HealthPartners®

Subject Care Coordination for Minnesota Senior Health Options and Minnesota Senior Care Plus (MSHO & MSC+)	**Attachments** ☐ Yes ☒ No
Key words Care Coordinator, MSHO/MSC+, Case Management	AC 011
Category Business Practices (BP)	**Effective Date** **9/1/2017**
Manual HealthPartners Administrative Manual	**Last Review Date** **4/1/2018**
Issued By Professional Services Network Management and Hospital and Regional Network Management	**Next Review Date** **4/1/2019**
Applicable All Primary Care Providers All Specialty Care Providers All Facilities and Providers Care systems, agencies, and counties that subcontract with HealthPartners to provide care coordination for MSHO/MSC+ members	**Origination Date** **9/1/2017** **Retired Date**
Review Responsibility Laurel Rose, Bev Vacinek, Carolyn Koch, and Cheryl Wilson	**Contact** Susan Oestreich

Products:
☐ Fully Insured ☐ Self-Insured ☐ Medicare ☐ Medicare Advantage ☐ Medicaid ☒ MSHO ☒ MSC+ ☐ SNBC ☐ WI Marketplace

I. PURPOSE Define the roles and responsibilities of MSHO/MSC+ Care Coordination services.

II. POLICY Every HealthPartners MSHO/MSC+ member is assigned a Care Coordinator who will be the member's primary contact for care and service needs. The Care Coordinator will ensure patient-centered service accessibility, identify and address individual needs, assure comprehensive and coordinated service delivery, facilitate culturally appropriate care, and promote appropriate utilization and member self-management.

III. PROCEDURE(S)

CARE COORDINATOR ROLES AND RESPONSIBILITIES

1) Perform the duties of Care Coordination and Case Management listed in the MN Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services with HealthPartners. Inc. Article 6 Benefit Design and Administration and perform other duties as assigned by HealthPartners.
2) Be informed of basic member protections requirements, including data privacy.

3) Encourage each member to have an established relationship with a primary care or other regular physician or clinic and to have an annual preventive care physical exam.

4) Provide information regarding services including procedures for promoting rehabilitation of members following acute events, and for ensuring smooth transitions and coordination of information between acute, sub-acute, rehabilitation, home care and other settings.

5) Work in partnership with the member and/or authorized family members or alternative decision makers, and primary physicians in consultation with any specialist care for the member, to develop and provide services, ensure all parties are involved in treatment planning, and consent to the medical treatment or service.

6) Make referrals to specialists and sub-specialists.

7) Coordinate care for American Indian members.

8) Coordinate with county social services and Case Management systems

9) New enrollees are provided the Member Services contact information with their new member materials. Member Services Specialists are knowledgeable about the MSHO/MSC+ programs and can assist members in transitioning to managed-care, accessing medications and services that require prior authorization.

10) Provide the member with the name and telephone number of their Care Coordinator within ten (10) days of assignment or change of Care Coordinator.

11) Refer providers, county staff, family members or others requesting the contact information of the member's assigned Care Coordinator to the HealthPartners Case Management Intake line at 952-883-6983 for this information.

12) Health-Risk Assessment (HRA)

    i) The HRA includes questions designed to identify health risks and chronic conditions, including but not limited to: Activities of daily living (ADL), risk of hospitalization, need for primary or preventative care, mental health needs, rehabilitative services, and protocols for follow-up to assure that physician visits, additional assessments or Case Management Interventions are provided when indicated. As part of the HRA process, the Care Coordinator offers each member the option of having a full, partial, or no care plan copy provided to each Elderly Waiver provider noted on the care plan as providing services to the member.

    ii) Use the DHS approved, Long Term Care Consultation (LTCC) referred to as HRA, tool to conduct initial, annual, and change of condition assessments. When MNChoices is available for use by Managed Care Organizations, use MNChoices to conduct the HRA.

    iii) Complete an initial HRA of MSHO/MSC+ members within 30 days of enrollment for all new HealthPartners members and an annual reassessment HRA within 365 days of the previous HRA.

    iv) Make best efforts attempt to locate correct demographic information for each member as necessary in order to successfully reach each member and document research/attempts to locate such information.

    v) Complete and document at least three attempts to contact each member for initial and annual HRAs including the date of each attempt. An 'unable to reach' letter must be sent to the member in addition to the three contract attempts; this letter does not count toward one of the three contact attempts. Results of outreach attempts must be communicated to HealthPartners monthly using the reporting template provided for this purpose.

    vi) For members who decline an HRA, outreach a minimum of every six months or according to a schedule as member requests. For members the care coordinator is not able to locate

or reach, complete and document at least 3 outreach attempts as well as sending an unable to reach letter within the first month and then attempts every six months. The care coordinator should attempt to establish a relationship with the member even if unable to complete an HRA.

vii) Offer face-to-face HRA visits to each member. If a face-to-face visit is declined or not possible, the HRA will be completed by telephone, or by mail. Care Coordinators are expected to make every effort to complete initial and annual HRAs.

viii) Complete a reassessment of MSHO/MSC+ members with a significant change of health condition that is expected to alter the course of the member's services and care plan. Care Coordinators may use professional judgment to determine when a change of condition warrants completing another HRA.

ix) Enter all DHS required information collected through the initial or annual health risk assessment including the refusal of the HRA into the Medicaid Management Information System (MMIS), for all non-institutional members until MNChoices is implemented and this information is auto-populated into MMIS automatically.

x) Inform the member that participation in the HRA is voluntary and that the Care Coordinator is available to assist members with their health and safety needs regardless of whether or not the member completes an HRA. If a member declines care coordination services, the Care Coordinator will continue to contact the member annually and upon notification of a hospitalization or of the member being identified as being high risk. If the member is unable to be located or declines assessment, documentation of attempted contact is required in the case notes. Members receiving EW services must receive a face to face assessment annually in order to maintain eligibility for waiver services.

13) Care Plans

i) Develop, implement and monitor care plans based on HRA results and person-centered principles and developed in conjunction with the member, member's regular physician and health care specialists as appropriate and applicable.

ii) Complete care plans within thirty days of the HRA which includes the Care Coordinator providing a copy of the care plan to the member and the member's regular physician.

iii) , Effective 1/1/2018, within thirty days of completing the care plan, send a full or partial care plan copy to each Elderly Waiver provider noted on the member's care plan as providing services to the member according to the member's preferences/instructions regarding same. Include with the care plan a request for the provider to return a signed copy to the Care Coordinator. If a signed copy of the care plan is not returned within 30 days, another copy of the care plan with request to sign and return should be sent to the provider. Documentation of sending the care plan(s) to the provider with a request to sign and return a copy, must be retained in the member's record along with signed care plans received from the provider.

iv) Act quickly upon any safety or self-preservation risks identified, whether environmental or medical.

v) Incorporate unique primary care, acute care, long-term care, mental health, rehabilitative and social service needs of the member into the care plan per DHS guidelines. Covered Medicaid and Medicare home care services and services available through community resources should also be included.

vi) Complete Personal Risk Management Plans. Include acknowledgment of risk for persons refusing services recommended to reduce personal risk and clearly document member's acceptance of the risk as part of the member's care plan.

vii) Develop care plans that address all needs identified by the HRA including the member's unstable or newly diagnosed chronic health condition(s).

viii) Develop goals that are person-centered and include target dates, interventions, and goal outcome dates. Include the amount, frequency, and duration of services for any formal services the member is receiving.

ix) Develop a plan for follow-up to assure primary and preventive care, mental health needs, additional assessments or other care management interventions are provided as planned. Follow-up plan includes target dates for follow up.

x) Assist the member and/or authorized family members or guardians to maximize informed choice of services and control over services and supports. Verify that the member has been offered a choice of supports and services and that the member agrees with the care plan.

xi) Make recommendations of how technology or equipment might increase independence or reduce reliance on human assistance (including assistive devices, augmentative communication devices, home modifications and other devices) if applicable.

14) Have interventions and protocols for management of disability or frailty related conditions common among members who are elderly or have disabilities such as skin breakdown & urinary tract infections available.

15) Provide self-management and educational materials to members with clinical instability, disability or frailty related conditions.

16) Coordinate with county social service agencies, community agencies, nursing homes, residential and home care providers and case management systems involved in providing care for MSHO/MSC+ members using Health Insurance Portability and Accountability Act (HIPAA) compliant electronic communication vehicles.

17) Include cover sheets, not including Protected Health Information (PHI) that incorporates a confidentiality statement for all fax transmissions.

18) Collaborate with lead agencies, waiver workers, or county case managers on the authorization of medical assistance home care services for rate cell A members open to a waiver using the DHS form "Managed Care Organization/Lead Agency Communication Form - Recommendation for Authorization of MA Home Care Services State Plan Home Care Services, DHS- 5841 as provided by the state. It is expected that a response will occur within ***10 (ten) business days of submission*** for this form.

19) Communicate the transfer of a member to another Health Plan or Local Agency upon disenrollment from HealthPartners using the Lead Agency HCBS Case Management Transfer Form, DHS-6037.

20) Communicate the transfer of a member to another contracted care coordination entity within HealthPartners using DHS form "HCBS Waiver, AC and ECS Case Management Transfer and Communication Form", DHS-6037-ENG, and providing the most recent HRA and care plan to the receiving entity or to HealthPartners.

21) Collaborate with Local Agency case managers, financial workers and other staff, as necessary, including use of the DHS form "Lead Agency Assessor/Case Manager/Worker LTC Communication Form," DHS-5181-ENG as provided by the STATE.

22) Make referrals and/or coordination with County Social Service staff when the member is in need of the following services:

i) Pre-petition screening

ii) Court ordered treatment

iii) Case Management and service providers for people with developmental disabilities

iv) Case Management and service providers for people with mental health disabilities

v) Relocation service coordination

vi) Adult protection,

vii) Assessment of medical barriers to employment

viii) State medical review team or social security disability determination,

ix) Working with Local Agency social service staff or county attorney staff for members who are the victims or perpetrators in criminal cases.

23) Coordinate with Local Agency human service agencies for assessment and evaluation related to judicial proceedings.

24) Make reasonable efforts to coordinate with services and supports provided by the Veteran's Administration (VA) for members eligible for VA services.

25) Help determine if members with HIV/AIDS and related conditions may have access to federally funded services under the Ryan White CARE Act, 42 U.S.C. § 300ff-21 to 300ff-29 and Public Law 101-381, Section 2.

26) Collaborate with the Senior Linkage Line and other social service staff to ensure that the Pre Admission Screening (PAS) process is completed for members entering a nursing facility. The Care Coordinator conducts a PAS, including provision of OBRA Level I screening documentation to the admitting nursing facility. Care Coordinators will enter Pre Admission Screenings into the MMIS system for members not currently on a waiver.

27) Emphasize to members the importance of maintaining Medical Assistance eligibility and assist members to retain/regain eligibility as needed.

28) Determine if the member has an Advance Directive and their code status; if none exists, educate member about Advance Directives, and inform member of resources available for planning based on individual needs and cultural considerations.

29) Participate in Performance Improvement Projects (PIP), Quality Improvement Projects (QIP), and Chronic Care Improvement Projects (CCIP) as requested by HealthPartners.

30) Report to HealthPartners any difficulty locating providers to meet the service needs of MSHO/MSC+ members. HealthPartners will ensure this information is relayed to our Contracting department so they may locate providers or pursue contracting with additional providers.

31) Cooperate with annual and periodic audits of care coordination services by documentation review conducted by HealthPartners or an entity contracted for this purpose.

32) Facilitate safe, well managed care transitions for members experiencing a transition between settings of care. The Care Coordinator provides a consistent support person to the member or caregiver/family including supporting safe discharges to help members prevent avoidable readmissions. Complete and document all care transition requirements as defined by HealthPartners. Additionally, complete a post-discharge assessment of community members upon return to their usual setting according to HealthPartners Post-Discharge Assessment form. Results of the Post-Discharge Assessment must be communicated to HealthPartners monthly using the reporting template provided for this purpose.

33) Direct home-care providers of skilled, intermittent services, or Medicare covered services to contact HealthPartners Quality and Utilization Management department for services requiring prior authorization.

34) Follow HealthPartners defined *Benefit Exception Request* process if a Care Coordinator recommends member benefits outside the standard benefit set.

35) Notify HealthPartners of enrollment discrepancies based on reconciliation of delegate enrollment with HealthPartners enrollment.

36) Use the forms and tools required by MN DHS for certain waivered services including: Individual Community Living Support Services (ICLS), Customized Living Services (CLS) and Consumer Directed Community Supports (CDCS). Submit the tools to DHS as required.

37) Effective 1/1/2018, notify members referred for home-health care services that they must be seen by their physician in the 90 days prior to the referral or within 30 days after the referral (2018 DHS Contract).

38) Effective 1/1/2018, offer Adult Day Care Services provider's information as part of the Health Risk Assessment (HRA) process. The Care Coordination entity may determine the method of outreach to such providers requesting their input to the HRA process.

39) Include Customized Living Services providers' information as part of the Health Risk Assessment (HRA) process. The Care Coordination entity may determine the method of outreach to such providers requesting their input to the HRA process.

40) Effective 1/1/2018, DHS approval must be sought prior to any use of cameras or video equipment in a member's bedroom.

41) Effective 1/1/2018, identify requests for services needing approval/ authorization as urgent when the service clearly is intended to prevent institutionalization so that HealthPartners can review and make a determination in an expedited time frame of within seventy-two hours.

42) Participate in stakeholders' meetings as requested.

IV. DEFINITIONS

Care Coordinator qualifications: HealthPartners requires MSHO/MSC+ Care Coordinators to be licensed social workers, registered nurses, nurse practitioners, physicians, or physician assistants.

Care Coordinator Training: All Care Coordinators will be trained in the use and referral parameters for home care and mental health services covered by HealthPartners as well as the linkages to referrals for services covered by fee for service payment.

Health Risk Assessment (HRA): The Health Risk Assessment tool meets DHS and HealthPartners requirements. The tool used is the state's Long Term Care Consultation tool. The health risk assessment shall include questions designed to identify health risks and chronic conditions, including but not limited to:

1. Activities of daily living
2. Risk of hospitalizations
3. Need for primary and preventive care
4. Mental health needs
5. Rehabilitative services
6. Protocols for follow up to assure that physician visits, additional assessments or Case Management interventions are provided when indicated.

Intensive Case Management: Intensive Case Management may be provided within the Care System or County or externally by another provider for the members including but not limited to the following:

1. Case Management for serious and persistent mental illness
2. Case Management for pre-petition screening

3. Court ordered treatment, developmental disabilities, assessment of medical barriers to employment.
4. A State medical review team or social security disability determination
5. Services offered through social service staff or county attorney staff for enrollees who are visits or perpetrators in criminal cases.

Minnesota Senior Care Plus (MSC+): The Minnesota mandatory PMAP program for Enrollees age sixty five (65a0 and over. MSC+ used § 1915 (b) waiver authority for State Plan services, and § 1915 (c) waiver authority for Home and Community-based Services. MSC+ includes Elderly Waiver services for Enrollees who qualify, and one hundred and eighty (180) days of Nursing Facility care.

Minnesota Senior Health Options: The Minnesota prepaid managed care program, pursuant to Minnesota Statues, § 256B.69, subd. 23, that provides integrated Medicare and Medicaid services for Medicaid eligible seniors, age sixty-five (65) and over. MSHO includes Elderly Waiver services for Enrollees who qualify and one hundred and eighty (180) days of Nursing Facility care.

Personal Health Information (PHI): Information that directly identifies an individual or from which there is reasonable basis to believe an individual could be identified. PHI relates to either past, present or future physical or mental health condition of the individual; or (1) the treatment provision, coordination, or management of health care to the individual; or (2) the payment the provision, coordination, or management of health care to the individual; or (3) is obtained through an insurance transaction that permits judgments to be made about an individual's character, habits, finances, credit, health or any other personal characteristics. PHI includes oral information and information records in any form or medium. PHI does not include data that is de-identified or aggregated information.

Prepaid Medical Assistance Program: A Minnesota program authorized under Minnesota Statutes, § 256B.69 and Minnesota Rules, Parts 9500.1450 through 9500.1464.

V. COMPLIANCE

Failure to comply with this policy or the procedures may result in disciplinary action, up to and including termination.

VI. ATTACHMENTS

2018 HealthPartners and DHS Contract for MSHO/MSC+

VII. OTHER RESOURCES

None

VIII. APPROVAL(S)

Laurel Rose Director, Disease and Case Management