Did a fall result in a fracture within the last 12 months?   00 No   03 Yes

I.5c If yes, how did that happen? _____

F.4a What is your goal for your health?
I want to lose 5 lbs

Emotional Health
How would you rate your emotional health?*
◉ 05 - Poor
○ 06 - Fair
○ 07 - Good
○ 08 - Excellent
○ 12 - Chose not to answer

My Future Plans

E.19 What are some of your plans for the future? Things you might like to do, or want to accomplish?
I want to visit with my family more

E.19a Is anything needed to support or help you do these activities?
I need a phone

Bathing
How well can you bathe or shower yourself?* Bathing or showering by yourself means washing all parts of the body including your hair and face. Would you say that you:
○ 00 - Need no assistance
○ 10 - Yes, needs assistance, met by current supports or help from others or equipment
◉ 11 - Yes, needs assistance NOT met by current supports or help from others or equipment
○ 12 - Chose not to answer

Managing and Improving My Health

Screening for my health	Check if educational conversation took place with me	Goal is needed	Check if N/A, contraindicated, declined	Notes
Annual Preventive Health Exam	☒	☒	☐	June 2021
Mammogram (Within past 2 years ages 65-75)	☒	☐	☒	

All HRA fields are completed or noted as Not Applicable or Not Needed

I. My Safety

Self Preservation *(Assessor, in your opinion based on observation and input from others)*

I.1 Do you think (NAME OF PERSON) would be able to evacuate safely if there was a fire?
☐ Yes ☑ No   Why not? _____

My Medical Treatments/Therapies

F.10 Do you regularly receive any of the following medical treatments, such as:
(Code "None" if no treatment received OR needed)

	Yes	Needs		Yes	Needs
Bedsores treatment	☐	☐	Respiratory treatment	☐	☐
Bowel care	☐	☐	Suctioning	☐	☐
Catheter care	☐	☐	Wound care	☐	☐
Colostomy care	☐	☐	Occupational therapy	☐	☐
Dialysis at home	☐	☐	Speech therapy	☐	☐
Dialysis outpatient	☐	☐	Respiratory therapy	☐	☐
IV therapies	☐	☐	Physical therapy	☐	☐
Ostomy care	☐	☐	Diabetes education	☐	☐
Oxygen	☐	☐	Other	☐	☐
Pacemaker	☐	☐	(Specify) _____		
			None ☐		

Assessor Evaluation of Environment

I.6 Assessor, please indicate the specific area(s) in which there are potential safety or accessibility problems for the person. Check "None" if no potential problems.

Yes	Area	Yes	Area
☐	Structural damage	☐	Insufficient hot water/water
☐	Barriers to access (including steps and stairs)	☐	Insufficient heat
☐	Electrical hazards	☐	Shopping not accessible
☐	Signs of careless smoking	☐	Transportation not accessible
☐	Other fire hazards	☐	Telephone not accessible
☐	Dangerous floors? Scatter rugs	☐	Neighborhood environment unsafe
☐	Unsanitary conditions/odors	☐	Other
☐	Insects or other pests		(Specify) _____
☐	Poor lighting	☐	None

F.4b Pain Screening

PAIN SCREENING	DATE 5/20/2023

Are you experiencing any pain now or in the last 2 weeks? ☑ Yes ☐ No

Has your pain affected your function or quality of life (e.g., activity level, mood, relationships, sleep or work)? ☐ Yes ☐ No

How often do you experience pain (Constantly, Daily, Once a Week or Not Often)?
Daily

At its worst, how severe is your pain (1 to 10 with 10 being the worst)?
7

Have you talked to your doctor or someone else about the cause of your pain?
☐ Yes ☐ No
If yes, who? _____ When? _____

Have you talked to someone about how to handle your pain? ☐ Yes ☐ No
If yes, who? _____ When? _____

Pain management plan: _____

Memory

How well would you say that your memory is?
- ○ 00 - Excellent
- ○ 01 - Good
- ○ 02 - Fair
- ○ 03 - Poor
- ○ 04 - Unable to answer
- ○ 05 - Chose not to answer

Do you have any current dental concerns?*
- ⦿ Yes
- ○ No
- ○ Chose not to answer

COMMENTS
_____

MEDICATION LIST

See attached

Assessments are completed timely

Initial Assessment

Plan/Product	Timeline for Completion	Member Category
MSHO members	Within 30 calendar days of enrollment	Non-EW (A) EW (B) Institutional (D) Transfer
MSC + members with PCA or EW services	Within 30 calendar days of enrollment	Community w/ EW or PCA Transfer
MSC+ members without PCA or EW services	Within 60 calendar days of enrollment	Community Non-EW/Non PCA Transfer
SNBC/SNBC Enhanced members	Within 60 calendar days of enrollment	Community Institutional Other Waiver Transfer

Early Reassessment/Functional Needs Update (EW only)/Requested Assessment

Plan/Product	Timeline for Completion	Member Category
All	Within 20 calendar days of member request or identification of change in needs	All

Annual Reassessment

Plan/Product	Timeline for Completion	Member Category
All	Within 365 calendar days of last full assessment (THRA and Functional Needs Assessments are NOT considered full assessments)	All

- Document the date you receive enrollment from Medica in your case notes. Auditors realize it is not always the first of the enrollment month

- If there is a change in member needs, attempt to address by realigning resources within the person's current support plan
  - If not possible, complete early reassessment (Non-EW, EW, SNBC) or Functional Needs assessment (EW only)
  - This must be completed within 20 calendar days of member request or identification of change in needs
  - For third party request- the CC must contact the member as soon as possible to determine if they would like an assessment. The 20-day timeline starts when the member confirms they want an assessment

- UTRs and refusals follow the same timelines as initial and annual assessments (e.g., all outreach attempts or the refusal conversation must occur within required timelines)

- If an assessment is attempted but not completed, document a member-related explanation in the case notes.

Reminder: Complete Brief HRA Survey

- In May, we sent supervisors HRA timeliness results and a link to a brief survey

- Goal of survey is to better understand best practices and challenges to tracking and completing timely HRAs

- Thanks to those who have already completed the survey!

- If you haven't had a chance to complete the survey yet, please designate one person from your organization do so (supervisor or delegate)

- We're also happy to meet to review the data. Please reach out to Lisa.Benrud@medica.com or the Reg Quality mailbox with any questions.

HRA Timeliness Survey:

https://www.surveymonkey.com/r/HRATimeliness

Communication with Primary Care Physician (PCP) or clinic

Primary Care Physician

Requirement	Member Type	Contact Options	Special Considerations
Communication of care plan elements with Primary Care Physician must occur annually, with change in condition, with change in product, with change in CC, or following a transition	All members	• PCP Letter • PCP Fax Notification • Case Notes stating name of PCP, mode of PCP contact, & documentation of discussion	PCP letters are an opportunity to address findings from the most recent HRA, identify services the member is receiving, identify the PCP as an integral part of the Interdisciplinary Care Team & provide CC contact information. MSHO & ISNBC PCP letters also include Model of Care Training Requirements for Physicians PCP Fax Notification allow CC's to complete PCP communication of admissions & discharges during a transition

- Letters identified as being sent must be available for audit
- PCP listed on the HRA, Care Plan, & PCP letter must be the same

Care Plan includes SMART goals

DHS: Person Centered Focus vs CMS Clinical Focus

Specific	• Try and make your goal as precise and defined as possible
Measurable	• Establish a criteria to measure your progress • How will you know when you are on your way?
Accountable	• Determine a person who will help you and keep you responsible for your goals
Reachable	• Set reachable goals that you will be able to attain (high expectations are good) • Set small goals toward bigger goals
Time specific	• Create a timeline • Having an end time will help you stay accountable to your goals

Examples:

Jane will decrease her pain by 1-2 points on a scale of 1-10 by the target date (or by her 6 month Follow Up).

Jane will visit with Dr. Smith, who manages her pain medications, to discuss her desire to decrease the dosage by her birthday.

Audit References

- DHS or Medica Audit Protocols

- CC Hub Policies

- CC Hub Tools & Forms
  - Care Plan Instructions
  - TOC Log Instructions

- CC Hub Newsletter
  - Auditors Corner (New in May)

- CC Hub Training
  - SMART Goals Training, Examples, FAQ
  - Training Module (Coming Soon!)

If you have questions about an audit element, please reach out to your auditor or email **MedicaSPPRegQuality@Medica.com**

MDH Triennial Compliance Audit

- The Minnesota Department of Health (MDH) completed Medica's triennial compliance audit in May

- Included review of Medica's delegation oversight process for care coordination and case review of a sample of MSHO elderly waiver cases

- **Thank you** to everyone who provided documentation for the audit!

- MDH was complementary and appreciated the great work care coordinators do for Medica's members
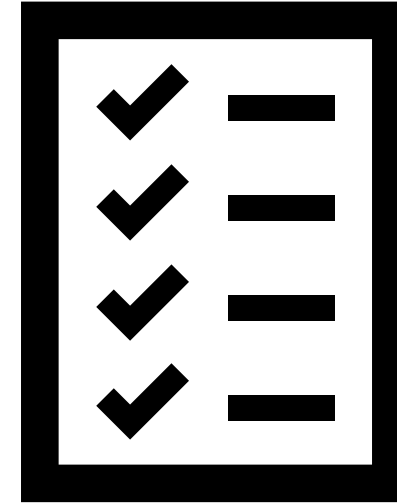
Reminder: Minnesota Senior Health Options (MSHO) Vendor - Reema

 *Note: although their names are similar…**Reema is a different company than Reemo**. Reemo is our vendor partner for the Smartwatch and Activity Tracker supplemental benefit.

Who are they?

- They are a Minnesota team of trained "Community Guides"

What do they do?

- Make outbound calls, send text messages, and do some in-home visits to support MSHO members with complex needs

- Assist members with addressing Social Determinant of Health (SDOH) needs

- Educate members on the importance of annual PCP visits and address some gaps in care

- Assist with scheduling appointments and transportation

What else?

- The work Reema is doing is meant to provide additional support and outreach to members and does not duplicate the support that Care Coordinators provide

- Members contacted by Reema are identified by Medica, no additional referrals are able to be made into the program

If a MSHO member contacts you about receiving outreach from a Reema Community Guide who identifies themselves as working with Medica, please encourage your member to engage with the Reema Community Guide. You may also receive a call from a Community Guide who might want to relay information related to your member, or they may be trying to put the member in touch with you. If you receive a call, please work with the Community Guide in support of your member.

Care Coordination Updates

Chore service and Transitional Services (Senior products only), Supplemental benefit re-cap, SIU, Other, Nurse's Week and Success Story

Chore service overview and auths/Transitional services

Chore Services authorizations and EW transitional services will be submitted to support specialists for entry.

- Refer to Claims Referral Guidelines under tools and forms

- Include brief notation about the chore task in Service Description Code column on the Referral Request Form (RRF)

- For Transitional Services include current housing setting and setting the member is moving to in the Service Description Code column on the RRF

- When sending in the referral form for either service, in the email subject line enter Chore Service or Transitional Service

CC's are **not** to start services until they receive a confirmation email from the support specialist team that the auth has been entered.

There will now be a review process for these authorizations prior to entry

Supplemental Benefit Re-Cap

Medica Special Investigations Unit (SIU)

The mission of Medica SIU is to prevent, identify, investigate, report and, when appropriate, recover money from health care fraud and abuse.

Care Coordinators should notify SIU of suspected provider or member fraudulent or abusive activity. Examples may include asking you to bend the rules or observations of a member's or provider's behavior that indicate potential Fraud Waste and Abuse (FWA). "If something doesn't seem quite right, report it."

Located on the main CC Hub page at the bottom under
Useful contacts:

Report Fraud, Waste and Abuse
Special Investigations Unit (SIU)
SIU Team
Fraud Hotline: 1-866-595-8495
Online SIU Referral Form

Other Updates

- **Elderly Waiver/Housing Stabilization Service provider training planned for July 19, 11:30 a.m. - 1 p.m. and the registration is found here:** Medica | Provider College Class Registration

Nurses Week

In May we acknowledged the contributions of nurses and called attention to their work. Sponsored and promoted by the American Nurses Association, the week-long event highlights the crucial contributions that nurses make to the community.

Care Coordinator Success Story

Medica®

THANK YOU