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** July 1, 2024
Issued By Provider Relations and Network Management	**Next Review Date** June 1, 2025
Applicable Programs/ Staff 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 Carolyn Koch, Bev Vacinek, Emi Bennett Vo, Florence Okoampa	**Contact** Annette Fagerlee

HP Product Categories:

☐ Commercial Fully Insured	☐ Commercial Self-Insured	☐ Medicare Advantage
☐ Medicare Cost	☐ Medicaid/PMAP	☒ MSHO
☒ MSC+ EW	☒ MSC+ Non EW	☐ SNBC

HPUPH Product Categories:

☐ Commercial Fully Insured ☐ Commercial Self-Insured ☐ Medicare Advantage

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

II. **POLICY** All HealthPartners MSHO/MSC+ members, except for MSC+ institutional members, are 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 sensitive care, and promote appropriate utilization and member self-management.

Equitable Care Coordination All Care Coordinators and support staff who work in MSHO/MSC+ Care Coordination Programs are expected to provide services to our members in a culturally, linguistically appropriate, and equitable manner. This includes at a minimum, providing effective, sensitive, non-discriminatory communication and using language interpretation services, including written documentation, when appropriate.

The CC will make every effort to increase the understanding of health and well-being from the members' experience, values, or perspective, and being open to the creative application of services regardless of their race/ethnicity, income, geographical location, immigration status, gender, religion, disability status, sexual orientation, health status and/or any social determents of health.

We intentionally recruit and hire culturally diverse care coordinators to meet the needs of our members who cross the spectrum of languages, religions, and cultures. We make every attempt to assign members to Care Coordinators who speak their native language, and Care Coordinators receive ongoing cultural diversity training about the provision of culturally sensitive care and services. Care Coordinators are trained to recognize, address, and promote preventive care needs at the member level and within high-risk populations to help reduce equitable gaps in care.

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) Provide a holistic, person-centered approach when working with all members. This includes encompassing cultural and religious beliefs and customs, gender identify, disabilities, sensory impairments, health literacy, and any Social Determinants of Health
3) Be informed of basic member protection requirements, including data privacy.
4) 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 and dental exam. Help facilitate primary, specialty care and dental appointments as needed.
5) Provide information regarding services including processes for promoting rehabilitation of members following acute events, and for ensuring safe transitions and coordination of care and information between acute, sub-acute, rehabilitation, home care and other settings.
6) Work in partnership with the member and/or authorized family members or alternative decision makers, and the primary physician in consultation with any specialty 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.
7) Make referrals to specialists and sub-specialists.
8) Coordinate care for Native American Indian members and collaborate with the Tribal Nation's care management team when needed.
9) Coordinate with county social services and Case Management teams and/or systems.
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 and psychosocial risks, social determinants of heath and chronic conditions, including but not limited to: Activities of

daily living (ADL), Instrumental Activities of Daily Living (IADLs), risk of hospitalization, need for primary or preventative care, behavioral health needs, rehabilitative services, food insecurity, transportation access, housing stability, and protocols for follow-up to assure that physician visits, additional assessments or Case Management Interventions are provided when indicated.

ii) Use the DHS approved, Long Term Care Consultation DHS-3428 (LTCC) or Minnesota Health Risk Assessment (DHS-3428H) referred to as HRA, or the MnCHOICES tool to conduct initial, annual, and change of condition assessments. For members receiving Adult Day services, Foster Care and/or Customized Living Services, complete the Person's Evaluation (DHS 3428Q) form when completing the LTCC. The DHS LTCC should also be used in conjunction with DHS-3428D, Supplemental Waiver PCA Assessment and Service Plan when completing a personal care assistance (PCA) assessment or utilize the MnCHOICES assessment tool. Use DHS-required CFSS assessment and care planning tools when CFSS is implemented. Use HealthPartners Transitional HRA or the DHS MnCHOICES process for Functional Needs Update, for program changes (MSC+ to MSHO or MSHO to MSC+) or when you receive a new waivered member and you have received all required paperwork: most recent HRA, care plan and DHS 6037 HCBS Waiver, AC and ECS Case Management Transfer and Communication Form. For members residing in skilled nursing facilities, CCs will use the Minnesota Health Risk Assessment (DHS-3428H) or when released, HealthPartners Skilled Nursing Facility HRA. When MnCHOICES is available for use by Managed Care Organizations, use MnCHOICES to complete the HRA, the comprehensive assessment for nursing facility level of care eligibility and the DHS version of a mailable HRA.

iii) Complete an initial HRA of all MSHO members and MSC+ waivered members within 30 days of enrollment and within 60 days of enrollment for MSC+ non waivered members new to HealthPartners. Complete an annual reassessment HRA for all MSHO/MSC+ members within 365 days of the previous HRA. HRAs for MSC+ Institutional members are not required.

iv) Make best effort attempts 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 MSHO member for initial and annual HRAs including the date of each attempt. Attempts should be made on different days and at different times of day. An 'unable to reach' letter must be sent to the member in addition to the three contact 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 MSHO 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 outreach as described above and then attempt every six months to locate the member. The care coordinator should attempt to establish a relationship with the member even if unable to complete an HRA.

vii) Offer in-person HRA visits to each MSHO and MSC+ waivered member. If an in-person 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 or functional needs update assessment, of MSHO/MSC+ members with a significant change of health condition that is expected to alter the course of the member's services and support plan. Care Coordinators determine when a change of condition warrants completing another comprehensive HRA.

ix) For rate cell A members who request an Elderly Waiver service, complete the ~~comprehensive LTCC or~~ MnCHOICES assessment within 20 days of request date.

x) When members request Personal Care Assistant services, the assessment must be completed within 30 days of request date.

xi) Enter all DHS required information not populated by MnCHOICES and collected through the initial or annual health risk assessment including the refusal of the HRA or when unable to reach the member, into the Medicaid Management Information System (MMIS) within 30 days of completing the assessment.

xii) 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. 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 an in-person assessment annually in order to maintain eligibility for waiver services unless otherwise stated by MN DHS. Assess for housing instability and/or homelessness and refer as needed for Housing Stabilization Services

xiii) Identify caregivers and provide support per caregiver request. Special emphasis applied to members with diagnosis of dementia.

xiv) Delegated nurse practitioners that see members/patients in Skilled Nursing Facilities have a dual role of primary care provider and care coordinator for MSHO enrollees.

xv) Complete falls risk assessment as needed.

xvi) Complete cognitive assessment

13) Care Plans

i) Using the results of the HRA and with the input of the member and/or their caregiver, and their interdisciplinary care team, develop a person-centered and inclusive support plan with an equitable lens to reflect items that matter most to the member. Facilitate the support plan and monitor per follow up plan.

ii) Develop support plans based on available information for MSHO members who do not complete an HRA. All MSHO members will havesupport plans developed and provided to them regardless of completed HRA status,

iii) Complete support plans within thirty days of the HRA date or the unable to reach or decline HRA date for members not completing an HRA. The Care Coordinator provides a copy of the support plan to the member, the member's regular physician and anyone else as directed by the member.

iv) Within thirty days of completing the support plan, send a full or partial support plan copy to each Elderly Waiver provider noted on the member's support plan as providing services to the member according to the member's preferences/instructions regarding same. Include with the support plan any special instructions related to delivering the service and a request for the provider to return a signed copy to the Care Coordinator. If a signed copy of the support plan is not returned within 30 days, another copy of the support plan with a request to sign and return should be sent to the provider prior to the 60th day of completing the support plan.. Documentation of sending the support 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 support plans received from the provider.

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

vi) Incorporate unique primary care, acute care, long-term care, mental health, HCBS, 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.

vii) 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 support plan.

viii) Complete Emergency Back Up Plans for members receiving essential services.

ix) Complete Community Wide Disaster plan as part of each community member's support plan.

x) Participate in care conferences for members residing in Skilled Nursing Facilities or other congregate settings such as hospital, assisted living or foster care as needed.

xi) Participate in ethics committee meetings regarding the treatment of an MSHO/MSC+ member as needed.

xii) Collaborate with the member to develop a support plan that addresses all needs identified by the HRA including the member's unstable or newly diagnosed chronic health condition(s).

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

xiv) Develop a plan for follow-up to ensure primary and preventive care, mental health needs, Home and Community Based Service's needs, additional assessments or other care management interventions are provided as planned. Follow-up plan includes target dates for follow up.

xv) Ensure data privacy practices are reviewed with member.

xvi) Let members know that they should contact the Care Coordinator to make any changes to their support plan and may request a different Care Coordinator at any time.

xvii) 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 support plan.

xviii) 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.

xix) Develop support plans that address social determinants of health.

xx) Verify that Elderly Waiver providers are enrolled with DHS or contracted with HealthPartners before initiating services.

xxi) Offer a range of choices to meet the individual needs of each member.

xxii) Provide the member and others who have participated in the support planning process as the member wished, a copy of the support plan within 30 days of completing the HRA.

xxiii) Provide best efforts to have the member or their representative sign a copy of the support plan.

xxiv) Discuss the importance of preventive care with the member or their representative during the support planning process. Facilitate making primary care visit appointment as needed.

xxv) Encourage members to complete an Annual Wellness Visit in conjunction with a primary care visit.

xxvi) 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.

14) Interdisciplinary Care Team (ICT)
   i) All MSHO members must have an ICT documented in their case files
   ii) ICT at a minimum consists of the member, their primary care physician or specialist and the care coordinator
   iii) Review the ICT annually and update as needed.
   iv) Invite PCP to be a member of the ICT

15) 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. Delegates complete and document all care transition requirements and update the member's support plan to reflect the care transition as defined by HealthPartners. All care coordinators have access to resources to ensure a safe discharge. The Care Coordinator provides post discharge outreach to all members who are returning to their home setting.,
Provide self-management and educational materials to members as needed.

16) Coordinate with county social service agencies, tribes, 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), which incorporate 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.

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) 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.

21) Make referrals and/or coordination with County Social Service staff when the member needs the following services:
   i) Pre-petition screening
   ii) OBRA Level II referral for Mental Health and Developmental Disability
   iii) Spousal Impoverishment Assessments
   iv) Adult Foster Care

v) Group Residential Housing Room and Board Payments

vi) Substance Use Disorder room and board services covered by the Consolidated Chemical Dependency Treatment Fund

vii) Adult protection

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

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

26) Help determine if members with HIV/AIDS and related conditions may have access to federally funded services under the Ryan White CARE Act.,

27) 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. Refer to county services for PAS Level II triggers.

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

29) Participate in quality improvement initiatives 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 Provider Relations and Network Management 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, a regulatory agency or an entity contracted for this purpose.

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

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

34) Notify HealthPartners Membership Accounting of enrollment discrepancies based on reconciliation of delegate enrollment with HealthPartners enrollment.

35) Use the forms and tools required by MN DHS for certain waivered services including but not limited to: Individual Community Living Support Services (ICLS), Customized Living Services (CLS) and Consumer Directed Community Supports (CDCS). Submit the tools to DHS as required.

36) 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.

37) 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.

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

39) DHS approval must be sought prior to any use of cameras or video equipment in a member's bedroom.

40) 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.

41) Participate in MSHO stakeholder and enrollee advisory council meetings as requested.

42) Report any vendor/provider concerns to HealthPartners MSHO/MSC+ liaison immediately upon identification of issue(s). In addition, escalate severe issues to proper DHS reporting authorities.

43) The CC cannot be employed by a provider providing long term support and services and who is listed on the individualized care plan unless HealthPartners approves an exception which demonstrates that the only willing and qualified entity to provide service in the geographic area also provides long term support and services.

44) For MSC+ members, coordinate with Medicare and support members by identifying the correct provider and payer source per service. The Care Coordinator coordinates all the member's services regardless of payer, working with provider who can bill Medicare when appropriate to do so, thus reducing a level of complexity for the member and responsible party.

45) Review MSHO Supplemental Benefits with eligible members and facilitate ordering any services/items requested.

46) Complete DHS trainings as required for the RS Tool and MnCHOICES HRA/Comprehensive Assessment/Transitional HRA/Support Plans.

47) Have established caseload ratios for care coordinators serving all MSHO members.

48) Provide/utilize DHS Relocation Services and/or Moving Home Minnesota services as appropriate, for long-term care members who desire to return to a community setting.

49) Participate and/or stay informed regarding DHS initiatives such as, for example, Community First Service and Supports, Housing Stabilization Services, and Electronic Visit Verification.

50) During in-person visits for MSHO members, review the safe disposal of medications.

51) Participate in Medical Director rounds, dialysis rounds, psychosocial rounds or other interdisciplinary meetings as needed.

52) Refer to MTM as needed

IV. DEFINITIONS

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

Health Risk Assessment (HRA): The Health Risk Assessment tool meets DHS and HealthPartners requirements. The health risk assessment shall include questions designed to identify health risks and chronic conditions, including but not limited to:

1. Cognitive
2. Medical

3. Psychosocial
4. Functional
5. Behavioral
6. Food insecurity
7. Housing stability
8. Transportation access

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Interdisciplinary Care Team: Each MSHO member has an ICT. At a minimum, the ICT includes the member, their primary care provider, and the Care Coordinator. Others may be added per the member's discretion and/or based on their current health care needs.

Minnesota Senior Care Plus (MSC+): The Minnesota mandatory Medicaid program for enrollees age sixty five (65) 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 Nursing Facility care and 180 days of nursing facility care.

Minnesota Senior Health Options: The Minnesota Medicaid 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 Nursing Facility care and 180 days of nursing facility care.

MnCHOICES: MnCHOICES is the name of the Minnesota's assessment and support planning tool used by counties, tribal nations, and managed care organizations. It is a single, streamlined, and comprehensive process to assess individuals, identify their needs and develop support plans, for individuals with a disability or in need of long-term support and services.

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 (PMAP): A Minnesota program authorized under Minnesota Statutes, § 256B.69 and Minnesota Rules, Parts 9500.1450 through 9500.1464.

Support Plan: Each MSHO member has a support plan regardless of the HRA status. MSC+ members who complete an HRA have a support plan. The support plan (or care plan) is a document that outlines the treatment and support needed, and services provided, that is tailored to the specific needs and goals of an individual. The support plan is customized towards the individual's cultural choices, preferences, interests, and goals regarding their health. Support plan is synonymous with individualized care plan (ICP), care plan, plan of care and person-centered plan.

V. COMPLIANCE

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

VI. ATTACHMENTS

None

VII. OTHER RESOURCES

2024 DHS Contract for Seniors (MSHO/MSC+), Articles 6.1.4, 6.1.5, 6.1.6, 6.1.25, 6.1.26, 6.1.27, 7.1.5, and 7.8

VIII. APPROVAL(S)

Annette Fagerlee,
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