Medica Care Coordinator Training Manual: Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) Members

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Plan Overviews

Minnesota Senior Health Options (MSHO) Overview:

- Medica product name: Dual Solution
- DHS product name: MSHO (Minnesota Senior Health Options)
- Eligibility
    - 65+ years old
    - Eligible for Medical Assistance/Medicaid
    - Has Medicare A and B
- MSHO is a voluntary program; member must elect

Additional Supplemental Benefits are offered annually to MSHO members.

Minnesota Senior Care Plus (MSC+) Overview:

- Medica product name: Medica Choice Care
- DHS product name: MSC+
- Eligibility
    - 65+ years old
    - Eligible for Medical Assistance/Medicaid
    - May have Medicare
- MSC+ is the default program

Additional Benefits: Healthy Savings, Personal Health Advocate and Smoking Cessation

Rate Cell and waiver designation

- MSHO has Rate Cells A, B, C, D, & F
    - Rate cell A - a member living in the community and not open to the elderly waiver.
    - Rate Cell B - a member open to the elderly waiver
    - Rate Cell C - assigned for members aged 65 and older who is eligible for Moving Home Minnesota services while open to the Elderly Waiver program.
    - Rate cell D – Institutional member
    - Rate cell F – a member receiving hospice services
- MSC+ is designated as either Non EW or EW

The Value of Care Coordination:

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

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Care Coordinators (CCs) have the unique responsibility of assisting the member across all settings of care, transitions, and stages of the aging process. The CC is the member's primary contact for accessing all benefits under MSHO or MSC+.

Enrollment

Upon receiving the enrollment information from Medica, Care Coordinators are to document the date the enrollment list was received. From that date, Care Coordinators have 10 business days to contact the member by telephone or letter to:

- Introduce themselves to the member
- Provide Care Coordinator contact information
- Answer any questions the member has about their plan and/or benefits
- Offer a Health Risk Assessment

Assessment

Health Risk Assessment

Members new to managed care will receive a complete Health Risk Assessment (HRA) within 30 calendar days of enrollment for MSHO and MSC+ EW and within 60 calendar days of enrollment for MSC+ non-EW. Reassessments will be completed annually (within 365 days) thereafter.

The CC should complete one of the following:

- MNChoice Assessment (upon launch) OR DHS 3428 https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3428-ENG
- MNChoice HRA-MCO (upon launch) OR DHS 3428H https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3428H-ENG
- Unable to Reach/Refusal Assessment
- Institutional Assessment

Follow Medica guidance regarding in-person visits.

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

DHS-3428/Long-term care consultation (LTCC) assessments and reassessments (MnChoices assessments upon launch) are used to determine access to home and community-based services

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and/or home care services performed as part of this assessment process. Upon completion of the assessment, the Care Coordinator is required to enter specified information into MMIS for all community members.

- To determine member case mix classification based on identified dependencies refer to the DHS-3428B https://mn.gov/dhs/general-public/publications-forms-resources/edocs/

Members on a waiver other than Elderly Waiver:

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

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

- A Care Coordinator can see in MN-ITs if the MSHO or MSC+ member is on another waiver.
- If the member has a legal guardian they must be contacted and invited to be present at the assessment. The legal guardian can decline to be present; if they do that must be documented. If present, the legal guardian signs any paperwork; if not present paperwork needs to be sent to the legal guardian for review and signature.
- If the member lives in a group home setting, the CC must communicate with and meet with the group home provider to let them know that they are involved and create a relationship for team work on the member's behalf.
- Assessment timelines, care plan timelines and, follow-up contact schedules apply.
- The waiver worker is seen as the member primary case manager (lead agency) as most of the member's Activities of Daily Living (ADL)/Instrumental Activities of Daily Living (IADL) needs are being met by the disability waiver services.
- The CC does not need to complete an LTCC (DHS 3428) or full MnChoice Assessment. The waiver worker enters a screening document into MMIS.
- The CC completes the Minnesota Health Risk Assessment (3428H) annually and with significant change of condition and keeps it in their records. The document is found on the DHS eDocs site by clicking here and searching for 3428H.
- Request a copy of the waiver workers care plan and refer to that when completing the MSHO/MSC+ care plan/support plan.
    - The CC completes a care plan/support plan and indicates on this plan when items are being managed by the waiver worker and refer to the waiver plan if received. Include copy of the waiver plan in the member's records. CC completes sections of the plan not addressed by the waiver worker including by not limited to: advanced directives, preventative areas, PIP related areas, etc.

- The CC communicates with the waiver worker (DHS MCO/County/Tribal Agency Communication form # 5841) throughout the year when necessary, and request that the

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waiver worker includes them in their annual assessment of the member. The CC also provides the waiver worker with a copy of the completed care plan as a way to create a collaborative, integrated care plan.

Transfer Member Health Risk Assessment

Medica Transfer Member HRA may be completed for members changing products (MSC+ to MSHO or MSHO to MSC+) or changing Care Coordination entity.

- The Transfer Member HRA cannot be used for Unable to reach/refusing members.
- The Transfer Member HRA includes a review of the current assessment, care plan, and member signature sheet.
- If there are any changes noted when reviewing the previous assessment and care plan with the member, a new assessment may be needed. If not, the Transfer HRA can be completed.
- The member's annual reassessment will be due within 365 days of their last full HRA.
- Refer to the Medica Transfer Member Health Risk Assessment document on the Care Coordination Hub

Unable to Reach/Refusal Assessment

Unable to Reach/Refusal Assessment may be completed if the member declines an assessment or is unable to be reached.

- A minimum of 3 contact attempts plus a mailed letter are required.
- If unable to reach, enter #50 unable to contact into MMIS.
- If member declines the assessment, enter #39 refusal of HRA into MMIS.

Change in Condition Assessment

A Change in Condition Assessment may be necessary if:

- The member has requested an updated assessment
- The member has had a marked improvement or decline

Care Coordinators have 20 days to complete the assessment following notification.

A Functional Needs Update is a remote assessment that can be used to document a change to a person's assessed need(s) any time during the service agreement year. This does not count as a full assessment. This only applies to members on EW with a MnCHOICES assessment.

Institutional Care Coordination

If a member is admitted to a nursing facility, and during that time is due for their annual assessment, Care Coordinators can complete the Institutional Assessment found on the Care Coordination Hub.

If the member is in the process of discharging to the community, complete the LTCC/MnCHOICES assessment. Follow the pre-admission screening process, also known as PAS when needed. See the Partner Nursing Home Checklist for more information.

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MMIS entry of the Preadmission Screening activities (PAS) is needed to follow state and federal requirements that prohibit medical assistance payments for NF services provided prior to completion of required preadmission screening. It confirms the need for nursing facility level of care and screens people for mental illness or developmental disabilities. This MMIS entry is done by day 30 of placement. Activity type would be 01 Telephone Screen. Communication of the nursing facility admission is made to the financial worker using the DHS-5181 ***Lead Agency Assessor/Case Manager/Worker LTC Communication Form*** and the OBRA activities completed. The document is found on the DHS eDocs site by clicking here and searching for 5181.

Institutional members are to be assessed annually at a minimum and with changes in condition. CC to communicate with PCP, if known, annually at a minimum. This assessment is to be done by gathering information from the member, their responsibility party and the facility staff.

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

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

For nursing home inquiries, refer facility to NFCommunications@medica.com.

Annual Reassessment

Care Coordinators are required to complete annual reassessments within 365 days from the last full assessment.

If the member is on Elderly Waiver or utilizes PCA services, the Care Coordinator should ensure their assessments are entered in MMIS by the monthly capitation date. Refer to the Care Coordination Hub for the list of Capitation Dates under the product, Tools and Forms, Miscellaneous.

MMIS Entry

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

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Per DHS MMIS entry manual for MSHO/MSC+ (DHS edoc #4669):

> *"Because this document plays a critical role in establishing payments for a variety of long term care services, including nursing facility services, each agency must ensure timely submission of the LTC screening document information into MMIS. It is strongly recommended that no more than fourteen (14) calendar days lapse between completion of any LTCC or case management activity and the submission of the data into MMIS".*

The document is found on the DHS eDocs site by clicking here and searching for 4669.

DHS resources related to MMIS entry:

- DHS-3428 *Minnesota Long Term Care Consultation Services Assessment Form*

The document is found on the DHS eDocs site by clicking here and searching for 3428.

- DHS-3428H *Minnesota Health Risk Assessment Form*

The document is found on the DHS eDocs site by clicking here and searching for 3428H.

- DHS-4669 *Instructions for Completing and Entering the LTCC Screening Document into the MMIS for the MSHO and MSC+ Programs*

The document is found on the DHS eDocs site by clicking here and searching for 4669.

- Pre-Admission Screening Bulletin #19-25-02R

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

MMIS must be kept current with the name of the current CC assigned to each member per DHS contract. See the Assessment Schedule Policy on the Care Coordination Hub for more information on this process.

Note: Upon implementation of MnCHOICES, Care Coordinators will be required to use the state's MnCHOICES Assessment or MnCHOICES Health Risk Assessment (HRA) form.

Care Plan/Support Plan

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

- A Collaborative Care Plan/MnCHOICES Support Plan is written and maintained for each engaged member on MSHO and MSC+.
- MSHO Unable to Reach or Refusing members require the *Unable to Reach/Refusal Care Plan*.

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- Members who reside in long-term care (have a completed Institutional Assessment) do not require a separate care plan to be written.

Care Coordinators develop, monitor, and update the member's care plan based on the assessment, including person-centered principles and practices within thirty (30) days of assessment completion.

Care Plans/Support Plans must include the following components:

- **Interdisciplinary/Holistic Focus**- The care plan should incorporate the primary, acute, long-term care, mental health and social service needs and wishes of each member with coordination and communication across all providers.
  - For community members, communication with primary care (see PCP letter template), attending appointments as needed and involving family in care planning process and visits.
  - **Preventative Focus-**For community members: this may include immunizations, vision, hearing, and dental exams, tobacco cessation, alcohol use, fall risk, medications, and nutrition.
- **Disease Management**- Adoption of protocols and best practices are encouraged. Care Coordinators are to provide education to members as needed. See the Health Improvement Programs section under tools and forms on the CC webpage for more information.
- **Back up for emergency situation**- Assist the member/responsible party in planning for emergency situations, such as sudden illness, accident, worsening of chronic conditions. This planning should also include back up plans for essential services.
- **Safety Plan**- This is completed when there is a safety concern or risk identified with the member. If there are identified health and safety risks, document how these will be addressed with services or the members plan for managing risk in the applicable portion of the care plan. If the member doesn't have a plan because member doesn't have the risks identified or doesn't believe they have any risks, note this on the applicable section of the care plan. If the Care Coordinator offers a service that is critical to the member's health and safety that is not accepted by the member, this should be noted.
- **Advance Directive Planning**- Care coordinators review health care directives annually and with changes in care needs. These reviews are documented on the care plan. This includes documentation of refusals. All Medica MSHO and MSC+ members receive a health directives packet in their enrollment materials.
- **Annual Comprehensive Primary Care Visit**- Care planning should document efforts to ensure all members have had an annual comprehensive PCP visit.

Member goals must be written in SMART format and include:

- Identified goals and member specific interventions; including who is responsible for each intervention (for example: "Jane Doe will…."; "care coordinator will….")
- Monitoring and evaluation of goal outcomes must include dates; the date to evaluate outcomes will be the date of the next follow-up contact or at a minimum be the next scheduled reassessment date.
- Identify possible barriers, such as lack of transportation, language, cognition, and design interventions that address these barriers so goals can be achieved.

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- Underlying barriers/issues can be discussed under CC recommendations.
- A schedule for a follow-up plan and communication.

Assessment Documents & Post Visit Follow-up

OBRA Level 1 Activity

Medica Care Coordinators are to complete an OBRA level 1 form for all MSHO and MSC+ community members during the initial assessment as well as with annual reassessments. This is a DHS contract requirement. See below for the DHS form and for information on why this is completed as well as the instructions. If the member "triggers" for an OBRA Level II, the Care Coordinator is required to make a referral to the county for completion.

- OBRA Level I Criteria – Screening for Developmental Disabilities or Mental Illness (DHS-3426) (state.mn.us)
- If completing MnCHOICES assessment, form is located under evaluation and screening forms.

Caregiver Assessment

The Caregiver Assessment is required when an informal care giver is identified. The assessment is included on the LTCC. The DHS 3428H does not inquire if the member has an informal caregiver. If the Care Coordinator determines that a member has an unpaid/informal caregiver, they should conduct the Caregiver Assessment, DHS 6914. The form is found by clicking here to access edocs.

Caregivers are a very important part of the members care team. We want to ensure that informal caregivers have their needs met as they provide a tremendous amount of support to our membership, allowing them to remain in the community. We want to ensure they have the supports they need to continue to be successful in meeting both their own needs and the member's needs. This may mean caregiver training/education, caregiver support groups, additional services to ease the burden on the caregiver (HHA, SNV).

Care Coordinator Leave Behind Document

It is required that Care Coordinators document that the Leave Behind is provided to the member annually. It can be left with the member at time of assessment or mailed. Leave Behind document can be found on the Care Coordination Hub site under *Tools and Forms*.

County/Tribal Nation Communication

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

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

The Care Coordinator communicates with lead agencies (counties/tribal nations) for members on waivers such as BI, CADI, DD related to the members need for state plan home care services using the DHS-5841 ***Managed Care Organization, County and Tribal Agency Communication Form - Recommendation for State Plan Home Care Services***. The document is found on the DHS eDocs site by clicking here and searching for 5841.

Care Coordinators are required to communicate with the receiving health plan if the member has changed health plans or with the lead agency (county/tribal nation) if the member has dis-enrolled and is receiving services which may need to be paid for Fee-For-Service. This communication is done using the DHS-6037 ***Home and Community-Based Services Case Management Transfer Form***. The document is found on the DHS eDocs site by clicking here and searching for 6037. See the instructions for this form related to communications that are required.

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

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

- Pre-petition Screening
- OBRA Level II Screening for Mental Health and Developmental Disability
- Spousal Impoverishment Assessments
- Adult Foster Care
- Group Residential Housing Room and Board Payments
- Chemical Dependency room and board services covered by the Consolidated Chemical Dependency Treatment Fund
- Adult Protection

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

Information as to what Mn Tribal Nation provides waiver case management can be found here: DHS CBSM Manual

Referral Request/Authorizations/Operations:

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Care Coordinators will assist members by making appropriate referrals for services.

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

- The ***Referral Request Form*** can be found on the Care Coordination Hub website under *Tools and Forms → Referrals*.

- Refer to *Claims Referral Guidelines* for a list of services that require a service authorization. The guide can be found on the Care Coordination Hub website under *Tools and Forms → Referrals*.

When the Referral Request Form is completed, the Care Coordinator will email this request to the Support Specialist Team ReferralRequest@medica.com

Medica Support Specialists will enter the member authorizations in the system for billing. Providers who have questions related to claims payment should contact Medica Provider Service Center at 1-800-458-5512

Letters

Letters are another communication tool used with our members. Letters that are sent by Care Coordinators to members must be approved by DHS/CMS. These approved letters are found on the CC HUB. There are several letters that are required to be sent out. Remember to utilize the Assessment Checklists on the CC Hub to ensure you are utilizing the appropriate required letters.

- Post-Visit Letter: Must be sent within 30 days following an HRA.
- PCP Letter: Must be sent to PCP within 30 days following an HRA. This letter may also be sent if there is a change in condition to report or a transition.
- Member Refusal Letter: sent to members within 30 days who have refused an assessment.
- On-going No Contact Letter: sent to members who the Care Coordinator is unable to reach.
- Refer to **Care Coordination Hub** the for the full list of letters.

Ongoing Follow Up

Care Coordinator documents their plan for member contact based on member request, identified risks, needs and fragility. Contact may include the following:

- Medica requires 6 month follow-up at a minimum.
- Documentation of follow-up contacts can be summarized on the care plan & detailed in the case notes.
- If this contact does not occur as indicated, documentation needs to be present why the plan wasn't followed.
- Care Coordinators are sent the Enhanced Care Coordination Report quarterly. This report shows the Care Coordinator which members are at the highest risk and may

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require increased intervention. Care Coordinators should review the report quarterly and follow up with the member as appropriate.

- Assist with facilitating annual physician visits for primary and preventive care and assist in removing any barriers member is facing related to obtaining this care.
- Care Coordinators are to assist members in locating and accessing specialists and sub-specialists including those with experience in working with persons with disabilities.
- Arrange and coordinate supports and services identified through the assessment and care planning process.
- Monitor and record outcomes in order to evaluate the adequacy of services and interventions.
- Assist the member and/or authorized family members or alternative authorized decision makers, if any, to maximize informed choice of services and control over services and supports.
- Assist the member with health plan related issues as needed. This could include referring the member, family, or provider to the appropriate contact point within Medica. Care Coordinators are not the primary contact for billing issues for providers. For these issues providers should be referred to Medica Provider Services.
- Educate member about good health practices, including wellness and preventative activities. The CC will obtain and distribute self-management materials and education to members regarding disability related conditions common among persons with disabilities.
- Participate in Quality Improvement Projects (QIPS) or Chronic Condition Improvement Projects (CCIP) for applicable members.
- Assist members in accessing resources and services beyond the Medical Assistance/Medicaid and Medicare benefit sets including formal and informal supports.
- Stay up to date with changes that relate to Medical Assistance/Medicaid benefits and program changes. Attend trainings offered by DHS, PIP collaborative, Medica and other entities as needed.
- Care Coordinators are to be familiar with the Medica twenty four (24)-hour, seven (7)-day-per-week nurse line members can access. Care Coordinators are to direct members to the nurse line phone numbers on their member ID cards for use by the member when needed and educate members on the importance of this resource.
- Medica Care Coordinators shall make reasonable efforts to coordinate with services and supports provided by the Veteran's Administration (VA) for members eligible for VA services.
- Medica Care Coordinators will be aware of the contract requirement stating that members with HIV/AIDS and related conditions may have access to federally funded services under the Ryan White CARE Act, 42 USC § 300ff-21 to 300ff-29 and Public Law 101-381, Section 2.
- Care Coordinators work with members to ensure access to an adequate range of elderly waiver and nursing facility services and will provide appropriate choices among nursing facilities and/or elderly waiver services to meet the individual needs of members who are found to require a nursing facility level of care.
  These procedures must include methods for supporting and coordinating services with informal support systems provided by families, friends, and other community resources. These procedures must also include strategies for identifying institutionalized members

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whose needs could be met as well or better in non-institutional settings and methods for meeting those needs, and assisting the institutionalized member in leaving the nursing facility. For purposes of this section, the word "assisting" includes, but is not limited to, discharge planning and care management responsibilities.

Transitions

When a member goes to the hospital or other care setting due to a change in condition, this is considered a transition. Admissions include both medical and behavioral health. Monitoring and managing transitions, whether they are planned (ex. scheduled knee surgery) or unplanned (emergency admission due to an acute episode) are an important function of the CC. Care Coordinators should remind members to inform them of both planned and unplanned transitions. Not only does CC involvement make the transitions more seamless, it also is a requirement from the Centers for Medicare and Medicaid Services (CMS).

Transition requirements
Within one business day of notification of admission:

- Document date of transition
- Communicate with the receiving facility to share key elements of the care plan. This may include but is not limited to:
  - Current services
  - Informal supports
  - Advance directives
  - Medication regimen
  - CC contact information
- Communicate with primary care provider (PCP), if known, within one business day of notification unless PCP was the admitting physician
- Communicate with the member/responsible party to learn about any changes in health status and/or care needs. Explain the transition process and provide CC contact information for additional support.

As needed after notification of admission:

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

Upon discharge to the member's usual or "new" usual care setting:

- Communicate discharge with primary care provider (PCP), if known, within one business day of notification unless PCP was the admitting physician
- Communicate with the member and/or authorized family members or alternative authorized decision makers about:
  - The care transition process
  - Changes to the member's health status

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- Plan of care updates
- Educating member/responsible party about transitions and how to prevent unplanned transitions/readmissions. Education should include but is not limited to:
  - The importance of keeping appointments
  - Understand discharge instructions
  - Medication self-management
  - Knowledge of warning signs and response needed
  - Addressing potential barriers (adequate food, housing transportation, home safety, vulnerability concerns etc.)

Transition care resources located on the Care Coordination Hub

- Transition of Care Policy
- Notification of Care Transition Fax
- Transition Log

The Transition Log is only required for MSHO members and does not need to be completed for MSC+ members. However, care coordinators should work to support and manage members during all transitions regardless of whether the log is required. If log is not used for MSC+, it is expected that the Care Coordinator will document transition management activities. The Transition Log ensures all required documentation elements have been addressed.

Pre-Admission Screening (PAS)

Refer to Medica Nursing Home Checklist on the Medica Care Coordination Hub

- Complete all necessary activities surrounding nursing home placements including but not limited to DHS-3427T *LTC Screening Document - Telephone Screening* per the DHS pre-admission screening process (PAS). The document can be found on the DHS eDocs site by clicking here and searching for 3427T.
- Conduct DHS-3426 *OBRA Level 1 Criteria - Screening for Developmental Disabilities or Mental Illness* and convey any information obtained during the screening to the Local Agency and send copy to nursing facility (NF). The document can be found on the DHS eDocs site by clicking here and searching for 3426. Follow the OBRA Level II process if indicated.
- NH Members who will remain in long term care should be transferred back to the Medica Care System by day 100 unless the assigned delegate is contracted to provide institutional care coordination. CC's should notify the member's county of financial responsibility (COR) of the admission.
- MMIS entry of the Preadmission Screening activities (PAS) is needed to follow state and federal requirements that prohibit medical assistance payments for NF services provided prior to completion of required preadmission screening. It confirms the need for nursing facility level of care and screens people for mental illness or developmental disabilities. This MMIS entry should be done by day 30 of placement. Activity type would be 01 Telephone Screen. Communication of the nursing facility admission should be made to the financial worker using the DHS-5181 *Lead Agency Assessor/Case Manager/Worker LTC Communication Form* and the OBRA activities completed. The document can be found on the DHS eDocs site by clicking here and searching for 5181.

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Benefit Exception Inquiry (BEI)

The Benefit Exception Inquiry process is a way for Care Coordinators to ask Medica if a member can receive something outside of the benefit set.

If the Care Coordinator is asked by a member to authorize benefits outside the standard benefit set, the Care Coordinator should refer to the **Benefit Exception Inquiry (BEI) instructions, policy, and form** found on the Care Coordination Hub under Guidelines to determine if a BEI would be appropriate.

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

If an item has been approved through BEI, and the member continues to have the need past the approval timeline it is the Care Coordinator's responsibility to submit the new/updated BEI request prior to the end of the current authorization.

All requests for care outside of the network are submitted to Medica Utilization Management by the primary care provider (PCP) or other referring provider, not through the BEI process. Documentation from a PCP or other medical professional regarding the medical necessity to access care outside of the network is required.

Denial/Termination/Reduction (DTR)

If a service is being denied (based on lack of need), terminated (based on member's request or other reason) or reduced (based on member's request or other reason) a Care Coordinator must complete a DTR form found on the Care Coordination Hub under *Guidelines* and submit to Medica.

Medica will review, and assign a date which the denial, termination or reduction will be effective. The Care Coordinator will be alerted to the final decision. This process takes the CC out of the position to make the final decision, and leaves the final decision with Medica, helping the CC to maintain the positive relationship with the member. DTR's and the timelines around them are a contract requirement by DHS.

Transfer Process

When members transfer between Care Coordinators (change of care system, member relocated, etc.), the exchange of the transfer paperwork is not only a requirement, but is important for

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continuity of care for the member. It allows the receiving Care Coordinator to review and continue the work done by the previous Care Coordinator without always requiring the member to go through the full assessment and care planning process again.

With all transfer requests transfer paperwork is required to accompany the request. At a minimum this includes:

The DHS-6037 MnCHOICES Lead Agency Transfer and Communication Form. The document can be found on the DHS eDocs site by clicking here and searching for 6037.

- A copy of the current assessment
- A copy of the current care plan.
- A copy of the member signature page

Note: The only exceptions to this is:

- Member is an unable to reach member or has refused an assessment, the minimum amount of information we require are notes related to your attempts to reach or engage the member. Refer the Unable to Reach-Refusing Member Policy on the Care Coordination Hub for further details.

If there are additional documents you are still completing and plan to send at a later date, indicate that with the transfer request so the receiving Care Coordinator knows when to expect it. Medica enrollment confirms the transfer. The transfer documents are sent via Sharefile, a secure file sharing site used to transfer documents securely between Medica and delegate leadership. Sharefile folders are set up as part of our delegate onboarding process.

The *Transfer Responsibilities* policy is found on the Care Coordination Hub site under *Policies and Procedures*.

Condition Management/Health Improvement Programs

Medica offers various telephonic programs for members such Tobacco Cessation, Disease Management Programs (also referred to as Condition Management/Health Improvement Programs), and Complex Case Management for members who meet certain criteria. Care Coordinators can help support members in the following ways:

Tobacco Cessation:
Trained health coaches assist members with tobacco cessation at their own pace. Refer to the program details on the Care Coordination Hub.

Condition Management:

Medica has a telephonic disease management program for the following conditions:

- Asthma

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- Diabetes
- Cardiac

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

Complex Case Management:
Medica also offers a telephonic case management program for members.

- Care Coordinators can refer members to the Disease Management program and the Tobacco Cessation program at Medica by completing the Complex Case Management/Health Support Referral Form found on the Care Coordinator Hub site under Tools and Forms → Health Improvement Programs.

Other Resources:

- Refer the member to leading organizations materials when providing education to members such as American Cancer Society, National Alliance of Mental Illness (NAMI), etc.
- Use websites such as Medline Plus, Center for Disease Control (CDC), etc. as a reference
- Use materials and resources on the Care Coordinator Hub site under Tools and Forms → Health Improvement Programs
- Record all disease management intervention and education on the member's case notes.

Services and Supports

Following is a non-exhaustive list of benefits covered under the MSHO and MSC+ products. Care Coordinators use these formal benefits when developing the plan of care for a member in addition to informal and quasi-formal services. MSHO members have access to supplemental benefits through Medica that may change each calendar year. To learn more about these supplemental benefits see the MSHO Supplemental Benefits document found on the Care Coordinator Hub site Policies and Guidelines → Benefits Guidelines.

See the Member Handbooks on each Medica product page and the benefit guidelines for detailed information regarding benefits.

- Medica has created benefit guidelines to help guide Care Coordinators in service planning. These can be found on the Care Coordination Hub under Guidelines → Benefit and Clinical Guidelines.

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

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Medical Services

- MSHO members are entitled to all services covered under Medicare, Medical Assistance and elderly waiver (if eligible for and open to EW).
- For MSC+ members who do not have Medicare, providers will bill Medica.
- For MSC+ members who have Medicare, providers will bill Medicare first; Medica will coordinate benefits (referred to coordination of benefits or COB) with Medicare.
- The role of the CC is not to make medical decisions. The CC often times will receive requests for approval of medical services. Providers are to call Medica Provider Service for verification of benefits and to inquire whether prior authorizations through care management are required. Care systems may choose to direct members to in-network care. Refer to the Quick Links on the Care Coordination Hub and choose which product you are coordinating for and from that product page choose find care.
- Prior Authorizations (PA): Medica has a list of selected procedures which require a prior authorization. These claims will not pay without a referral in the system. Medical procedures on the PA list are determined by Medica Health Management. The Health Services department at Medica reviews the requests for Medical Prior Authorizations.

Elderly Waiver (EW) Services

The Elderly Waiver (EW) program is a federal Medicaid waiver program that funds home and community-based services for people 65 years old and older who are eligible for Medical Assistance (MA), require the level of care provided in a nursing home, and choose to live in the community. MSHO and MSC+ members eligible for EW can receive waiver services and MA services funded through a managed care organization (MCO).

- Refer to CBSM Elderly Waiver and DHS MHCP Manual for EW overview.
- MSHO and MSC+ use the same list of EW services and criteria for eligibility provided by traditional EW. Refer to DHS provider manual for a list of EW Covered Services.

  Medica does not contract directly with EW providers, but rather utilizes the Minnesota Health Care Programs (MHCP), the state's network of EW providers. Providers do need to contact Medica Provider Service Center at 1-800-458-5512 to get set-up to bill as an EW or out-of-network provider in order to submit claims and be paid accordingly.

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- See the complete listing of what requires a referral on Care Coordination Hub go to Tools and Forms → Claims Referral Guidelines for MSC+, MSHO and SNBC.

- **CDCS**
  Consumer-directed community supports (CDCS) is a unique service option that gives members flexibility and responsibility to direct their own services and supports. CDCS may include services, supports and items currently available through the Medical Assistance waivers, as well as additional services.

  Access the CDCS community support plan form here: CDCS Community Support Plan Form, DHS-6532
  Consumer-directed community supports

- **Individual Community Living Supports (ICLS)**
  Individual community living supports: Bundled service that includes six service components. ICLS services offer assistance and support for older adults who need reminders, cues, intermittent/moderate supervision, or physical assistance to remain in their own homes.
  ICLS planning form: Required communication and planning tool for the person, lead agency and ICLS provider. Access the form here: ICLS Planning Form, DHS-3751.
  Individual community living supports (ICLS)

- **Residential Services: Customized Living and Foster Care Services**
  Residential services can be funded under the Brain Injury (BI) Waiver, Community Access for Disability Inclusion (CADI) Waiver, or Elderly Waiver (EW) and typically are provided in assisted living or adult foster care settings. Care Coordinators will be responsible for managing the residential services plan & budget for only MSHO and MSC+ members open to the Elderly Waiver.
  - CBSM Customized living (including 24-hour customized living)
  - Customized Living and Foster Care Services

  For rate determination, a Residential Services rate tool is completed within the MnCHOICES application based on the member's assessed needs and dependencies. DWRS and EWRS Tool.
  - All users of the MnCHOICES application are required to complete the following Handling MN Information Securely-Data Privacy Courses prior to having access to the MnCHOICES application and annually thereafter.
    - Data Security and Privacy (15 minutes)
    - How to Protect Information (35 minutes)
    - Managing Security Information Problems (15 minutes)
    - Federal Tax Information (10 minutes)
    - Social Security Administration Information (15 minutes)
    - Protected Health Information (PHI) (15 minutes)
    - Data Security for County Staff and Assisters (10 minutes)

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Customized living (CL) is an individualized package of regularly scheduled, health-related and supportive services provided to a person age 18 years or older who resides in a qualified setting.

- 24-hour customized living (CL): Includes 24 hours of supervision of the individual, provided in a way which is designed to meet that person's documented, assessed needs, and preferences. Criteria for authorization of 24 Hour Customized Living includes dependencies in toileting, transferring, positioning, active behavioral support, orientation dependency, clinical monitoring, and/or medication administration + 50 hours/month of CL service + 3 ADL's (eating score = 3)

Adult foster care:

- Individual waiver services that provide ongoing residential care and supportive services to adults living in a home licensed as family foster care or a community residential setting (CRS). These services are individualized and based on the needs of the adult, as identified in the support plan.

- Family foster care setting: A licensed family foster care setting where the license holder resides in the home.

State Plan Home Care Services

MSHO and MSC+ include all state plan homecare services. Search for home and community-based services through the provider directory DHS contracted providers**.** Additional search for providers can be done through MinnesotaHelp.info. State home care service providers must be in Medica's network. In-Network Home care and Personal Care Assistance (PCA) providers can be located Care Coordination Hub under product/guidelines/PCA.

- **Home Care Services**
  Home health aide, extended home health aide, home care nursing (HCN – formerly private duty nursing or PDN) and homemaker services require a referral in our system. Refer to the Care Coordination Hub for Home Care Policy and Claims Referral Guidelines for MSC+, MSHO and SNBC .
  Medica Home Care at a Glance

- **Personal Care Assistance for MSHO and MSC+**
  Personal care assistance (PCA) is a Minnesota health care program that provides services to seniors and people with disabilities to help them remain independent in the community. PCA workers provide covered services in a person's home or in the community.

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PCA covers these four basic categories of services:

- Activities of daily living (ADLs): Activities a person needs to carry out on a daily basis to remain healthy and safe. The covered ADLs are dressing, grooming, bathing, eating, positioning, transfers, and mobility.

- Instrumental activities of daily living (IADLs): Activates a person needs to carry out on a regular basis to remain independent. Examples include shopping, paying bills and meal preparation.
- Health-related procedures and tasks: Tasks such as supporting a person with self-administered medications or help with range of motion exercises.
- Observation and redirection of behaviors: Monitoring a person's behaviors and redirecting them to more positive behaviors when needed.

The care coordinator is responsible to complete the PCA assessment using the DHS 3428D Supplemental Waiver PCA Assessment and Service Plan or MnCHOICES assessment. The 3428D document is found on the DHS eDocs site. The PCA assessment (DHS 3428D) is a supplement to the LTCC assessment, and must be completed along with the LTCC (DHS-3428).

NOTE: Upon implementation of the revised MnCHOICES application, Care Coordinators will be required to use the MnCHOICES assessment to determine PCA/CFSS units based on the member's assessed needs and dependencies.

Medica requires that all CC's view the DHS Legacy PCA training video series on YouTube or through DHS Trainlink.

SELECT	DSDPCAL	PCA LEGACY ASSESSMENT	PCA, CFSS	Web Based Training	Online / On Demand
SELECT	PPOL2018	PCA POLICY FOR LEAD AGENCIES	PCA, CFSS	Web Based Training	Online / On Demand

CC's are also required to review Medica's PCA Training under Training Resources on the Care Coordination HUB.

PCA requires an authorization in Medica's system. Authorizations may not exceed 365 days in length. PCA assessments are completed at least annually and with change of condition/supports. The CC may need to complete more than one HRA in the first year to align the LTCC/HRA with the PCA assessment. See the Assessment Schedule Policy MSHO/MSC+ on Care Coordination Hub under policies and processes.

- If an MSHO or MSC+ members is new to Medica and is already receiving PCA services, Medica will honor the current authorization and no new PCA assessment is required.
- If a member new to Medica already receiving PCA services from a provider that is ***not*** in the Medica network, Medica will authorize PCA services with that out-of-network provider for up to 120 days. In that time the CC must work with the member to find an in-network PCA provider. The CC will

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complete the Referral Request Form, indicating on the form that services are being received temporarily from an out of network provider. The Referral Request Form can be found on the Care Coordination Hub site under Tools and Forms

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

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

Hospice/Palliative Care

Palliative Care

Palliative care is comfort care that treats pain and other physical symptoms, as well as emotional and spiritual concerns for those with serious or chronic illness (Examples: heart failure, chronic obstructive pulmonary disease, cancer, dementia, Parkinson's disease, and many others). It helps patients and their families understand their illness and treatment choices, as well as address financial and community resource options. Palliative care can be started anytime during the stage of an illness whether the member is terminal or not.

Hospice

Hospice care is end of life care provided by health professionals and volunteers. They give medical, physiological and spiritual support. The goal of hospice care is the help people who are dying have peace, comfort and dignity. Caregivers and care providers try to control pain and other symptoms so a person can remain as alert and comfortable as possible. Hospice programs also provide services to support a person's family.

Hospice Election

If the recipient eligible for both Medicare and Medicaid and elects hospice, they must elect Medicare hospice care in addition to Medicaid hospice care. Federal guidelines prohibit recipients from choosing hospice care through one program and not the other when they are eligible for both.

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For a member who has elected hospice, Care Coordinators continue to stay involved, complete all care coordination processes including annual reassessments and corresponding paperwork, and communicate and collaborate with the hospice provider.

Care Coordinator Role in Hospice Care

- Facilitate communication with the interdisciplinary care team involved in member's care. Hospice will have regular care coordination conferences. Consider asking to join for case discussion.

- For further information refer to the Hospice Benefit Guideline on the Care Coordination HUB under Policies and Guidelines.

Note: Hospice agencies can be found through the online provider directory.

Interpreter services

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

- Medica has contracted providers for interpreter services and the use of non-par vendors is not permitted. If a member speaks a language that is not provided by an in-network vendor, the care coordinator can reach out to the provider oversight team about approving an out of network (OON) provider.

- Telephonic translation services are available for CC's to use when contacting members who speak a different language. TransPerfect is the vendor resource used for telephonic translation services.

- **CC's can reach out to ProviderOversight@medica.com for further information.**

Medication Therapy Management (MTM)

MTM is a service designed to help the member get the most benefit from their medications and avoid problems, get education on prescribed medications, and often results in reduced costs for medications. The analytical, consultative, educational, and monitoring services provided by pharmacists under this benefit facilitate the achievement of positive therapeutic and economic results from medication therapy.

- How and when to take their prescriptions and over-the-counter medicines.

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- How their medicines work and what they can expect them to do.
- What they should do if they think a medicine isn't helping them, or if they are having problems with side effects.
- Help them to identify medications that are interacting in negative ways, and improve how all medications work together.
- Review any non-prescription medications or supplements to make sure they are appropriate for the member's conditions and other medication therapy.
- Identifies goals that the member has for their medications, to engage the member in their own treatments.

For MSHO members

Medica will determine if MSHO members meet the criteria for MTM. Medica will then provide information to eligible members via mail or over the phone.

MSC+ members *with* Medicare

MTM is provided through their Medicare part D. Members must receive MTM services through providers who accept the members Medicare Part D coverage such as the pharmacy from which they receive their prescriptions.

MSC+ members *without* Medicare

MTM is provided by a DHS MHCP credentialed provider. DHS credentialed MTM pharmacists found on the DHS website.

How it works for members without Medicare:

1. The member calls a participating pharmacy to make an appointment to meet with a pharmacist.
2. The member brings their Medica ID card along with all of their prescription medications, over-the-counter (OTC) medications, and herbals/supplements.
3. The pharmacist reviews the medications with the member to identify any areas of concern, duplication, and cost savings for the member.

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Mental Health/Behavioral Health and Substance Use Disorder Services

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

- MBH assigns a "care advocate" to all inpatient mental health stays. Please contact MBH to coordinate care planning efforts.
- The CC coordinates with county mental health providers for those services provided through the county.
- MBH is available for case consultation by completing a consultation request form which can be found on the Care Coordination Hub under tools and forms-other forms.
- Members can find support & resources related to mental health and chemical dependency on Medica Behavioral Health Live and Work Well site. https://www.liveandworkwell.com/content/en/member.html

NurseLine™ by HealthAdvocate™

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

- Medica 24 hour nurse line is 1-866-715-0915. Hearing impaired members, call the National Relay Service at 1-800-855-2880 and request Medica 24 hour nurse line at 1-866-715-0915. These numbers are available twenty-four (24) hours per day, seven (7) days per week.

Pharmacy

MSHO includes Medicare Part D pharmacy coverage. MSHO also covers medications under Medical Assistance, such as over-the-counter medications with a prescription.

MSC+ includes medications covered under Medical Assistance including over-the-counter (OTC) medications.

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- If an MSC+ member does not have Medicare, Medica pays for all medications and medications must be obtained at a Medica contracted pharmacy. Contracted pharmacies can be located under the member product page under my prescriptions/find a pharmacy.

Formularies are available on Care Coordination Hub, under each specific member product page under my prescriptions.

- Medications must be obtained at a Medica contracted pharmacy.
- Medica customer service can be very helpful in terms of pharmacy questions for members and/or care coordinators.
- Co-pays for prescriptions:
  - Members who have Medicare and reside in the community (MSHO and MSC+) have co-pays for their Part D medications.
  - MSHO members do not have co-pays for over the counter (OTC) medications.
  - MSC+ members may be charged a low co-pay for OTC's.
  - When the member has been changed to an institutional living setting in the county system the co-pays will stop.
  - Members in nursing facilities for short stays will continue to have Part D co-pays.

Medication Overrides and Prior Authorizations

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

Medication overrides

- The best option is to have the pharmacist contact Medica to request an override on the member's behalf. The pharmacist will work directly with the prescribing healthcare provider to gather needed information.
- The member may call Medica Customer Service to request an override.

Prior Authorizations

- The best option is to have the member's healthcare provider submit a prior authorization request using the provider resources on medica.com.

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

Medica Customer Service can be very helpful in terms of pharmacy questions for members and/or care coordinators. The phone number can be found on the Care Coordination Hub under useful contacts.

Transportation

If a member does not have access to their own transportation, Medica Provide-A-Ride℠ will help schedule transportation to and from medical, dental, mental health and substance abuse appointments.

- If Member's health condition requires assistance or a specially-equipped vehicle, the member will need a Certificate of Need (CON) on file. This form can be completed online by the member's physician or clinic. The Care Coordinator or member calls special transportation vendors directly for these rides.

- MSHO members can access unlimited public transportation where available to One Pass gym locations.

More information regarding transportation can be found on the Care Coordination Hub site under Templates, tools, and additional resources → Transportation.

If a member has access to a vehicle and is interested in exploring whether mileage reimbursement for use of that vehicle for medical appointments is possible, Care Coordinators are to refer members to their county of residence.

Care Coordinators can also arrange transportation through the QRyde portal. If you are interested in learning more please contact ProviderOversight@medica.com to get started. A recorded QRyde training can be found on the Care Coordination Hub site under Training resources. QRyde allows for CC's to set-up rides for members on their behalf in the Medica QRyde portal.

Restricted Recipient Program (RRP)

The Restricted Recipient Program (RRP) is for members who have been determined by Medica, or a previous health plan to have received or are still receiving prescription drugs in a quantity or manner that might be harmful to their health. Members who only have Medicaid and not a primary insurance such as Medicare, are eligible for RRP. Members in the RRP program are

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restricted to using only one in-network physician (PCP) to prescribe all their medications at one in-network pharmacy. The members remain on this program for 24 months, where they will be reevaluated to determine if they are eligible to be released from the program.

Each member of the Restricted Recipient Program is assigned a nurse from the RRP team (under Health Services UM). The member is given the nurse's first name and contact information. The care coordinator should redirect members with questions about the RRP to their assigned RRP nurse at Medica. A care coordinator can see the member's assigned PCP, clinic, hospital and pharmacy by looking up the member in MN-ITS. If a care coordinator or member would like to contact the RRP nurse call 1-888-906-0970.

Additional information on the RRP and referrals can be found on Medica.com and the Provider Administrative Manual.

Member Death

When the Care Coordinator becomes aware of a member death, the Care Coordinator will clearly document the date of death and source of this information in the member record. The Care Coordinator will:

- Send DHS 5181 to county financial worker
- Send DHS 5841 to waiver case manager as applicable
- Add member information to agency Date of Death Report
- Ensure you contact providers to inform them so they end services.

Care Coordination HUB (Website)

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

- Product specific Care Coordination resources including manuals, policies and processes, guidelines, templates, tools, and additional resources.
    - Care Coordination Training & Resource manuals (Medica, DHS, MHCP manuals)
    - Policies and Procedures - This section has current Medica policies, procedures that guide care coordination activities and operations.
    - Guidelines - This section includes benefit and clinical guidelines that outline specific benefit coverage and are a resource to care coordinators.

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- Transition Care and Gaps in Care - Care Coordinator toolkits, fliers, and other information related to the member transition process details.

- Denial, Termination, Reduction (DTR's) and Benefit Exceptions – This section includes forms, instructions, and policies to guide Care Coordinators through these processes.

- Letter Templates - Prepared letters to correspond with Medica members and primary care providers. These are the letters that are to be used for member correspondence as they have gone through the appropriate approval process.

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

- Transportation – This section includes transportation request and authorization forms & process guides.

- Training Materials - The Medica Care Coordinator Training Manuals are provided to assist you with your job duties. The training manuals describe the Care Coordinator role and responsibilities, member classifications, provision of services, and benefit guidelines. All recorded trainings can also be found under this section.

- News - Care Coordination Monthly Communications are found here which provide CC's with updates on policies, process and forms etc.

- Useful contacts – Includes frequently used contracts and Medica resources for Care Coordinator support.

- Helpful Websites – This section includes external links to resources for Care Coordinators.

- Member Product Pages – This section includes direct links to the product pages for additional information and resources for Care Coordinators.

Clinical Liaison

Medica has Clinical Liaisons devoted to assisting our care coordinators by developing trainings, communicating updates, and offering support. You can reach out with questions via email, medicaccsupport@medica.com or by phone at 1-888-906-0971

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- The Medica Clinical Liaisons will facilitate trainings to Care Coordinators in a variety of areas including but not limited to:
  - New processes
  - DHS policy changes
  - Form updates
  - Use of reports
  - Working collaboratively with county/tribes
  - Use and referral process for home care and mental health services covered by Medica

- Medica has clinical consultation services available to identify the health care needs of the member and develop a care plan that appropriately addresses the individual's health care needs. This is met and/or coordinated through our Medica Clinical Liaisons who are available to all Care Coordinators

- The Medica Clinical Liaisons will reach out to assigned care coordinators related to member inquiries, service plans, etc.

- Special training requests or training topic requests can be sent to the Clinical Liaisons

Reporting

Delegates receive several reports form Medica. Some reports require action on the part of the Care Coordinator. Delegates are asked to review the reports training/overview and reports grid found on the Care Coordination Hub which can be found under training.

Additional Resources/External Contacts

Medica Care Coordinated Products Customer Service 888-347-3630 (toll-free); TTY: 711, 8 a.m. – 6 p.m. Monday – Thursday; 9 a.m. – 6 p.m., Friday
Provide-A-Ride/Interpreter Services 888-347-3630 (toll-free); TTY: 711, 8 a.m. – 5 p.m. Monday – Thursday; 9 a.m. – 5 p.m., Friday
Medica Behavioral Health 800-848-8327 (toll free); TTY: 711, 8 a.m. – 5 p.m., Monday – Friday **Behavioral health crisis services 24 hours a day, seven days a week**

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Delta Dental *Member services* 800-459-8574 (toll-free); TTY: 711, 8 a.m. – 5 p.m., Monday – Friday ***Care Coordinators only*** 866-303-8138 (toll free); TTY: 711 8 a.m. – 5 p.m., Monday – Friday
Member Pages MSHO: https://www.medica.com/ls/find-care/select-your-medicaid-plan/medica-dual-solution-msho MSC+: https://www.medica.com/ls/find-care/select-your-medicaid-plan/medica-choice-care-msc-plus
NurseLine by Health Advocate 866-715-0915 (toll-free); TTY: 711, **24 hours a day, seven days a week**
Care Coordination Support (Clinical Liaison) 888-906-0971 (toll free); TTY: 711 Email: MedicaCCsupport@medica.com
Medica Regulatory Quality Team Email: medicasppregquality@medica.com
Care Coordination Hub website Care Coordination Hub
Medline Plus (Medical and Health Care Resources including: health topics, medical encyclopedia, genetics, drug & supplements, medical tests, and healthy recipes) https://medlineplus.gov/
Tobacco Cessation Program 866-905-7430 (toll-free); TTY: 711, 8 a.m. – 5 p.m., Monday – Friday
Transplant Program 888-906-0958 (toll free); TTY: 711, 8 a.m. – 5 p.m., Monday – Friday Email: caresupport@medica.com
Restricted Recipient Program 888-906-0970 (toll-free); TTY: 711, 8 a.m. – 5 p.m., Monday – Friday
Minnesota Department of Human Services (DHS) http://mn.gov/dhs/ *eDocs* https://mn.gov/dhs/general-public/publications-forms-resources/edocs/index.jsp

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Disability Hub MN 866-333-2466 (toll free); TTY; 711, 8:30 a.m. to 5 p.m. Monday – Friday Email: info@disabilityhubmn.org Web: https://disabilityhubmn.org/
Health Care Directive lightthelegacy.org Or under Helpful websites and links on the Care Coordination Hub main page.

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