Medica Care Coordinator Training Manual: SNBC/SNBC Enhanced Care Coordination

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Plan Overviews

SNBC Overview:

- Medica product name: AccessAbility Solution
- DHS product name: SNBC (Special Needs Basic Care)
- Eligibility
    - 18-64 years old
    - Eligible for Medical Assistance
- Members with Medicare
    - Medica will coordinate benefits with Medicare
    - Members must have a Part D Plan and will have their Medicare Part D copays
    - Medica covers some Over the Counter (OTC) medications
- Members without Medicare
    - Medica is the primary payer for all covered services.
- Does not include Waivers, PCA or Home Care Nursing benefits
- SNBC is an opt-out program, members can choose to leave the program at any time

SNBC Enhanced Overview:

- Medica product name: AccessAbility Solution Enhanced (SNBC Enhanced)
- DHS product name: ISNBC (Integrated Special Needs Basic Care)
- Eligibility
    - 18-64 years old
    - Eligible for Medical Assistance
    - Have Medicare part A and B
- Medica will coordinate benefits for Medicaid, Medicare, and Medicare part D
- Medica covers some Over the Counter (OTC) medications and Part D covered medications.
- Medica is the primary payer for all covered services.
- Does not include Waivers, PCA or Home Care Nursing benefits
- SNBC Enhanced is a voluntary program; member must elect to be enrolled

The Value of Care Coordination:
As a representative of Medica, the Care Coordinator (CC) helps members build and maintain an independent and healthy life. Although SNBC and SNBC Enhanced do not include waiver benefits, personal care attendant (PCA), or home care nursing benefits (formerly called private duty nursing), the Medica CC still has the responsibility to assist the member in understanding their SNBC and SNBC Enhanced benefits, coordinating care across payers including Medicare, assisting across all settings of care, and being involved with member transitions. In

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addition, the CC will also communicate with any county case managers and others to coordinate efforts and advocate for the member. The CC is the member's primary contact for accessing all benefits under SNBC and SNBC Enhanced.

Members turning 65

The Care Coordinator will assist members turning 65 years old in understanding their transition to a senior product. SNBC and SNBC Enhanced members are not able to remain on the SNBC programs after age 65; these members are required to choose a senior program. DHS requires that SNBC and SNBC Enhanced members turning 65 years old either default into the MSC+ program, or actively enroll into MSHO if they are eligible. See the policy on the Care Coordination Hub under *policies and processes* for more information.

Enrollment

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

- Introduce yourself 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

Refer to the Assessment Schedule Policy SNBC found on the Care Coordination Hub under Policies and Procedures for information related to assessment details and timelines.

Health Risk Assessment

Members new to managed care will receive a complete Health Risk Assessment (HRA) within 60 calendar days of enrollment and annually (within 365 days) thereafter.

- HRA (DHS 3428H) must be offered face to face for members not on a waiver. HRAs must be fully complete.
  DHS-3428H-ENG (Minnesota Health Risk Assessment Form) (state.mn.us)
- Entry in MMIS is done as "H" type screening documents.
- The Medica health plan code in MMIS is **MED**

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Transfer Member Health Risk Assessment

- Medica Transfer Member HRA may be completed for members changing products (SNBC to SNBC Enhanced or SNBC Enhanced to SNBC) 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

- 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 using the DHS 3428H form.

Institutional Care Coordination

- Institutional Members require the same documentation as community members.
    - In addition, the Care Coordinator should work with Nursing Facility staff to ensure the member's needs are being addressed, request to be invited to care conferences, assist with relocating into the community as appropriate.
    - Refer to the Partner Nursing Home Checklist on the Care Coordination Hub
- Medica is responsible for paying a total of 100 days of nursing home room and board. If the member needs continued nursing home care beyond 100 days, the Minnesota Department of Human Services (DHS) will pay directly for their care. Upon enrollment into the plan, if DHS is currently paying for the member's care in the nursing home, DHS, not Medica, will continue to pay for the care. Facilities are responsible to contact Medica related to admissions.
- Nursing homes can reach Medica via email NFCommunications@medica.com or by calling Media Provider Service Center.

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MMIS Entry

- MMIS Entry is required for all SNBC and SNBC Enhanced members. This 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.
    - Timeliness of when the assessment data is gathered and when it gets entered into MMIS are very important. Per DHS-5020A Instructions for Completing and Entering the LTCC Screening Document/Health Risk Assessments into MMIS for the Special Needs Basic Care (SNBC) Program:
      "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 can be found on the DHS eDocs site by clicking here and searching for 5020A.

Note: Upon implementation of MnCHOICES with a Medica SNBC or SNBC Enhanced member Care Coordinators will be required to use the state's MnCHOICES Health Risk Assessment (HRA) form.

Care Plan/Support Plan

Information obtained during the HRA is incorporated into a care plan/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. This care plan serves as a "living document" which is updated or adjusted as the member's needs and services change.

- A comprehensive care plan is written and maintained for each member on SNBC and SNBC Enhanced that is not identified as unable to contact or a refuser; for SNBC Enhanced members the *Unable to Reach Refusal Care Plan* must be completed.
- Care Coordinators develop, monitor, and update the member's care plan based on the HRA, including person-centered principles and practices within thirty (30) days of HRA completion.

Care Plans must include the following components:

1. **Interdisciplinary/holistic focus -** The care plan should incorporate the primary, acute, long term care, behavioral health and social service needs of each member with coordination and communication across all Providers.
   For all members: this includes communication with primary care, attending appointments as needed and involving family in care planning process and visits.

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2. **Preventative focus-** For all members: this may include immunizations, vision, hearing, and dental exams, tobacco cessation, alcohol use, fall risk, medications, and nutrition.
3. **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 Care Coordination Hub for more information.
4. **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.
5. **Advance Directive planning** - Care coordinators should review health care directives annually and with changes in care needs. These reviews should be documented on the care plan. This includes documentation of refusals. Downloadable versions of Healthcare Directives are available in 7 different languages from the lightthelegacy.org which can be accessed under Helpful websites and links on the Care Coordination Hub.
6. **Annual comprehensive primary care visit** - Care planning should document efforts to ensure all members have had an annual comprehensive PCP visit.
7. **Care plans 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
    - Underlying barriers/issues can be discussed under CC recommendations
    - A schedule for a follow-up plan and communication

Assessment Documents & Post Visit Follow-up

Caregiver Assessment

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 support groups or additional services to ease the burden on the caregiver (HHA, SNV).

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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/Case Manager Communication

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

- Per the DHS contract CC's are to communicate with a member's waiver worker if they want to put any state plan home care or therapy services in place for the member using the DHS-5841 ***Managed Care Organization, County and Tribal Agency Communication Form - Recommendation for State Plan Home Care Services***. The document can be found on the DHS eDocs site by clicking here and searching for 5841. This is to ensure that the waiver case manager accounts for these services in the member's waiver budget and on their service agreement and to ensure duplication of services is not occurring. A listing of county contacts, as well as county managed care advocate at each county is located on the DHS website.
- 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 SNBC and SNBC Enhanced members. Communication will include HIPAA compliant electronic communication vehicles.
- With any referrals of the member to the county for waiver services, the Care Coordinator is required to submit to the county a summary of the member's strengths and needs, and services the managed care organization has authorized to meet the members identified needs. The Care Coordinator will provide, at minimum, a copy of the complete health risk assessment and current care plan.
- The Care Coordinator will coordinate 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 living setting, death, or disenrollment. The document can be found on the DHS eDocs site by clicking here and searching for 5181.
- Care Coordinators will coordinate and communicate with tribal assessors and case managers. Care Coordinators will accept the results of home care assessments, reassessments and the resulting service plans developed by tribal assessors for Tribal Community Members as determined by the tribe. 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 Community Members residing on or off the reservation.
- Referrals and/or coordination with county social service staff will be required when the member needs the following services (as outlined in the DHS contract):
    - Pre-petition screening
    - Preadmission screening for Home and Community Based- Waiver Services (HCBS)

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- County Case Management for HCBS
- Child protection
- Court ordered treatment
- Case Management and service providers for people with developmental disabilities
- Relocation service coordination
- Adult protection
- Assessment of medical barriers to employment
- State medical review team or social security disability determination
- Working with Local Agency social service staff or county attorney staff for members who are the victims or perpetrators in criminal cases

Referral Request/Authorizations/Operations:

Care Coordinator will assist members by making appropriate referrals for services outside of the SNBC and SNBC Enhanced benefit set such as waiver services, PCA/CFSS services, etc. With these referrals, the Care Coordinator will provide the county with information related to the members assessed need which may include a copy of the member's last HRA and care plan.

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.

NOTE: Skilled Nursing Visits do not require an authorization in our system but the recommendation is for the Care Coordinator to give the Provider verbal authorization and document this communication in the members file and include this on the member care plan. CC should maintain open communication with the Home Care Nurse/agency and any changes or additional visit requests should be documented.

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 Care Coordinator HUB. There are several letters that are required to be sent out.

- Post-Visit Letter: Must be sent within 30 days following a HRA.

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- PCP Letter: Must be sent to PCP within 30 days following a 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.

Ongoing Follow Up

SNBC 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 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.
- 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.
    - SNBC members under age 21 are eligible for Child and Teen Check-ups provided by their primary care provider or pediatrician. Care Coordinators are asked to educated members/responsible parties of the importance of annual PCP visits.
- Participate in Performance Improvement Projects (PIPS) or Chronic Condition Improvement Projects (CCIP) for applicable members.
- Assist members in accessing resources and services beyond the Medical Assistance and Medicare benefit sets including formal and informal supports.
- 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.

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- 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.
- **Members who are unable to be located or refuse to complete a HRA**
  Members who are not able to be located or who refuse to work with a CC to complete a HRA remain on the CC's caseload. The CC will continue to be a resource for that member if they have any questions or concerns and will continue to be available to complete a HRA with the member when the member is ready to receive this level of support.

Transitions

When a member goes to the hospital or other care setting due to a change in condition, this is considered a transition. 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.

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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
  - 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 SNBC Enhanced members and does not need to be completed for SNBC 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 SNBC, 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.
- Members assigned to agency SNBC delegates only: NH Members who will remain in long term care should be transferred back to the Medica Care System by day 100 unless the

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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.

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 Coordinators should refer to the Benefit Exception Inquiry (BEI) instructions, policy, and form found on the Care Coordination Hub under *Guidelines.*
  - Any supportive documentation of the member need must be submitted with the BEI form.
  - When sending in multiple BEI's be sure to send them separately. This allows the operations staff to easily identify them and process them accordingly.
  - Include the cost of the item that you are requesting.
  - On the BEI form, there is a section for the member's PCP information, as well as service provider information. "Service Provider" is the provider of the item or service you are requesting; note whether they are in network or out of network providers with Medica.

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.

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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 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 (Home and Community-Based Services) HCBS Waiver, AC, and ECS Case Management 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.

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

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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 by making referrals to the following programs.

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
- 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 Tips:

- 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.

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Services and Supports

Following is a non-exhaustive list of benefits covered under the SNBC and SNBC Enhanced product. Care Coordinators use these formal benefits when developing the plan of care for a member in addition to informal and quasi-formal services.

See the Member Handbooks on each 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 under Benefit and Clinical Guidelines.

Reminder: The SNBC and SNBC Enhanced do not include waiver benefits, personal care attendant (PCA), home care nursing (formerly private duty nursing). SNBC Enhanced does include Medicare benefits. Care Coordinators are to assist members in contacting the county if determined through the assessment there is a need for waivered services.

Medical Services

- SNBC members receive their Medical Assistance benefits through Medica.
- SNBC members who do not have Medicare or another primary insurance- providers only bill Medica.

- SNBC members who have Medicare through other primary insurance- providers will bill Medicare first; Medica will coordinate benefits (refer to coordination of benefits or COB) with Medicare.
- SNBC Enhanced members receive their Medical Assistance and Medicare benefits through Medica.
- 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* for the member product pages on the Care Coordination Hub and choose the appropriate product and then 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.

State Plan Home Care Services

- SNBC and SNBC Enhanced covers state plan homecare services including skilled nurse visits (SNV) and home health aide (HHA).

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    - **Services must be obtained through a Medica contracted provider.** All services should be coordinated with the agency.
- If an SNBC or SNBC Enhanced member on a waiver is receiving any state plan home care services, the Care Coordinator is **required** to communicate this to the county waivered worker using the DHS-5841 *Managed Care Organization, County and Tribal Agency Communication Form - Recommendation for State Plan Home Care Services*. The waiver worker must account for these services in their service agreement. The document can be found on the DHS eDocs site by clicking here and searching for 5841.
- Home Health Aide services require an authorization in our system.

Hospice/Palliative Care

Care Coordinator Role in Hospice Care

- Continue to facilitate communication with the interdisciplinary care team involved in members care. Hospice will have regular care coordination conferences. Consider asking to join for case discussion.
- Continue to communicate with the member's waiver worker if applicable.
- For further information refer to the *Benefit Guideline: Hospice* on the Care Coordination Hub.

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

Interpreter services

- SNBC and SNBC Enhanced members are eligible for sign and spoken language interpreter services that assist the member in obtaining covered medical services. 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.
- 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 is 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.

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- How and when to take their prescriptions and over-the-counter medicines.
- 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 SNBC Enhanced members:

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

For SNBC members with Medicare:

The MTM benefit is provided through their Medicare part D benefit. Members must receive MTM services through providers who accept the member's Medicare coverage such as their pharmacy.

For SNBC members without Medicare:

This benefit is provided by DHS Minnesota Health Care Programs (MHCP) credentialed providers. DHS credentialed MTM pharmacists can be found on the DHS site DHS website.

How it works for SNBC 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.

Mental Health/Behavioral Health and Substance Use Disorder Services

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

- MBH assigns a "care advocate" to all inpatient mental health stays. Please contact MBH (800)848-8327 to coordinate care planning efforts.

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- The CC should coordinate with county mental health providers for those services provided through the county.
- MBH is also a care coordination partner with Medica for SNBC and SNBC Enhanced members.
- 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.

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

Please refer to the SNBC Member Handbook for detailed pharmacy information. For SNBC members on Medicare refer to their Medicare part D provider for questions regarding coverage. SNBC includes medications covered under Medical Assistance including over-the-counter medications.

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

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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.
- SNBC Enhanced members can also receive transportation to & from Fitness Program location.

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. SNBC members who only have Medicaid and not a primary insurance such as Medicare, are eligible for RRP. Members in the RRP program are restricted to using only one in-network physician (PCP) to prescribe all of 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 is 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

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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

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.
    - 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.

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- 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

- 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 identity the health care needs of the member and develop a care plan that appropriately addresses the individual's health care

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needs. This is met and/or coordinated through our Medica Clinical Liaisons who are available to all SNBC & SNBC Enhanced 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 from Medica via ShareFile. 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**
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 SNBC Enhanced: https://www.medica.com/ls/find-care/select-your-medicaid-plan/medica-accessability-solution-enhanced SNBC: https://www.medica.com/ls/find-care/select-your-medicaid-plan/medica-accessability-solution-snbc

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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
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
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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