# March Quarterly CC Meeting

March 7, 2023

# Agenda

Medica Behavioral Health – MSHO Case Management Program, ICBS and the Medica SUD Program

Becky Bills – DHS Updates:  MA reinstate, EVV

Courtney Chupurdy - Model of Care Review

Kristi Hocking – Referral Request (RRF) update

Joy Boser/Shelley Lano – Relocation Services vs Transitional Services

Theresa Wappes/Shelley Lano (Clinical Liaisons) – Care Coordination Updates

# DHS Updates

Medicaid Redeterminations and Electronic Visit Verification (EVV)

# Medicaid Redeterminations

- With the end of the PHE, all persons on Medicaid must complete renewal paperwork
- Renewals for Medical Assistance enrollees take place based on the anniversary month of the members application for coverage.
- Medica will receive lists from DHS as to who due for renewals in each month (called cohorts)
- Members in each cohort will receive a letter from DHS prior to renewal packet.
- Members in the first cohort will lose their eligibility effective 7/1 if they do not complete their renewal paperwork.
- Members who renew 7/1 will receive a letter in April and renewal packet in May. If their information is not received and processed at the county/tribe on time, they will lose eligibility on 6/30.
- Medica will be sending member letters, posting on social media and contacting members via text and phone.
- Care Coordinators are to support members in the following way:
  - make sure addresses are updated at the county
  - review lists of members in each cohort
  - outreach to members

# Electronic Visit Verification (EVV)

- 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.

# 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

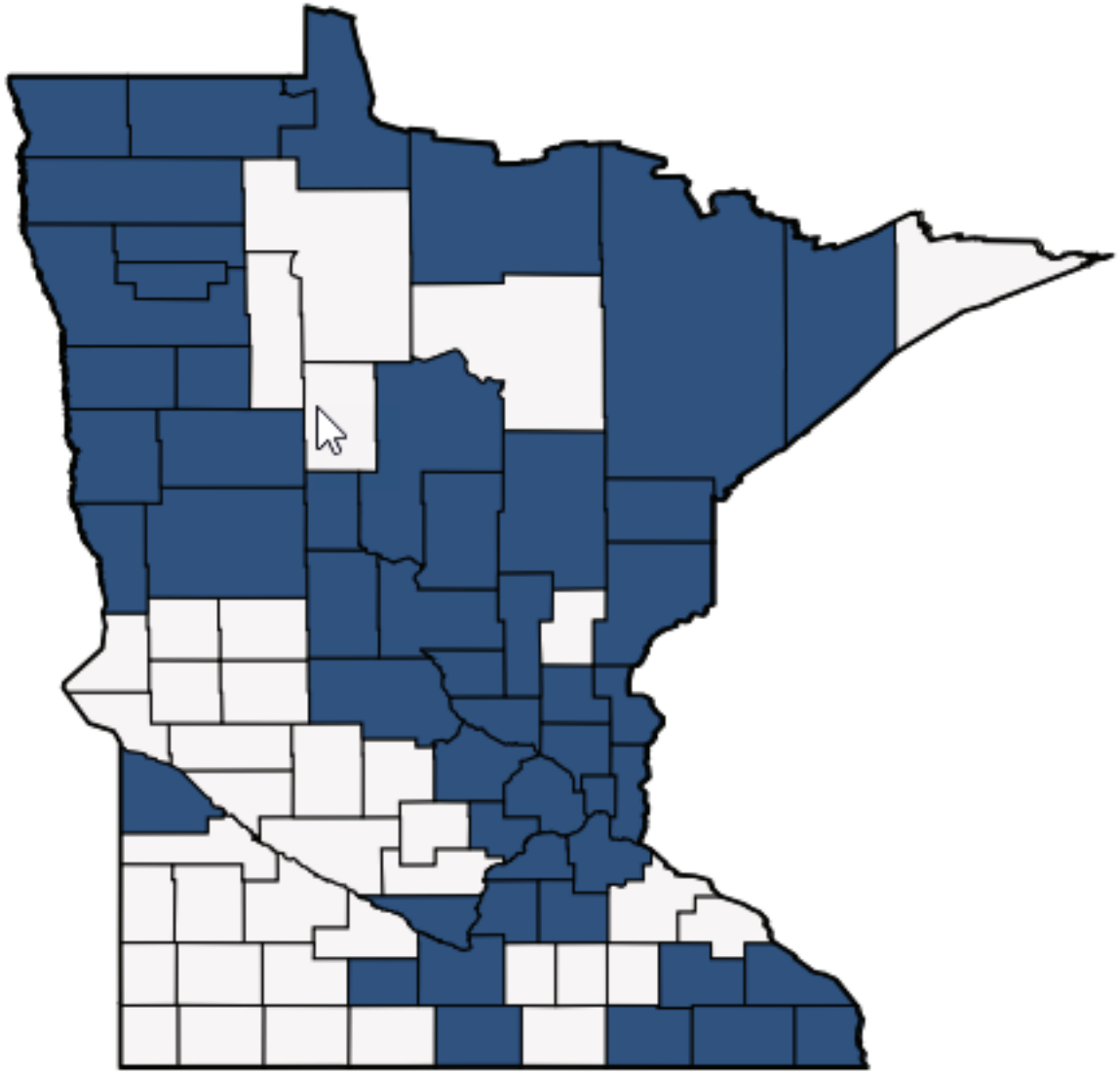
- Chronic Condition Special Needs Plan
- Enrolls beneficiaries with certain chronic and disabling conditions

# Medica 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 I-SNBC) | D-SNP |

# MSHO Eligibility

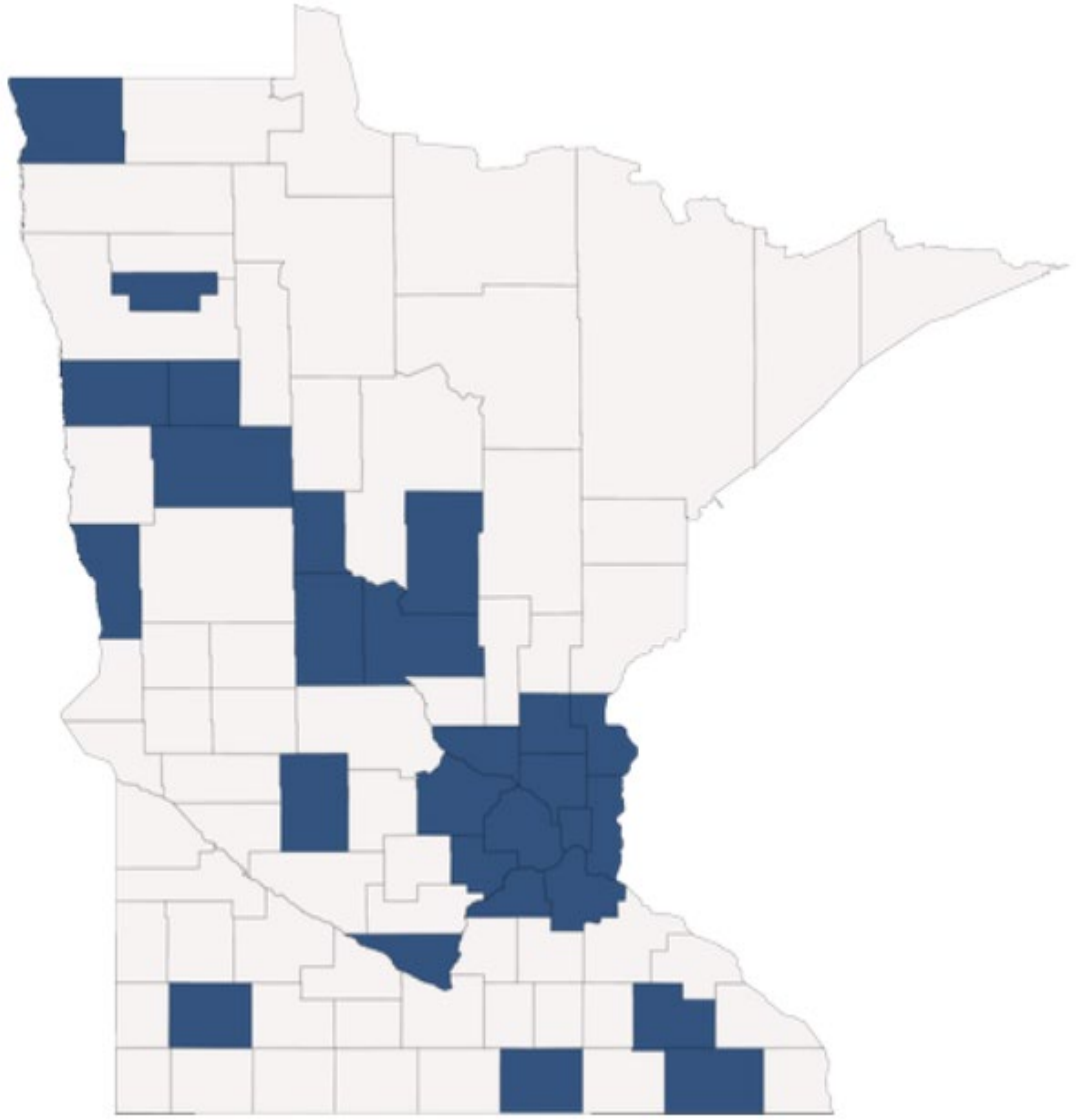
- Be 65 years or older
- Live in the Medica Dual Solution® service area
- Enrolled in Medicare Parts A & B
- Medicaid eligible



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

# I-SNBC Eligibility

- Be at least 18 and under age 65
- Live in the Medica AccessAbility Solution® Enhanced service area
- Enrolled in Medicare Parts A & B
- Medicaid eligible
- Have a certified disability through the Social Security Administration or the State Medical Review team.



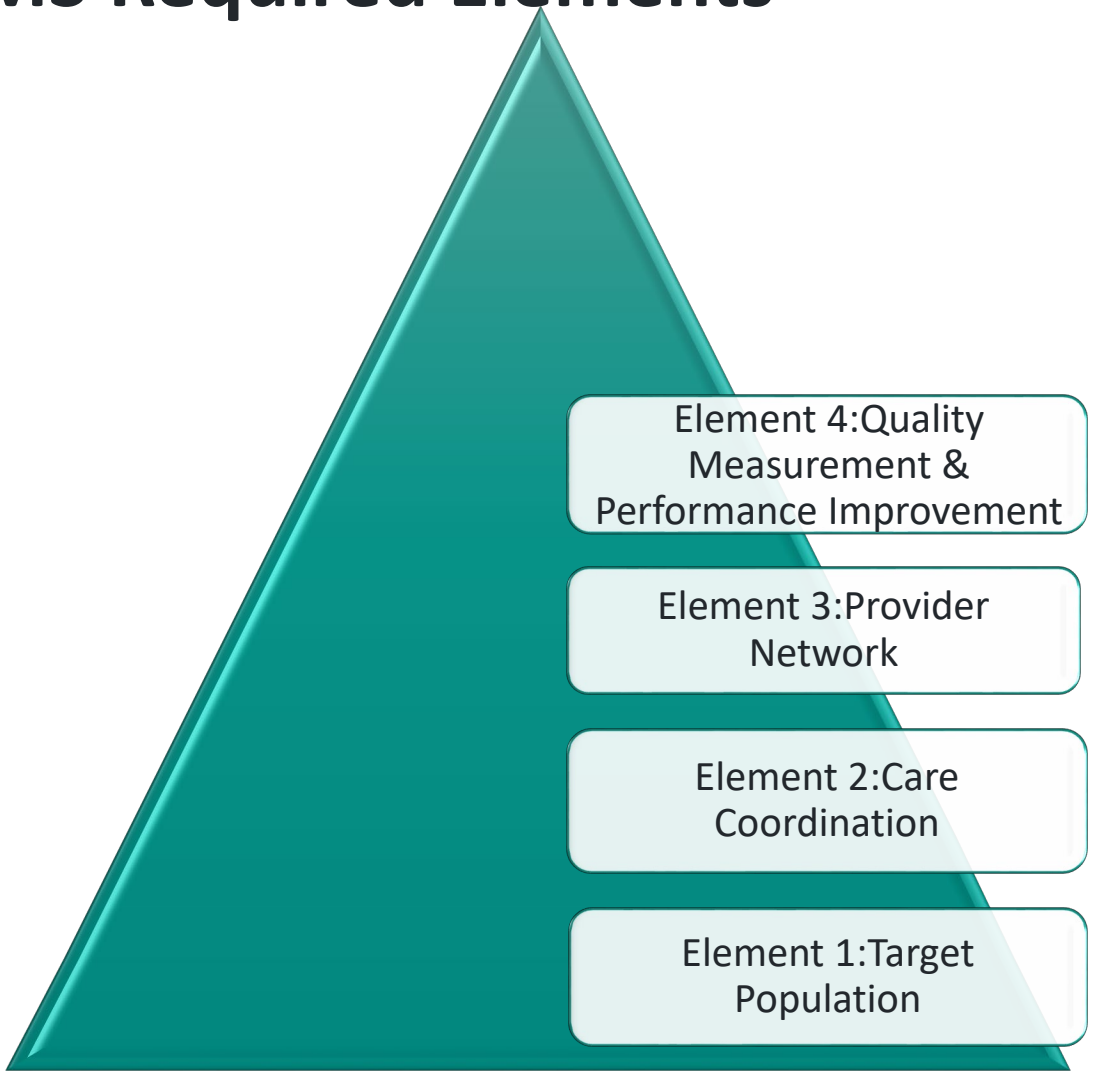
❖ ***Inclusive list of product eligibility, sales and enrollment process, benefits and services can be found at*** www.medica.com

# Model of Care

# Special Needs Plans and CMS Requirements

- Submission and Approval of Model of Care (MOC)
- CMS awards approval of MOC for 1 to 3 years
- CMS requires MOC Training be completed annually

# Model of Care: CMS Required Elements



# MOC 1: Description of Population

| Medica AccessAbility Solution® Enhanced (I-SNBC) (D-SNP) | Medica DUAL Solution® (MSHO) (D-SNP) |
|---|---|
| Gender: 57% female and 43% male | Gender: 69% female and 31% male |
| Average age: 50 | Average age:77 |
| Ethnic breakdown:<br>66.4% White; 24.7% Black; 3.1% Asian; 1% American Indian or Alaska Native; 0.3% Native Hawaiian or Other Pacific Islander; 3.4% Unknown/Other | Race breakdown:<br>70.3% White; 13.1% Black; 9.4% Asian; 2% American Indian or Alaska Native; 0.2% Native Hawaiian or Other Pacific Islander; 5.1% Unknown/Other |
| Average number of chronic conditions: 7 | Average number of chronic conditions: 8 |
| Top Chronic Conditions: Depression, Hypertension, Hyperlipidemia, Low Back Pain, Persistent Asthma, Diabetes | Top Chronic Conditions: Hypertension, Hyperlipidemia, Depression, Diabetes, Low Back Pain, Chronic Renal Failure |
| 98% live in the community; 2% live in an institutional setting | 86% live in the community; 14% live in an institutional setting |

# MOC 2: Care Coordination

- Every MSHO and I-SNBC 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 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 care 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<br>I-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.<br><br>*See Appendix A & B for Care Coordinator qualification checklists |

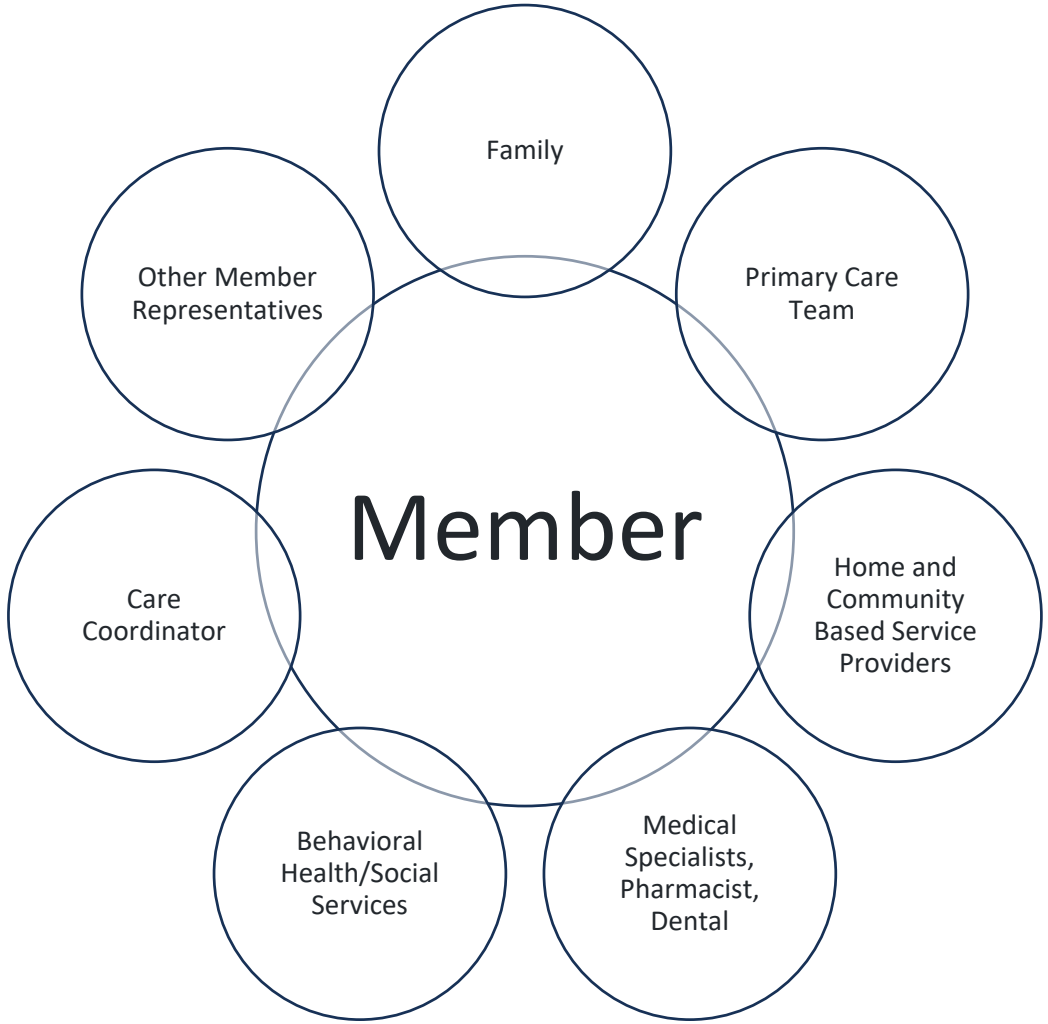
# Health Risk Assessment (HRA)

- Completed by Care Coordinator
  - Within 30 days of enrollment (MSHO); within 60 days of enrollment (I-SNBC)
  - 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, and mental health needs.
- The HRA provides insight into:
  - Determining and identifying a member's needs, wants, and concerns

# Care Plan/Support Plan

- Member Centered, addresses needs and concerns identified during HRA
- Includes member 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)

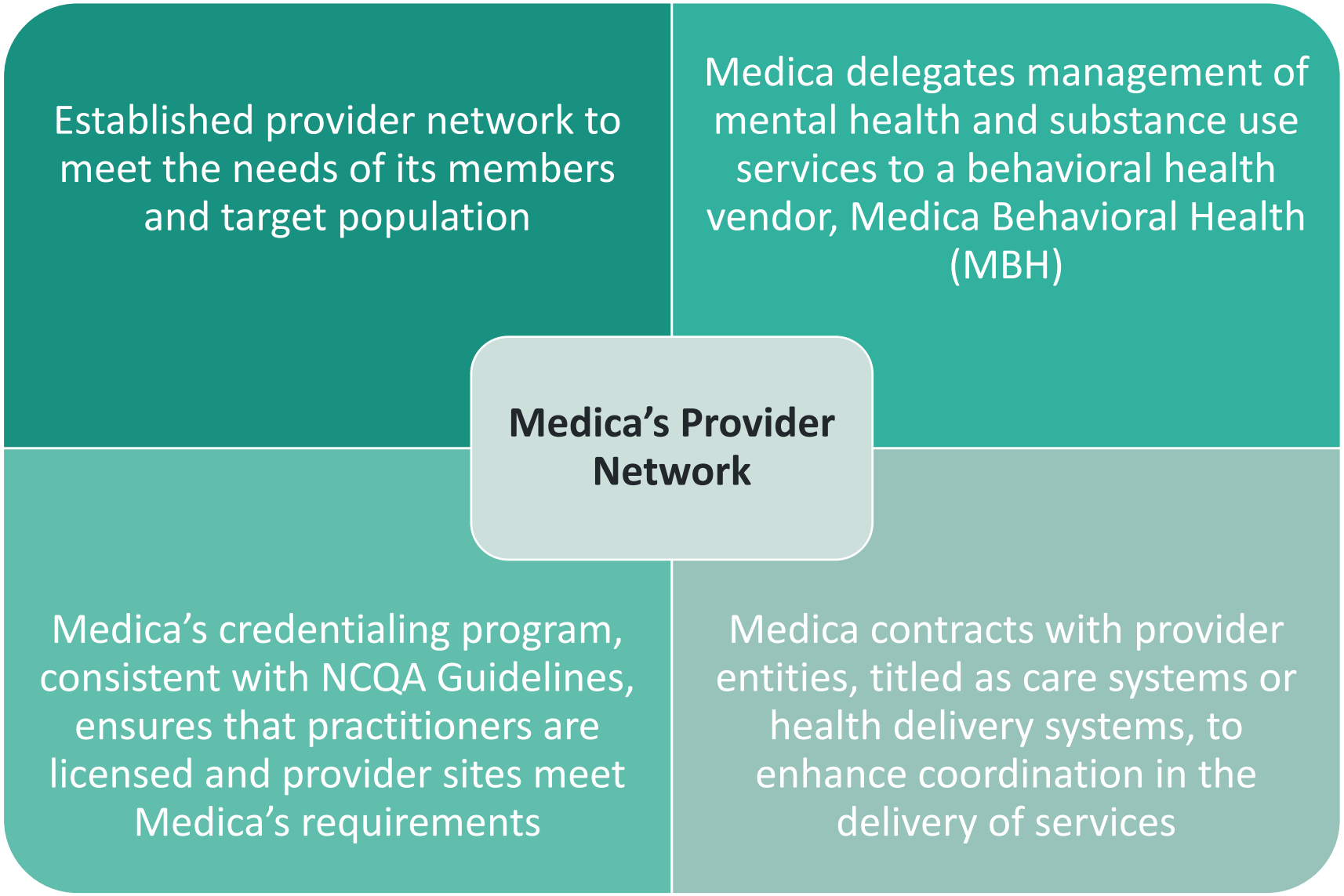



- ICT composition based on individual member needs and preferences
- Typically includes the member and/or their designee, PCP, and Care Coordinator, with other providers as appropriate (e.g., specialists, mental health providers, etc.)
- Care Coordinator is responsible for facilitating communication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

# 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 is able to 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)
- 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 care plan and shares this with the member and their Interdisciplinary Care Team, as needed

# 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:**

- Health Risk Assessment completion rates
- Implementation of the Individualized Care Plan
- Implementation of Transitions of Care processes
- Member satisfaction with the Care Coordination Program
- Medication adherence
- Hospital readmission rates
- ER utilization rates
- 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 (hold control + click to follow the link)

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

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

# APPENDIX A
# MSHO Care Coordinator Qualification Checklist

| **Hiring Organization:** | **Candidate Name:** |
|---|---|
| 1) Is the CC candidate a RN, PHN, Licensed SW, County SW evaluated under the Minnesota Merit System, PA, NP, or Physician? | If yes and MnCHOICES is **not** live→ Candidate is qualified to be an MSHO/MSC+ CC (please enter Candidate's credentials below)<br>If yes and MnCHOICES is live → Enter credentials below and go to question #4<br>**Candidate's Qualifying Credentials & License #:** _____<br>If no → Go to question #2 |
| 2) Will the CC candidate be supervised by a RN, Licensed SW, PA, NP, or Physician? | If yes→ Enter Supervisor's credentials below and go to question #3<br>**Supervisor's Qualifying Credentials:** _____<br>If no → Candidate is not qualified to be an MSHO/MSC+ CC |
| 3) Does the Candidate meet the DHS requirements for the provision of case management by virtue of meeting the social work standards under the Minnesota Merit System, which requires meeting the requirements in (a) **or** (b) **and** (c) below?<br>(a) a bachelor's degree from an accredited four-year college or university with a major in social work, psychology, sociology, or a closely related field;* ***or***<br>(b) a bachelor's degree from an accredited four-year college or university with a major in any field and at least one year of experience as a social worker/case manager/care coordinator in a public or private social services agency; **and**<br>(c) the knowledge, skills and abilities necessary to perform the job<br>*A **closely-related field** includes occupational therapy, physical therapy, speech-language pathology, audiology, recreational therapy, dietician, special education, rehabilitation counseling, nursing, human services or other field in health or human services that involves the job duties of a care coordinator/case manager, including assessment and service planning. | If yes → Complete below questions and go to question #4<br>Candidate's Qualifying Degree: _____<br>Candidate's Major: _____<br>If Candidate's degree is not listed in 3(a), describe qualifying experience (i.e., one year as a social worker, case manager or care coordinator in a public or private social services agency):<br>If no → Candidate is not qualified to be an MSHO/MSC+ CC |
| **4) (Effective once MnCHOICES is live):** Has the Candidate: (i) completed DHS training and received DHS certification as a Certified Assessor; **or** (ii) will they do so before being assigned any MSHO or MSC+ members; **or** (iii) do they meet an exception (Candidate is a PA, NP or Physician acting as a CC for members in nursing homes)? | If yes → Candidate is qualified to be a MSHO/MSC+ CC (please complete below)<br>**Date Certified Assessor Certification Obtained/Expected:** _____; **or**<br>**Exception Met (Credentials & CC Setting):** _____<br>If no → Candidate is not qualified to be an MSHO/MSC+ CC |

# APPENDIX B
# I-SNBC Care Coordinator Qualification Checklist

| **Hiring Organization:** | **Candidate Name:** |
|---|---|
| 1) Is the CC candidate a RN, PHN, Licensed SW, County SW evaluated under the Minnesota Merit System, PA, NP, or Physician? | If yes → Please enter Candidate's credentials below and go to question #4<br>**Candidate's Qualifying Credentials & License #:** _____<br>If no → Go to question #2 |
| 2) Will the CC candidate be supervised by a RN, Licensed SW, PA, NP, or Physician? | If yes→ Enter Supervisor's credentials below and go to question #3<br>**Supervisor's Qualifying Credentials:** _____<br>If no → Candidate is not qualified to be an SNBC/SNBC DSNP CC |
| 3) Does the Candidate meet the DHS requirements for the provision of case management by virtue of meeting the social work standards under the Minnesota Merit System, which requires meeting the requirements in (a) **or** (b) **and** (c) below?<br>(a) a bachelor's degree from an accredited four-year college or university with a major in social work, psychology, sociology, or a closely related field;* ***or***<br>(b) a bachelor's degree from an accredited four-year college or university with a major in any field and at least one year of experience as a social worker/case manager/care coordinator in a public or private social services agency; **and**<br>(c) the knowledge, skills and abilities necessary to perform the job<br>*A **closely-related field** includes occupational therapy, physical therapy, speech-language pathology, audiology, recreational therapy, dietician, special education, rehabilitation counseling, nursing, human services or other field in health or human services that involves the job duties of a care coordinator/case manager, including assessment and service planning. | If yes → Complete below questions and go to question #4<br>Candidate's Qualifying Degree: _____<br>Candidate's Major: _____<br>If Candidate's degree is not listed in 3(a), describe qualifying experience (i.e., one year as a social worker, case manager or care coordinator in a public or private social services agency):<br>If no → Candidate is not qualified to be an SNBC/SNBC D-SNP CC |
| 4) Does the Candidate have experience working with people with disabilities, primary care, nursing, behavioral health, social services and/or community based services? | If yes → Candidate is qualified to be an SNBC/SNBC DSNP CC<br>**Describe qualifying experience:**<br>If no → Candidate is not qualified to be an SNBC/SNBC DSNP CC |

# Model of Care Questions?

Contact:

Courtney Chupurdy, SNP Program Manager

Courtney.Chupurdy@Medica.com

# Operations Updates

Care Coordination Support Specialists

# Operations Team

- Delegates are each assigned CC Specialist (this is the person who enters your authorizations)
- Referral request forms:
  - Need to be emailed to ReferralRequest@medica.com
  - For services that require a referral in Medica's system, see the Claims Referral Guidelines on Medica.com
  - Authorization number will be emailed back to you
  - Support Specialists have 10 business days to complete authorization and send the authorization number back to the requestor
- Other communications:
  - Daily Admission Report (DAR)
  - PAS (Pre-admission Screening) notifications
  - Nurseline reports
  - Faxes from CADI/DD/BI/etc. workers
    - Please reach out to who completed the form.  If they don't hear from you they resend it.

# Care Coordination Delegate Support Specialists

Care Coordination Delegate Support Specialists Team
Medica Referral Request Forms emailed to:
ReferralRequest@medica.com
**Effective: 1/1/2023**

**Zach Tibodeau**
952-992-3019
Zachary.Tibodeau@medica.com

**Care Systems**
Axis Healthcare
Genevive
HCMC
LifeSpark MSHO
Medica Behavioral Health
North Memorial

**Agencies**
Lutheran Social Services
Meridian Services
Thomas Allen, Inc.

**Counties**
Freeborn County
Red Lake County
Watonwan County
Wilkin County

**Also specializing in:**
Behavioral Health Home
Daily Admission Report (DAR)

Nurseline Reporting
PAS Reporting

**Mai N Yang**
952-992-3834
Mai.N.Yang@Medica.com

**Care Systems**
Bluestone Physicians

**Agencies**
Hammer Residence
Jewish Family Services
Independent Lifestyles, Inc.
Mental Health Resources
MN Stroke Association

**Counties**
Kanabec County
Kittson County
Koochiching County

**Also specializing in:**
Housing Stabilization
Moving Home MN

**Elsbeth Volk**
952-992-3717
Elsbeth.Volk@medica.com

**Care Systems**
Fairview Partners
University of MN Physicians

**Agencies**
Pinnacle Services
ResCare MN

**Counties**
Becker County
Blue Earth County
Carlton County
Carver County
Clay County
Mahnonmen County
Mower County
Nicollet County
Norman County
Olmstead County

**Also specializing in:**
Benefit Exception Inquiry (BEI) initial contact
PAS Reporting

**Timothee Ly**
952-992-2644
timothee.ly@medica.com

**Care Systems**
CentraCare
Essentia Health

**Agencies**
Catholic Charities
Keystone

**Counties**
Cass County
Crow Wing County
Fillmore County
Houston County
Le Sueur County
Morrison County
Todd County
Wadena County

**Also specializing in:**
Daily Admission Report (DAR)
Housing Stabilization

# Referral Request form:

Provider information:

- Billing addresses are needed
- Double check the spelling of the provider name
    - Home Care vs Homecare vs Home Kare
- We are unable to search by UMPI numbers
- NPI numbers are helpful
- Tax ID numbers are better
- 2024 is a Leap year.  Do you really want to end your authorization on 2/28/2024, or should it be 2/29?

Assisted Living providers

- Is the facility where they live actually the billing entity?  Or is it different?  Please provide us with the billing entity.

# Referral Request form:

DME codes:

- If there is a HCPC code use it
  - Do not use code A9270 (non-covered item or service)
  - Only use T2029 for DME items if there isn't a code for the item
  - If you are using T2029 for multiple items, we need the break down cost per item
    - Example: $12 dollars for wipes, $20 for filters/month
    - Don't "round up" the price from the DME company.  Claims will deny the item if it doesn't match the authorization
  - If you are using T2029 for something out of the ordinary, an additional sentence or two of explanation is appreciated
    - Unusual requests we have received that needed further explanation:
      - 6 pairs of pants (they were actually some sort of pull up)
      - Power generator (we needed to know what it was being used for)

# Referral Request form:

Chore services:

- Please specify what the chore is being requested when submitting
- Has two codes
    - S5120 is billed by units (ex:  8 units/week for lawn care)
    - S5121 is billed by cost (ex:  $5000 to clean up hoarder house)

# Referral Request form:

If your Referral Request form gets sent back:

- Please respond timely
- Send the email back with the updated RRF form attached
- Send it back high priority

# Care Coordination Updates

- Interdisciplinary (IDT) Meetings
- High Cost Claims
- Medica CC Onboarding and Resource Guide
- MnCHOICES Update
- CC determination of appropriate services
- Transitional Services and Relocation Services
- CC Support Line Reminder
- Clinical Liaison Office Hours

# Interdisciplinary Meetings/Case Consultations

- The IDT process is posted on the CC HUB under policies and processes
- Purpose: to provide a process for reviewing complex members in an interdisciplinary team (IDT) setting to improve their quality of care, reduce unnecessary utilization, and identify target areas for future intervention.
- IDT's are the 3rd Wednesday of every month scheduling every 30 mins from 9am-noon
- Sign-up sheet is found in the IDT folder in Sharefile (if you need access to this folder, inform the CL's).
- If a CC would like a case consultation, preferred method is to use the IDT process. If urgent reach out to the CL's and another time can be arranged for.
- High cost claims reviewed may result in a request to have the CC present the case for IDTs.

# High Cost Claims (HCC)

- Member cases reviewed in relation to their cost of claims
- Team meets every other week to review cases pulled at random
- Team members research these claims and the member’s case to determine the reasoning behind the high cost claims.
- Note a team member may reach out to you for information, please comply and provide the with requested information.

# Medica CC Onboarding and Resource Guide

- As a result of suggestions made by our delegates, Medica developed a new CC Onboarding and Resource Guide
- It is an all inclusive guide that includes:
  - Overview of the Care Coordination HUB
  - Care Coordinator Trainings by product
    - The Care Coordinator Trainings section includes both required and additional trainings that are vital for new Care Coordinators to become familiar with their role.
    - These trainings can also be used as refresher trainings to sharpen skills and knowledge for all Care Coordinators.
  - Resources both internal & external

# MnCHOICES Update

- DHS will be implementing a phased launch of the MnCHOICES revision from April 3, 2023 through August 31, 2023
- Medica does not dictate your workflow.  Each delegate will need to determine what workflow works best for them.
    - MnCHOICES phased launch should be at the delegate level verses the CC level meaning all CCs should be completing documentation in the Revised MnCHOICES platform and gradually increasing workflow in that system so they are all becoming familiar with the new system.
    - The delegate will determine who will be entering assigned members (enrollment) from Medica into MnCHOICES; how much time you will allot for assessments (assuming assessments will take longer than previously) - will you complete the entire assessment via computer or take some notes and finish up at the office?
- Keep in mind, our contractual requirements and policies are NOT changing
- What is changing?  Care Coordinators will now be completing assessments, support plans, and some additional documents (RS Tool, OBRA, etc.) within the MnCHOICES platform vs on paper.

# MnCHOICES Update

- Mentors should continue attending all launch calls and mentor office hours.
  - Mentors should use this time to ask questions and develop an organizational plan for role out
  - Submit “Help Desk Form” with questions or issues you are having with functionality
- Mentors are responsible for training their organizations staff and tracking training
  - Make sure all required TrainLink trainings are completed
  - Encourage staff to practice in the MnCHOICES Training Zone (MTZ)
  - Utilize the Help Center training resources in MTZ (Smart guides, practice guides, and Micro-learnings)
- Mentors should plan to attend all Medica and DHS post-launch support meetings

**Medica MNCHOICES Mentor Touch Base is scheduled  March 14, 2023 11am-12noon**

# CC determination of appropriate services

- The Care Coordinator determines the appropriate service/s based on the member's assessed needs.
- The member is given choices on how their needs can be met and must be the most cost effective service to meet a member's needs while maintaining their health and safety.
- Services must also be within the waiver case mix budget limits.
    - If the Care Coordinator is asked by a provider to "switch" to or increase ICLS or chore services for example, and refuse to provide or accept a referral for another service they are enrolled with the Department of Human Services (DHS) to provide, such as Personal Care Assistance or homemaker, we ask that the Care Coordinator complete the Care Coordinator Concern form available on the Care Coordination Hub under Tools and Forms and Miscellaneous. Medica will then share this information with DHS Provider Enrollment.

# Transitional Services and Relocation Service Coordination

- **Transitional Services** is an EW service
- Transitional services for EW and disability waivers criteria is different
  - Moving from an eligible licensed setting to independent or semi-independent community-based housing
    - Hospitals
    - Adult Foster Settings
    - Certified facilities and intermediate care facilities
  - Moving from a setting where the items were provided to a setting where these items are not normally furnished
  - Not able to access the items or support from other funding sources.

https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs-292452#

- **Relocation service coordination targeted case management (RSC-TCM):** A form of TCM that provides coordination of activities to help a person who resides in an eligible institution gain access to medical, social, educational, financial, housing and other services and supports that are necessary to move to the community.
- **Moving Home MN (MHM**) - is usually used for persons who may take longer to transition to the community. It is a little bit more involved and members may not meet the eligibility criteria so you may want to check that out first. For MHM we do contract with providers and you as the CC can make a referral to DHS (online) and that gets the process going for the member. DHS determines eligibility and will let Medica know if member is eligible.

# CC Support Line Reminder

- MedicaCCSupport@medica.com is for CC use only. Please do not share this email with providers, county case managers etc. The same would go for the CC support phone line.
- Both email and phone line are dedicated to care coordinators needing assistance with member concerns, case consultation, care coordination inquiries r/t policy and process, etc.
- Please refer others to customer service or provider services accordingly.
- Keep in mind, customer service is best to reach out to if you have questions regarding coverage or benefits.
- Also note, questions regarding policy, care plans, audit and documentation requirements, delegation oversight and Model of Care should go to the Regulatory Quality team: MedicaSPPRegQuality@medica.com

# Clinical Liaison Office Hours

- The Clinical Liaisons will be hosting “Office Hours” for Care Coordinators monthly.
- Office hours will be twice a month:  one day for MSHO/MSC+ and one for SNBC/SNBC Enhanced
  - MSHO/MSC+ will be from 1-2pm the 2nd Wednesday of the month
  - SNBC/SNBC Enhanced will be from 1-2 pm the 4th Wednesday of the month
- The purpose of these hours is for CC’s to ask questions about care coordination process and policy.  Specific member issues should be addressed in an IDT or consult with one or both of the Clinical Liaisons.


THANK YOU