Quarterly Care Coordination Meeting

March 5, 2024

9 am – 10:30 am

Agenda

- **General Updates**
  - Behavioral Health Home (BHH) – All products
  - Model of Care Training – All products
  - Supplemental Benefits Review – All products
- **Regulatory Quality Updates**
  - New PIP Depression and Diabetes – All products
  - Care Plan translation process new CMS requirement – All products
  - Audit Protocol – All products
- **Clinical Liaison Updates**
  - Working with other waiver workers and ROI's – All products
  - Chore Services – MSHO/MSC+ Only
  - BEI's – All products
  - New Transportation Directory – All products
  - CFSS Update
  - Medica.com updates
  - MnCHOICES – All products
  - Success Story
  - National Social Worker Month 2024

General Updates

Angie Kluempke and Courtney Chupurdy

All Products: Behavioral Health Home (BHH)

Care Coordinator responsibilities outlined in the Behavioral Health Home Coordination policy found here: Care Coordinator HUB; BHH Coordination Policy

Process:

- When a member enrolls to work with a BHH, the BHH provider sends the DHS 4794 to Medica.
- Once Medica receives, this notification form is sent to the Care Coordination delegate managing the member along with an email detailing the Care Coordinators next steps.
- The individual Care Coordinator is responsible for contacting the person listed in the field PRIMARY CONTACT INFORMATION FOR BHH SERVICES TEAM MEMBER **within 10 business days** of receiving this notification for purposes of coordination and sharing Care Coordinator contact information with the BHH provider.
- The Care Coordinator will document this communication in case notes.
- This communication is a DHS contract requirement.

Care Coordinator Model of Care Training

Medica AccessAbility Solution Enhanced®

Medica DUAL Solution®

Objectives

- Special Needs Plan Description
- Model of Care Overview and Requirements
- Complete Training Attestation

Why do I need Model of Care Training?

Centers for Medicare & Medicaid Services (CMS) Requirement:

- All Medicare Advantage Special Needs Plans (SNPs) must have a Model of Care (MOC) that describes the care and services to be provided to SNP members
- The MOC is a detailed document (>100 pages) that provides the framework for how Medica identifies and addresses the unique needs of its SNP populations
- CMS carefully reviews the MOC during an audit to make sure we are implementing all processes as described, including MOC training

Medica Providers, Care Coordinators, member facing Support Staff who support the work of Care Coordinators (e.g., Case Aides, Community Health Workers), and member facing Medica staff who serve SNP members are required to complete annual training on the SNP MOC

MOC training helps you:

- Understand the unique characteristics and needs of SNP members
- Understand the importance of your role
- Understand the importance of collaborating with others involved in the member's care, including the Interdisciplinary Care Team (ICT)

What is a Special Needs Plan (SNP)?

- A type of Medicare Advantage Plan that focuses on certain vulnerable groups of Medicare beneficiaries
- Three types of SNPs:

I-SNP

- Institutional Special Needs Plan
- Enrolls beneficiaries who are institutionalized or require an institutional level of care (LOC)

D-SNP

- Dual Eligible Special Needs Plan
- Enrolls beneficiaries who are eligible for both Medicare and Medicaid

C-SNP

- Chronic Condition Special Needs Plan
- Enrolls beneficiaries with certain chronic and disabling conditions

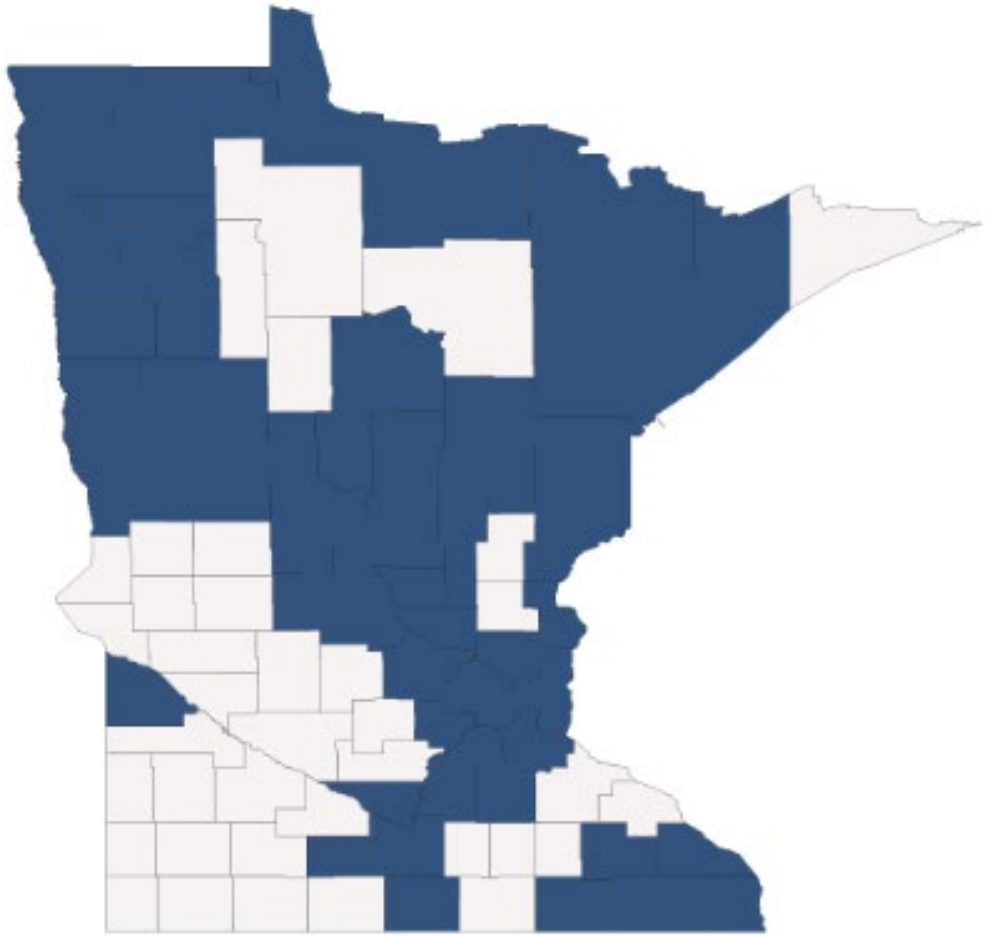
Medica Special Needs Plans

Plan Name	SNP Type
Medica DUAL Solution® (Minnesota Senior Health Options or MSHO)	D-SNP
Medica AccessAbility Solution Enhanced® (Special Needs BasicCare (SNBC) Special Needs Plan or SNBC D-SNP)	D-SNP

MSHO Eligibility Criteria

***Inclusive list of product eligibility, sales and enrollment process, benefits and services can be found at www.medica.com**

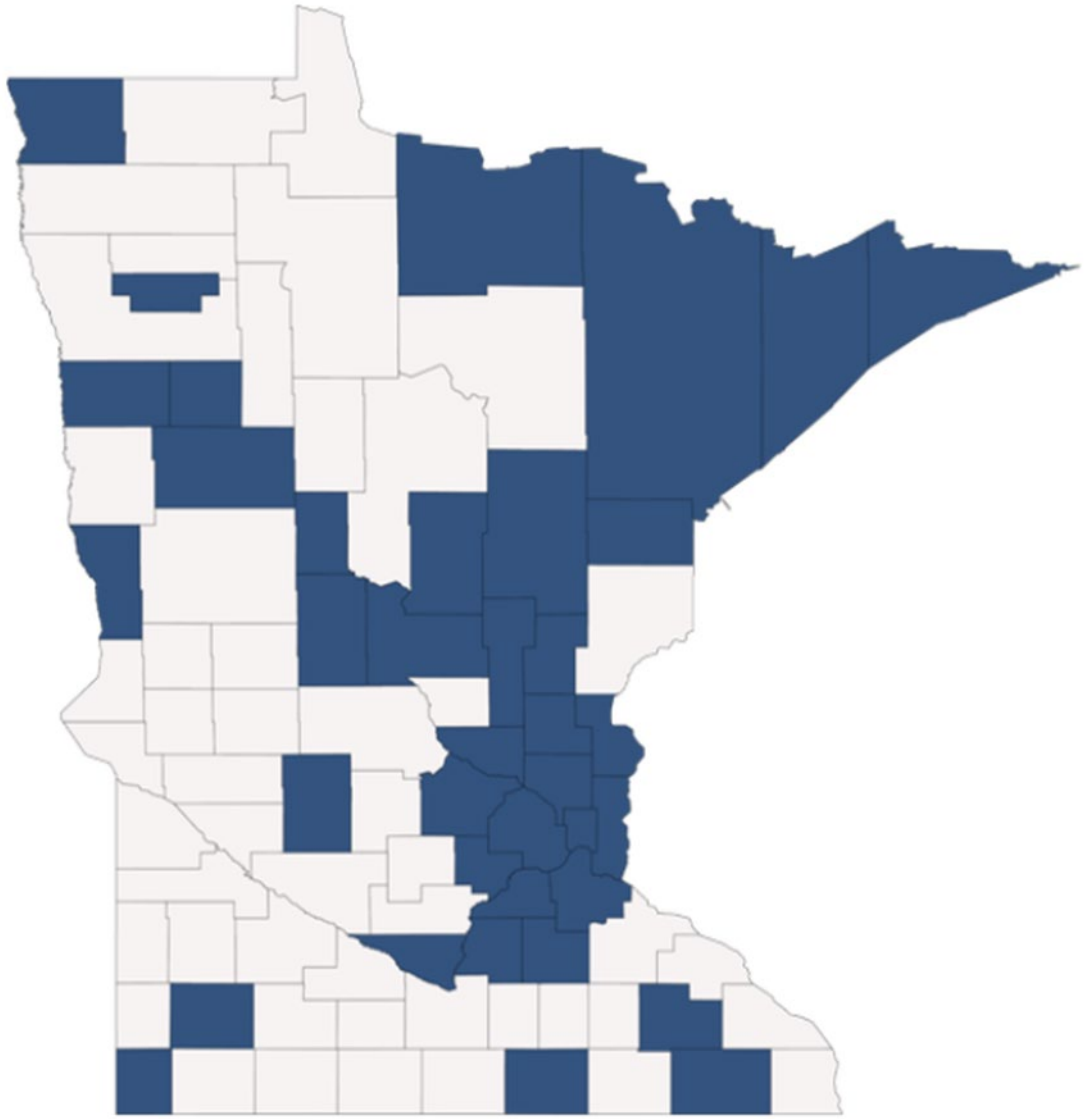
- 65 years or older
- Enrolled in Medicare Parts A & B
- Eligible for Medical Assistance
- Live in the plan's service area



SNBC D-SNP Eligibility Criteria

***Inclusive list of product eligibility, sales and enrollment process, benefits and services can be found at www.medica.com**

- Age 18-64 with a certified disability
- Enrolled in Medicare Parts A & B
- Eligible for Medical Assistance
- Live in the plan's service area



Sales and Enrollment Process

SNBC D-SNP	Members or Authorized Reps can complete an application through Medica's sales dept. (Paper, Telephonic, Online)	Enrollment Telephone Numbers: 1 (800) 266-2157 (TTY for the hearing impaired at 711) 8 a.m. to 8 p.m., seven days a week.	Members or Authorized Reps can reach out to their county financial worker	Disability Hub MN
MSHO	Members or Authorized Reps can complete an application through Medica's sales dept. (Paper, Telephonic, Online)	Enrollment Telephone Numbers: 1 (800) 266-2157 (TTY for the hearing impaired at 711) 8 a.m.-8 p.m. CT, 7 days a week.	Members or Authorized Reps can reach out to their county financial worker	Senior Linkage Line

- ***Inclusive list of product eligibility, sales and enrollment process, benefits and services can be found at*** www.medica.com

Some Benefits and Services (SNBC D-SNP and MSHO)

Medical, Dental, Vision Care, Hearing

Pharmacy: Part D, OTC, Medication Therapy Management

Care Coordination, Disease Management, Health Coaching, 24/7 Nurse Line Telephonic Support through Health Advocate

Transportation to Medical Appointments and the Gym, access to over 20,000 fitness locations, Save on Healthy Food through the Healthy Savings® Program

❖ ***Inclusive list of product eligibility, sales and enrollment process, benefits and services can be found at*** www.medica.com

Model of Care

What is the Purpose of the Model of Care (MOC)?

To ensure the unique needs of each member are identified and addressed through the plan's care management practices, and provide the foundation for promoting plan quality, access to services, care management, and care coordination processes.

- MOC must meet all CMS requirements
- CMS awards approval of MOC for 1 to 3 years
- CMS requires MOC Training be completed annually

Model of Care: CMS Required Elements

Element 1: Description of SNP Population

Element 2: Care Coordination

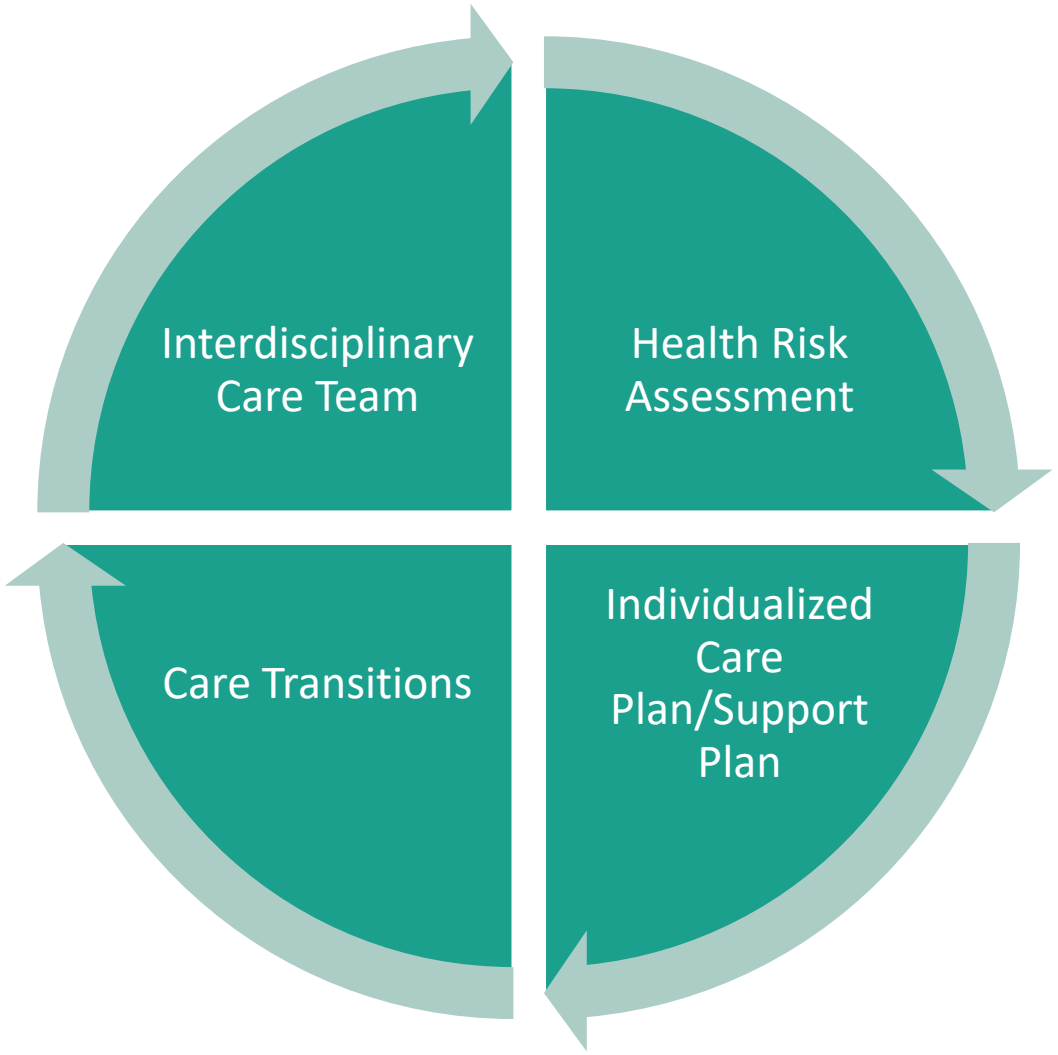
Element 3: Provider Network

Element 4: Quality Measurement & Performance Improvement

MOC 1: Description of Population

Medica AccessAbility Solution® Enhanced (SNBC D-SNP)	Medica DUAL Solution® (MSHO)
Gender: 57% female and 43% male	Gender: 66% female and 34% male
Average age: 50	Average age:77
Race breakdown: 69.3% White; 24.5% Black; 3.6% Asian; 2% American Indian or Alaska Native; 0.0% Native Hawaiian or Other Pacific Islander; 0.6% Unknown/Other	Race breakdown: 73.0% White; 14.5% Black; 10.0% Asian; 2.0% American Indian or Alaska Native; 0.2% Native Hawaiian or Other Pacific Islander; 0.5% Unknown/Other
% with Chronic Conditions: 96%	% with Chronic Conditions: 95.9%
Top Chronic Conditions: Depression, Hypertension, Hyperlipidemia, Low Back Pain, Diabetes, Persistent Asthma	Top Chronic Conditions: Hypertension, Hyperlipidemia, Depression, Diabetes, Low Back Pain, Chronic Renal Failure
88% live in the community; 12% live in an institutional setting	87% live in the community; 13% live in an institutional setting

MOC 2: Care Coordination



- Every MSHO and SNBC D-SNP member is assigned a Care Coordinator
- The Care Coordinator partners with the member and their Interdisciplinary Care Team (ICT)
- Primary Care Physicians are considered an integral part of the member's ICT
- The Care Coordinator is the primary point of contact to ensure there is ongoing communication between members of the ICT
- This is true whether a member lives in the community, a skilled nursing facility, adult foster care, or customized living

Care Coordinator Role

Conduct Health Risk Assessment and develop an Individualized Care Plan/Support Plan with the member based on their identified needs and preferences	Ensure the member's healthcare needs and preferences regarding their healthcare is shared across the ICT
Provide ongoing monitoring and updating of the Individualized Care Plan/ Support Plan, and education and advocacy	Connect the member to resources, health care, and services
Collaborate with different health and social services professionals and across settings of care	Work with the member to live in the least restrictive setting possible and that is the member's choice

Care Coordinator Qualifications

Care Coordinator Qualifications	
MSHO D-SNP SNBC D-SNP	Registered nurses, social workers (either licensed social worker or social worker who meets the social work standards under the Minnesota State Merit System), public health nurses, physician assistants, nurse practitioners, or physicians. *See Appendix A & B for Care Coordinator qualification checklists

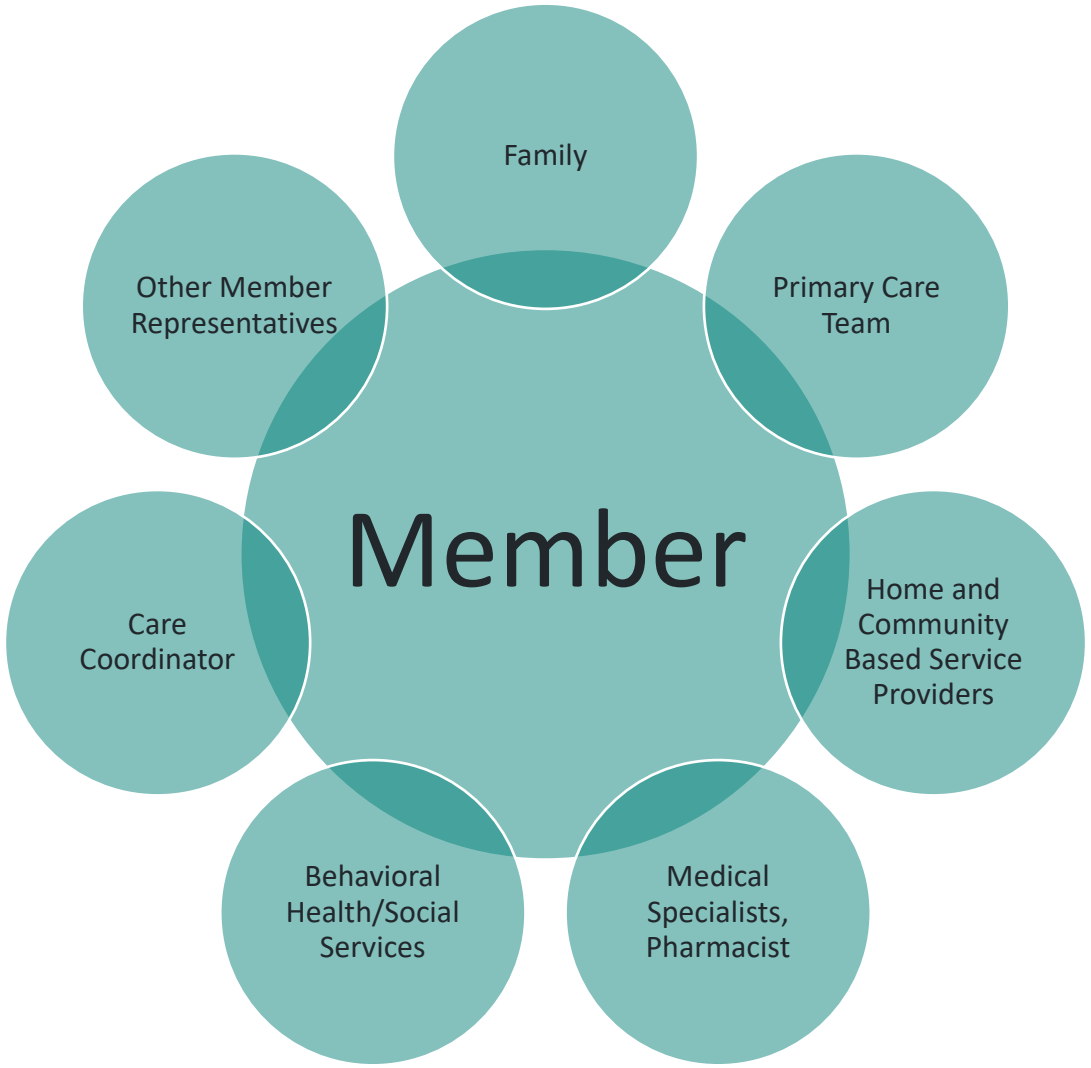
Health Risk Assessment (HRA)

- Completed by Care Coordinator
  - Within 30 days of enrollment (MSHO); within 60 days of enrollment (SNBC D-SNP)
  - With change of condition
  - Within 365 days of the last HRA completed
- An HRA provides the Care Coordinator with pertinent information about a member's medical, functional, cognitive, psychosocial, mental health, and Social Determinants of Health (SDoH) needs.
- The HRA drives the Individualized Care/Support Plan by identifying a member's needs, wants, and concerns

Individualized Care Plan/Support Plan

- Required for every member
- Person centered, addresses needs and concerns identified during HRA
- Includes person centered SMART goals
- Completed by Care Coordinator and sent to member within 30 days of HRA
- Summary shared with Primary Care Provider (PCP) and other members of care team per member discretion
- Ongoing monitoring throughout the year with documentation of goal progress based on member-specific follow-up schedule

Interdisciplinary Care Team (ICT)

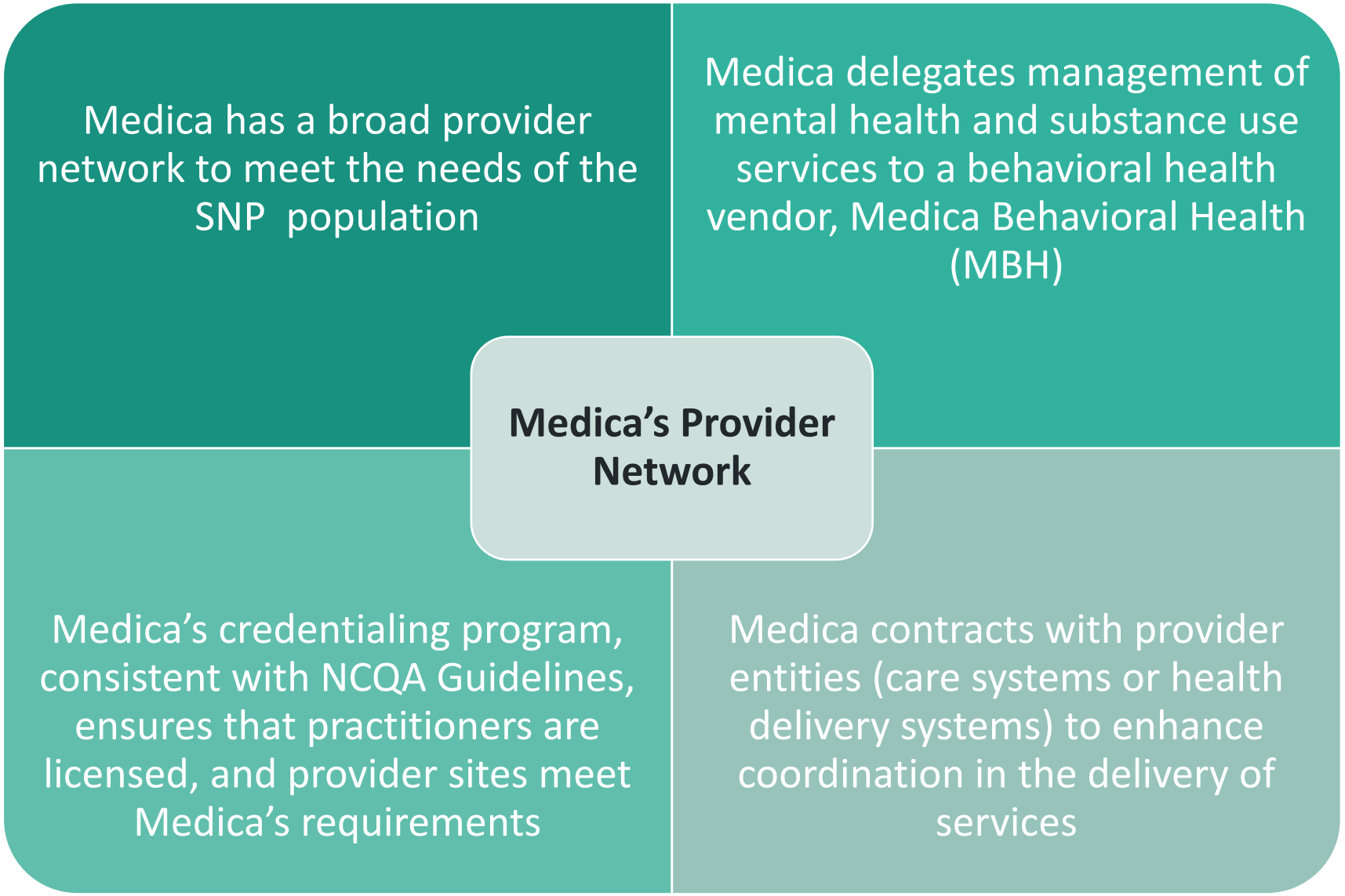


- ICT composition based on individual member needs and preferences
- Typically includes the member and/or their designee, PCP, and Care Coordinator, with other providers as appropriate (e.g., specialists, mental health providers, etc.)
- Care Coordinator is responsible for facilitating communication among the ICT
- Collaborative communication between the Care team members and the Care Coordinator is essential to best serve the member and their needs
- Care Coordinators send Individualized Care Plan/Support Plan information to the PCP at least annually, including a letter that has CC contact information.
- Information may be shared with other ICT members as applicable and based on member preference.

Transitions of Care

- When members move from one care setting to another, they are at risk of adverse outcomes due to fragmented care
- Care Coordinators follow up with the member throughout the transition to:
  - Discuss their health status changes and discharge instructions
  - Ensure follow up appointments have been scheduled
  - Ensure member understands any changes in their medication regimen
  - Ensure member can recognize warning signs and symptoms and how to respond
  - Determine if member requires any new services or supports upon discharge (and complete new assessment, as appropriate)
  - Assess SDoH concerns
- Care Coordinators also facilitate communication with the receiving setting and other providers involved with the member's care
- The communication between the Care Coordinator, Providers, and the member is critical to ensuring an effective transition from one care setting to another or back to home
- The Care Coordinator updates the member's Individualized Care Plan/Support Plan as necessary and shares with the member and their Interdisciplinary Care Team, as applicable

MOC 3: Provider Network



MOC 4: Quality Measurement and Performance Improvement

- CMS requires SNPs to have a comprehensive Quality Improvement Program that evaluates the effectiveness of the MOC
- For each of the SNPs, Medica establishes process and outcome measures tied to MOC goals, such as:
  - Improving access and affordability
  - Ensuring coordination of care across the care continuum
  - Appropriate utilization of services for preventive health and chronic conditions
  - Implementation of the MOC
  - Improving member satisfaction

Examples of measures include:

Member satisfaction with the Care Coordination Program	Health Risk Assessment Timeliness Rates	Implementation of the Individualized Care Plan
Medication Adherence	Follow-up after ER or Inpatient Admissions	Preventive Care Utilization

Next Steps

Thank you for completing the Medica SNP Model of Care Training

To acknowledge completion and receive credit for this training, please go to the link below to complete the MOC Training Attestation

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

**It is required that Medica follow up with any Care Coordination staff who has not taken the training within the calendar year*

Model of Care Questions?

Contact:

Courtney Chupurdy, SNP Program Manager

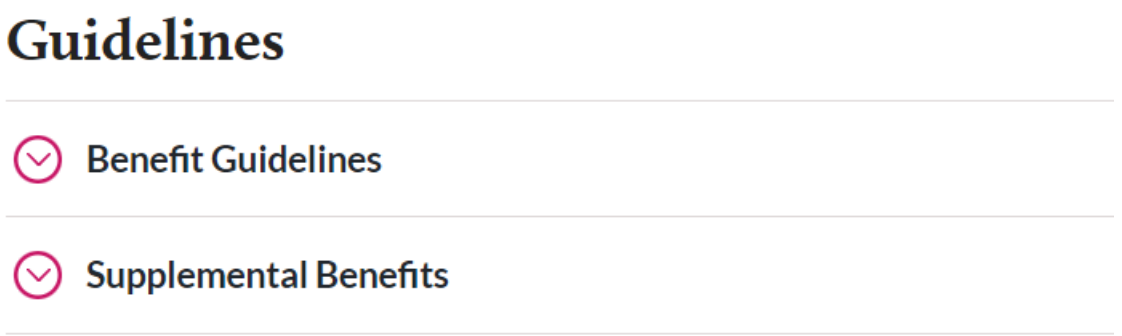
Courtney.Chupurdy@Medica.com

Supplemental Benefits

Angie Kluempke

Benefit Guidelines

Found on each product page under Guidelines



Resources

Care Coordination

- Supplemental Benefits
- 2024 Medica Additional Benefits Document
- MSHO and SNBC D-SNP product page under “wellness program”
- Medica Member Service Center/Provide-A-Ride: 1 (888) 347-3630

Members

- Member handbook and guide
- For Healthy Foods and Utility payments all currently enrolled members will receive a letter and new card in January, all newly enrolled members throughout the year receive these during the month they enroll.

Regulatory Quality Updates

Lisa Benrud, Ashley Heehn, Sheila Heskin

Performance Improvement Project

MSHO, MSC+, ISNBC, SNBC

Sheila Heskin

PIP Overview

- DHS tasked the MCO's to implement a Performance Improvement Project that focuses on "Addressing the Impact of a Behavioral Health Diagnosis on a selected physical condition or disease.
- Medica, along with the other MCO's chose to focus on Depression and Diabetes, since both are top conditions in our MSHO, MSC+ and SNBC populations.
- Medica continues to participate in the MCO PIP Collaborative.
- Project will run for three years 2024 – 2026

December 31, 2023

- Sundown of 2021- 23 Diabetes PIP

January 1, 2024

- Start of New PIP Depression & Diabetes

December 31, 2026

Depression & Diabetes PIP Sundowns

New 2024 Seniors & SNBC PIP: Impact of Behavioral Health on Physical Health

- Both Diabetes and Depression are top chronic conditions in the MSHO, MSC+ and SNBC populations

	Total Population	% with Diabetes	% with Depression	% with Diabetes & Depression
MSHO	11093	39.3%	52.2%	22.0%
MSC+	5833	31.5%	30.4%	12.1%
SNBC	10349	22.1%	45.3%	12.5%
I-SNBC	1950	33.9%	67.2%	24.9%

- M members with diabetes with and without depression
  - Kidney Health Evaluation for Patients with Diabetes (KED) stood out as a measure where there is opportunity for improvement across all populations
  - Medica aims to increase the HEDIS® Kidney Health Evaluation for Patients with Diabetes (KED) measure rate for this PIP's targeted population – members with comorbid diabetes and depression.

Interventions

- Medica Condition Management Program – Diabetes Education and Management Program - Nurses more attuned to depression impacts on diabetes management
- Express Scripts medication adherence programs for both diabetes and depression

- *Care Coordination- Care Coordinators play a key role in helping members be attuned to and manage both their diabetes and mental health conditions.*
  - CC Webinar Series-Webinars are planned that expand on the diabetes baseline knowledge and integrate the added element of dealing with a behavioral health condition while managing a chronic medical condition.

Care/Support Plan Translation

MSHO & I-SNBC

Care/Support Plan Translation – MSHO & I-SNBC

- New process for MSHO and I-SNBC
- Option to translate care/support plan for members whose preferred written language is not English

Discuss

- Talk with member during assessment/care planning visit
- If member would like written document translated, advise of time frame (est. 2-4 weeks)
- Note: Timeline for sharing Care/Support Plan with member does not change due to translation

Request

- Send request for translated Care/Support Plan to Support Specialists email box (see next slide for email template)
- Attach copy of Care/Support plan and Post-Visit Letter for translation

Document

- Document that discussion occurred and member's preference (e.g., requested written translation vs. verbal translation only)
- If member requests translated copy of Care/Support Plan, document date sent request to Support Specialists

Care/Support Plan Translation Requests – Email Template

- **Subject:** Care Plan Translation Request
- **Email Body:** Please translate the attached Care Plan and Post-Visit Letter for the below member.
  - Member Name: (first and last)
  - Member ID: (8 digits)
  - Member Mailing Address:
  - Product: (MSHO or I-SNBC)
  - Language Needed:

Send request via secure email to Support Specialists at ReferralRequest@medica.com

Attach a copy of the member's Care/Support Plan and Post-Visit Letter

Care/Support Plan Translation

- Medica will send translated documents directly to member (estimated 2-4 week TAT)
- Support Specialists will email Care Coordinator (requester) a copy of the translated documents for their records
- Once member requests translation of Care/Support Plan, that becomes a “standing request”

2024 Audit Updates

Ashley Heehn

2024 Audit Updates

- DHS 2024 Audit Protocol Meetings with the MCOs started in October.
- DHS has provided MCOs with the final SNBC, EW, and Non-EW Audit Protocols. All protocols will be sent to delegates prior to audit.
- DHS & CMS requirements have not changed.
- Once audit samples are pulled, Medica will rely on delegates to verify all care plan audit members pulled had a Legacy assessment completed in 2023.
- MnCHOICES assessments & UTR/Ref assessments will not be included in the EW, Non-EW, or SNBC audits.
- 2024 Training Element to include: mode of assessment for those that were assessed after 11/1/2023. This will not impact many files.

2024 MnCHOICES Audit

- Auditors plan to review a small number of MnCHOICES assessments.
- In 2024, audit samples (2023 charts) will have some documentation in MnCHOICES and some documentation outside of MnCHOICES. When possible, auditors will audit directly from MnCHOICES. Delegates will only need to submit things that can't be located within MnCHOICES such as 2022 HRA page #1, any letters not attached, case notes, etc.
- Auditors will be looking for the same elements as the Legacy audit. The main change is where documentation/evidence is located.
- 2024 will be learning curve for Care Coordinators and auditors.
- We appreciate the time and effort that go into ensuring a successful audit!

Care Coordination Updates

Clinical Liaisons and Joy Boser

Communication with other waiver workers (CADI, BI, DD)

- Per the DHS contract, CCs are to communicate with a member's waiver worker if they want to put any state plan home care or therapy services in place for the member using the DHS-5841 ***Managed Care Organization, County and Tribal Agency Communication Form - Recommendation for State Plan Home Care Services***. The document can be found on the DHS eDocs site by clicking here and searching for 5841.

- Communication between a Medica CC and a member's waiver worker or a member's targeted case manager is **essential and required**. Joint visits may be an option if it is in the best interest of the member.

- Release of Information (ROI) forms are not required to share information between the CC and waiver worker or financial worker. If you are receiving ongoing push-back from a county or sub-delegate of the county when attempting to communicate, share or request information on a member, please let us know.
- If you choose to use an ROI, Medica does not dictate which form you use but have historically referred CCs to the MDH ROI form if necessary. MDH Standard Consent Form_012615 (state.mn.us)

Chore Services Reminder – MSHO/MSC+ Only

New *Chore* specific RRF (Referral Request Form) When sending in the Chore RRF to the clinical liaisons for this service, in the email subject line enter **Chore Service.**

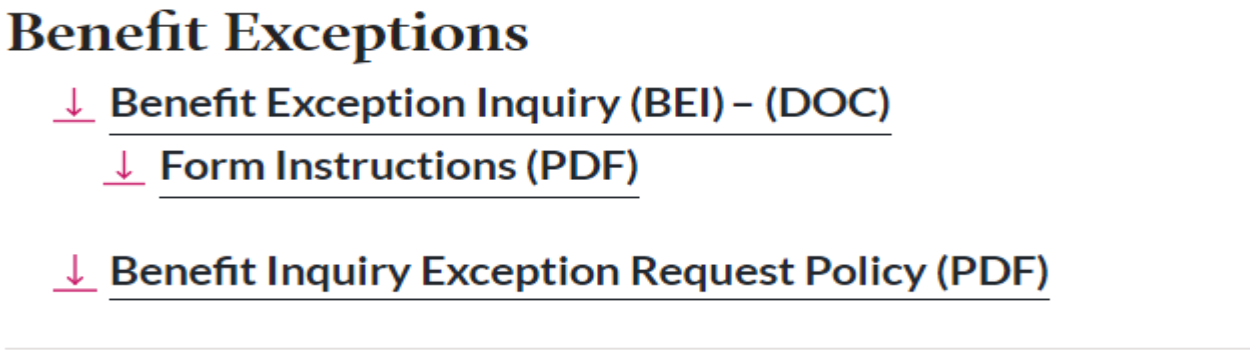
Include brief notation about the chore task in the Service Description Code column on the Referral Request Form (RRF). **(Please be specific if for example you are authorizing snow removal. Use appropriate auth timeframes such as current date through April 30th being snow season has begun).**

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 is a review process for these authorizations prior to entry.*

Refer to Claims Referral Guidelines under tools and forms if needed.

Benefit Exception Inquiries (BEI's)

- Reminder EAA requests to exceed the allowable cannot be reviewed
- BEI forms must be completed in their entirety
- Member address has been added to the BEI form
- Once you have all the necessary documentation, complete the BEI and date it accordingly, then submit
- If you are not completing BEIs frequently, please review the resources we have provided for you that can be found on each CC resource page under the DTR and BEI section:



New Transportation Directory

- Provider Oversight has created a new ***Medica Transportation Directory*** that can be found on each individual CC Resource page under the Tools and Forms section –*Transportation*.

- The directory contains county of vendor, vendor name, contact info, unassisted or common carrier, STS assistance provided, and hours of operation. Note there are two tabs on the grid: **transportation providers** and **public transit.**
- The directory will be updated as changes happen. Therefore, the most current list will always be on the CC Hub.
- If you have questions regarding the grid or contracted vendors, please reach out to ProviderOversight@medica.com

Community First Services and Supports (CFSS)

- Community First Services and Supports (CFSS) is a Minnesota health care program that offers flexible options to meet the unique needs of people. CFSS allows people greater independence in their homes and communities. CFSS will replace personal care assistance (PCA).
- DHS email announcement 2/28/2024 On Feb. 27, 2024, the federal Centers for Medicare & Medicaid Services (CMS) approved DHS' state plan amendments on CFSS.
- DHS will announce the CFSS launch date at least 90 days in advance.

Community Based Services Manual (CBSM) recent updates

- DHS Weekly Updates email 2/20/2024

Minnesota Health Care Programs (MHCP)

- MHCP Announcement 2/13/2024
- PCA now covers driving provided by PCA workers
- Review the PCA Manual Covered Services Section

Medica.com updates

Medica's Member Product Pages went through an update in mid February.

Bookmarked pages you may have had might not work any longer.

The main member pages links are below. From these main pages, you can choose activities such as find a provider, order a new member ID card, and locate plan materials such as the formulary, service area maps, member handbook, etc. under Forms + documents:

- https://www.medica.com/find-care/select-your-medicaid-plan/medica-accessability-solution-snbc
- https://www.medica.com/find-care/select-your-medicaid-plan/medica-accessability-solution-enhanced-isnbc
- https://www.medica.com/find-care/select-your-medicaid-plan/medica-choice-care-msc-plus
- https://www.medica.com/find-care/select-your-medicaid-plan/medica-dual-solution-msho

*These links can also be found on the CC Hub at the bottom of the page under Member Product Pages.

MnCHOICES

As you know we have been working in MnCHOICES revision project Phase 2 which was extended through March 29, 2024. This extension is rapidly coming to an end, and we will soon be moving into Phase 3.

Phase 3

This phase is scheduled to run from **April 1 to June 28, 2024**, during this phase lead agencies should:

- Continue to assign staff members to practice in the MTZ.
- Delegates should have 100% of users working in the production environment and completing HRAs, assessments and support plans in the production environment.
- Start all new assessments (including HRAs) in MnCHOICES revision.

MnCHOICES Continued

Phase 4

This is the final transition period – "**ALL-IN PHASE"** scheduled to **begin July 1, 2024**.

- Medica's expectation is that 100% of our delegate staff members will start all new assessments (including HRAs) in MnCHOICES revision. (Do not start new assessments in Legacy Systems.)
- Finish existing assessments and support plans in legacy systems by Sept. 30, 2024.

Note: MnCHOICES 1.0 assessments and support plans not completed by Sept. 30, 2024, will not migrate to MnCHOICES revision. DHS will deactivate MnCHOICES 1.0 after Sept. 30, 2024.

For full announcement: **Update on launch of MnCHOICES revision project**

Success Story - Bridging

Provided by:
Rose Seymour

Happy National Social Worker Month 2024


Medica®