MSHO/MSC+
Care Coordination Meeting

September 17th, 2020
Recorded WebEx

Agenda

- State Fair Hearings– Marie Berglund
- Quality Improvement-Preventive Care – Emily Eckoff
- PCA/EW Updates – Esther Versalles-Hester
- Transitions of Care– Cindy Radke
- Housing Stabilization Services– Dawn Sulland
- Mental Health/SUD Case Management-Jennifer Andersen/Malorie Cloutier
- Care Coordination Updates – Bobbi Jo Glood

State Fair Hearing Process

September 17th, 2020

Grievance, Appeal and State Fair Hearing Process

Any Managed Care Organization (“MCO”) Action or Grievance may be reviewed at a State fair hearing

An enrollee may request a State fair hearing for reasons that include, but are not limited to:

- A MCO's decision to deny, terminate or reduce services
- A MCO's resolution of a grievance or appeal which is not in favor of the member
- Other problems regarding service from a MCO
- Bills incurred by the enrollee, for which payment was denied by the MCO
- Any other ruling of a prepaid MCO

Statutory authority for Administrative Review of Human Services Matters is Minn. Stat. § 256.045

The Players

Petitioner

The petitioner is the enrollee who files a grievance, appeal, or State fair hearing request. It is the responsibility of the petitioner to:

- Have a clear understanding of the issue(s) that need resolution.
- Understand what remedy is being requested.
- Be prepared to articulate the facts surrounding the issue(s) or request a representative (e.g., an advocate or legal aid) to help.
- Provide evidence to support the appeal/State fair hearing by obtaining all pertinent records, letters from providers, etc.
- Notify the State fair hearing referee in advance if attendance at the scheduled hearing is not possible.
- Use the services of the county advocate, State ombudsman or legal assistance, if needed, with any part of the grievance, appeal, or State fair hearing process.

Service Related State Fair Hearings

If the State fair hearing involves a service issue, the enrollee may be referred to a County Advocate, Ombudsman or other personnel who can assist in resolving the complaint.

The Players

County Advocate

A County Advocate may explain the State fair hearing process to the petitioner. The County Advocate may help the petitioner:

- Gather documentation or evidence, such as, case summary, medical records pertaining to the case (e.g., doctor orders, hospital and clinic records), letters from providers letters of denial from the MCO, case notes, treatment plan, diagnostic evaluations, prognosis, etc. the MCO's Evidence of Coverage, PMHCP rules and appropriate statute citations.
- Obtain witnesses, and
- If necessary, help the enrollee prepare opening and closing remarks for the hearing.

The Players

Department Ombudsman

The ombudsman may assist enrollees in resolving service related problems with the MCO. If requested by the enrollee, the ombudsman will investigate the enrollee's complaint and attempt to resolve the problem informally. The ombudsman serves as an intermediary between the enrollee and the MCO.

The ombudsman will explain to the enrollee:

- Grievance, appeal, and State fair hearing options,
- How to file a grievance, appeal, or State fair hearing request,
- How to obtain a second opinion from the MCO,
- How to file an expedited appeal or State fair hearing request, and
- How the grievance, appeal, and State fair hearing process functions.

If a complaint cannot be resolved informally, the ombudsman may assist the enrollee in filing a grievance, appeal, or State fair hearing request.

The Players

Legal Aid

The enrollee has a right to legal assistance. Legal Aid telephone numbers are available to the enrollee when the initial request for a State fair hearing is made.

The Legal Aid attorney will serve as a zealous advocate for their client’s position, presenting legal arguments and aiding in the collection of evidence, documentation, etc. to support the petitioner’s request.

The Hearing

The Department’s Appeals unit usually schedules a hearing within two to three weeks of receiving the State fair hearing request. A Human Services Judge from the Department’s Appeals unit conducts the hearing. Expedited hearings are available for denial/reduction/termination of a previously authorized service.

The hearing may not be held earlier than five days after filing of the required notice with the county or state agency.

The state human services judge must notify all interested persons of the time, date, and location of the hearing at least five days before the date of the hearing.

The enrollee must attend the scheduled hearing or cancel before the hearing date, or she/he will lose the right to a State fair hearing.

The Hearing

The enrollee has a right to legal assistance. Legal Aid telephone numbers are available to the enrollee when the initial request for a State fair hearing is made.

Interested persons may be represented by legal counsel or other representative of their choice, including a provider of therapy services, at the hearing and may appear personally, testify and offer evidence, and examine and cross-examine witnesses.

The petitioner shall have the opportunity to examine the contents of the case file and all documents and records to be used by the county or state agency at the hearing at a reasonable time before the date of the hearing and during the hearing.

The Hearing

For complex matters, the human services judge may hold a prehearing conference before the hearing to narrow the issues and plan for the hearing.

Most hearings are held by telephone, but if requested, may be heard by video conference or in person.

During the hearing, the human services judge will listen to the arguments and testimony from both sides, and will review the evidence each side gives the judge. Each side will have the opportunity to ask the other side questions about their testimony and evidence.

Testimony

- **Be truthful and concise.**
- **Answer the question that is asked – take notes if it will help you remember what you want to say. Don’t exaggerate or editorialize.**
- **Take your time – listen (and think) before answering.**
- **Refer back to the documents or case file that was sent to the human services judge in advance whenever you need to. Your responses should be consistent with what was presented in the case file.**
- **If you don’t know something, it is ok to say so. Do not speculate.**
- **Be positive, polite and respectful in your interactions with all participants.**

Preventive Care

Emily Eckhoff

Colon Cancer Screening

- **Variety of testing options**
  - Colonoscopy every 10 years
  - CT colonography every 5 years
  - Flexible sigmoidoscopy every 5 years
  - Fecal occult blood test annually
  - Cologaurd every 3 years
- **UCare Incentive**
  - $50 gift card • Colonoscopy • Sigmoidoscopy • CT colonography
  - $20 gift card • At-home test kit option, such as fecal occult blood test (FOBT) or Cologuard®. UCare will mail after receiving the claim—do not need to mail in a voucher
- **UCare initiatives**
  - Sending home kits
  - Conducting member outreach

Breast Cancer Screening

- **Challenging due to absence of virtual screening options**
  - Restarting cancer screening requires careful consideration of the risks and benefits of screening, along with ensuring safety for both patients and healthcare personnel
- **MN testing locations**
  - Majority are providing routine care
  - Working through patient backlog
  - Decreased compacity
  - Telephonic COVID screening prior to appointment
- **UCare Incentive**
  - $50 gift card

Medicare Annual Wellness Visit

- **Utilize virtual care/telehealth**
  - Recommendations for other care needs and ordering screenings
  - Medication checks
  - Assessment of mood changes, physical activity, balance troubles, sleep, urine leakage
  - Blood pressure check
- **UCare Incentive**
  - $25 gift card

Flu Shot

- Flu Shots are more important than ever!
- Flu shots or nasal spray are available at no cost to all UCare members.
- UCare member who uses Health Ride to get to medical appointments, can use it to get their flu shot.
- Share the facts about flu
  - You CANNOT get the flu from the flu shot or nasal spray.
  - But the flu CAN lead to serious health complications and even death. Each year, about 200,000 Americans are hospitalized from the flu, and about 36,000 Americans die from the flu.

Flu Shot

- Everyone 6 months of age and older need a flu shot every year.
- It’s the best protection against the flu.
- Get your flu shot at any location convenient for the member.

Flu Fighter Clinic

- UCare and HealthFair 11 are teaming up to offer free flu shots at Flu Fighter Clinics in a safe drive-thru clinic. Doctors and pharmacists will be available to answer your questions.

When: Friday, September 25 – Sunday, September 27, 9 am - 3 pm

Where: Minnesota State Fairgrounds | 1265 Snelling Ave N, St. Paul, MN 55108 Enter at the Snelling Ave gate and follow the signs.

PCA/EW Updates

Reminders regarding Elderly Waiver Budget Exception Request

Please include the following information on Budget Exception Requests

- Complete the “Request to Exceed Case Mix Cap” Form
  - Include LTCC
  - Budget Worksheet
  - Customized Living rate tool (if applicable
  - Any other supporting documentation.

- Remember to include documentation of options that have been considered in order to stay under the case mix cap and any additional rationale or justification to exceed the case mix cap.
- For any complex related inquires or potential requests, please contact our CLS Liaisons or Intake Manager for additional assistance.

Elderly Waiver Service Requests

- As a reminder, medically necessary services such as mobility devices, hospital beds and oxygen equipment (etc.) , fall under the UCare members' medical benefit. Please contact UCare Intake team if you have questions as to whether an item should be covered under the medical vs EW benefit.

- Please allow 14 business days for the WSAF authorization to be reported on your daily care system authorization report.

- If the authorization does not appear on the daily authorization report, please contact the UCare Intake team via phone or email before resubmitting a duplicative requests.

Questions?

For assistance regarding general EW inquires or status of authorizations, Case managers can contact the CLS Intake team at:

612 676-6705, press option 2, then option 5 to speak to an Intake Authorization Coordinator.

Thank you!

Transitions of Care (TOC)

September, 2020

What is a “Transition of Care”?

- Member’s movement from one care setting to another setting due to changes in the member’s health status.

- Examples: member moves from home to a hospital as the result of an exacerbation of a chronic condition; member moves from hospital to a skilled nursing facility.

What is a “Care Setting”?

- The place where the member receives health care and health-related services
- Examples: member’s home; hospital; skilled nursing facility; rehabilitation facility
- “Usual care setting”
- “Receiving care setting”

Importance of TOC Coordination

- Older adults moving between health care settings are vulnerable to:
  - Fragmented care due to lack of follow-up.
  - Health care providers not communicating.
  - Unsafe care due to changes with medication regimes or lack of medications, and self-management concerns.
  - Readmissions to hospital.
- CMS requires all Medicare Advantage-Special Needs Plans to develop a process to coordinate care when members move from one care setting to another to avoid potential adverse outcomes.

Care Coordinators are the key to preventing problems during transitions.

TOC & Health Plan Collaboration

- Minnesota Health Plans worked together in a collaborative effort to streamline processes that make TOC simpler for care coordinators:
  - Core requirements are consistent across plans.
  - Common data elements across plans.
- To simplify the requirement to track the care transition process, the health plans have created a form called the *Individual Care Transition Log.*
- Use of this form is required whenever a TOC has occurred.
- Complete a log entry for each TOC.

Example of Care Transition

- Member has a total of **three** transitions and each one would have its own entry on the Individual Care Transitions Log.
  - Member leaves home and is admitted to a hospital. (one transition).
  - Member is discharged from a hospital to a skilled nursing facility. (one transition).
  - Member returns home. (one transition).

Providing Support

- Care Coordinators (CCs) act as a consistent person to support the member throughout the transition, and to help prevent transitions:
  - Educate to avoid unnecessary ER visits and hospitalizations.
  - Look for risks (falls, lack of preventive care, poor chronic care disease management) and take action.
  - Identify to hospital discharge planners the support and services the member currently has, assisting with discharge planning.
  - Identify when a member may need assistance to manage their medications.
  - Setting up crucial follow up appointments with primary care or specialists upon hospital discharge.

Identifying Transitions

- Daily Authorization Report
  - Hospitalizations.
  - Planned procedures requiring prior authorization.
  - Monthly MSHO Hospital and ER readmission report.

- Discussion with Members
  - Talk about outpatient procedures that might. require care plan changes, TOC management.

- TOC Brochure
  - Review brochure with members/responsible party, make them aware of their role in transitions.

Identifying Transitions, cont.

- Utilize the MSHO Hospital & ER Readmission monthly report
  - Sent by the second week of the month.
  - Shows hospital admissions, readmissions, ER visits over the previous 6 months.
  - Utilize this report as a tool to assist in identifying members who may benefit from:
    - A Disease Management Program
      - If a member has multiple ED visists for CHF, Asthma, Diabetes.
    - Educate members on how to prevent multiple ED visits. Options for urgent care, primary care, nurse line services.
    - A way to identify members that may need additional support.

CC Communication With Receiving (non-usual) Care Setting

- For transitions to settings other than member's usual care setting, the CC is required to
- Identify an appropriate contact within the unit/floor such as a discharge planner or social worker
- Communicate the following with the receiving setting within 1 business day of notification of the transition:
    - CC contact information.
    - **Current care plan or summary,** hospital/SNF discharge instructions, and services (home care, etc).
    - Current meds, chronic conditions, current treatments, etc.
    - Service providers
        - Usual provider and/or specialty care provider contact information;
    - Other relevant information.
- Communication may be done via phone, fax, or flag in an electronic system.

PCP Contact

- The CC is required to notify PCP of admission, if PCP was not admitting physician.
    - By fax, phone, or flag in an electronic system.
    - Within 1 business day of notification of the transition.
    - If PCP is admitting physician, no additional notification is required. Note on the log.

CC Communication for Transitions Back to Usual Setting or “New” Usual Setting

- For transitions back to their usual care setting, or “new” usual care setting (i.e. – a community member moves to permanent nursing home), the CC is required to:
  - Communicate with receiving setting:
    - CC contact information.
    - Current care plan and services, providers, etc.
    - Information about the transition.
    - Relevant information – current services, informal supports, medications, advance directives, etc.
  - Notify PCP of transition.
  - Communicate with Member/Responsible Party.

Communication with Member/Resp. Party Upon Return to Usual Setting

- Reach out to the member, **upon return to their usual setting**, within **1 business day of notification** of the transition, to assess needs and prevent readmissions.
- Outreach may be telephonic or face-to-face.
- Discussion should include:
  - Care transition process
  - Changes to member's health status
  - Changes to care plan
  - Educate about how to prevent unplanned transitions/re-hospitalizations
  - Provide contact info
  - 4 Pillars to Optimal Transition Management. –Follow up appointments, medication management, ability to verbalize warning signs, personal health record (discharge summary).

4 Pillars to Optimal Transitions

1. Medication Self-Management.
    - Medication changes/new prescriptions filled.
2. Patient Centered Health Record- across providers and settings.
    - Discharge instructions, care plan, etc.
3. Follow-Up.
    - Follow-up appointments, transportation, services, DME, supplies, etc.
    - Changes in functional needs (bathing, eating, dressing, transfers, etc.)
4. Red Flags.
    - Understanding if condition changes or gets worse.

Transition of Care Log and Tasks

- TOC tasks are identified on the TOC log.
- All TOC tasks should be completed by the CC within 1 business day of notification of each transition.
- Auditing shows issue of logs not being completed.
  - Missing elements.
  - If something doesn’t apply, mark N/A.
- Ensure you are completing the log for each transition that occurs.

Late Notice on Transitions

- If CC finds out about the transition 15 or more days after the transition after the member has returned to their usual setting, **no TOC log is required.**
- The CC is still required to follow up with the member/rep to:
  - Discuss the TOC process
  - Discuss changes to the member's health status and POC
  - Provide education about how to prevent TOCs
  - Discuss 4 Pillars of Optimal Transitions
    - Document this discussion in case notes.
    - Case Notes may be audited, so ensure this documentation is present in case notes, since no log is required.

Additional Notes

- Up to 3 transitions can be documented on each log.
- Remember to count each move as a separate transition, and document separate transition activities.
- TOC includes when a member goes back and forth between settings – each time is considered a separate transition.
- Save all transition documents in case notes.
- Be sure to complete all applicable areas of the log.

Summary

- The Care Coordinator is the key to preventing and managing care transitions by:
  - Educating members about prevention and avoidance of transitions of care.
  - Facilitating communication to improve member’s health and safety.
  - Developing relationships with members, local practitioners, hospitals, nursing facilities, etc.
  - Monitoring members at higher risk to prevent unplanned care transitions.
  - Ensure member has follow up appointments scheduled, primary care, specialty.


Thank You

Housing Stabilization Services

What is housing stabilization services?

- Housing Stabilization Services is a new Minnesota Medical Assistance benefit to help people with disabilities, including mental illness and substance use disorder, and seniors find and keep housing.
- People with disabilities often need support to live successfully in the community. However, that support is often unavailable. Affordable housing is not always enough; challenges such as mental illness and developmental disabilities can make it difficult for someone to find housing, budget, interact with landlords and neighbors, and understand the rules of a lease. With the right supports, provided by a professional with knowledge and experience in housing, more people can be successful.
- The purpose of these services is to:
  - Support an individual's transition into housing,
  - Increase long-term stability in housing in the community, and
  - Avoid future periods of homelessness or institutionalization.

Housing stabilization service types

Housing consultation services	Housing transition services	Housing sustaining services

• Services that assist a person in developing a housing focused person-centered plan, assist the person to access needed state plan services that support housing stability and provide referrals or information about to other needed services.
• This service is available to people on Medical Assistance who do not have a waiver case manager, mental health targeted case manager or MSHO/MSC+ care coordinator involved to complete an assessment and a person-centered plan of care.
	• Helps people plan for, find and move to homes of their own in the community by:
	  • Developing an individualized housing plan
	  • Identifying and assisting in resolving barriers to accessing housing
	  • Supporting the person in applying for benefits to afford their housing
	  • Contacting prospective housing options for availability and information
	  • Supporting the person with tenant screening and housing assessment
	  • Helping to understand and negotiate a lease
	  • Identifying resources to cover moving expenses
	  • Ensuring the new living arrangement is safe and ready for move-in
		Supports a person to maintain living in their own home in the community by:
		  • Prevention and early identification of behaviors that may jeopardize continued housing
		  • Assistance with the housing recertification processes
		  • Training on being a good tenant, lease compliance, and household management
		  • Supporting the person to understand and maintain income and benefits to retain housing
		  • Supporting the building of natural housing supports and resources in the community
		  • Housing sustaining services do not cover room and board

How services apply to MSHO/MSC+ & Connect/Connect + Medicare

- **Housing Consultation Services**
  - Members on MSHO/MSC+ do not qualify for housing consultation services as their care coordinator will fulfil the duties of this role which includes identifying the need for housing stabilization services, ensuring the member meets the criteria for housing stabilization services and completing the Collaborative Care Plan.

- **Housing Transition Services & Housing Sustaining Services**
  - Members on MSHO/MSC+ who have a need for housing transition services or housing sustaining services will receive assistance from the MSHO/MSC+ care coordinator to help the member select a housing transition services or housing sustaining provider.

The role of the MSHO/MSC+ care coordinator: Eligibility

Need for services due to limitations caused by disability + **Housing instability** + **Disability or disability condition**

- Members must have support needs in one of the four areas while completing the LTCC:
  - Communication
  - Mobility
  - Managing behaviors
  - Making decisions
- Through the LTCC assessment care coordinators will determine any limitations the member has.
- A member does not need to meet the definition of "dependency" on the LTCC in one of the above categories to qualify

- Members must also have housing instability to qualify for housing stabilization services.
- The member must meet one of the following criteria:
  - Homeless
  - At risk of homelessness (including could become homeless without continued housing services)
  - Institutionalized (currently or within the last 6 months)
  - Eligible for a waiver (a person with an institutional level of care is also deemed at risk of institutionalization)

- Members must meet a defined criteria for disability.
- For the purposes of qualifying for housing stabilization being age 65 or over is a qualifier under the disability and disabling condition category.

The role of the MSHO/MSC+ care coordinator: assessment & planning

- Members must be assessed to determine if they qualify for housing stabilization services.
- The LTCC (DHS-3428) can be used to assess the need for housing stabilization services.
  - The HRA (DHS-3428H) **cannot** be used to assess the need for housing stabilization services.
- The care coordinator takes the assessment information and adds housing stabilization services to the Collaborative Care Plan; as they do with other needed and selected services.
- The care plan must indicate which of the four support needs the member meets the criteria for – communication, mobility, managing behaviors or making decisions.
  - E.g. "John needs support **communicating** his needs".
- The care coordinator helps the member select a housing transition/sustaining provider; as they do with other needed and selected services.
- The care coordinator will follow the same process to receive a plan signature from both the plan's owner and the HSS provider.
- The completed Collaborative Care Plan is forwarded to the HSS provider.
- The HSS provider uploads information into the DHS eligibility review system.
- The assessment and plan must be updated annually as with other HCBS services.
- Reassessment is the same process as initial eligibility.

Who completes the assessment and plan

- **MSHO/MSC+ Care Coordinators**
  - Completes the LTCC and Collaborative Care Plan if the member does not have a disability waiver case manager
  - If the member has a disability waiver case manager and MSHO/MSC+ care coordinator the disability waiver case manager completes the assessment and plan.
  - If the member has a Targeted Case Manager and MSHO/MSC+ care coordinator the MSHO/MSC+ care coordinator completes the assessment and plan.

Frequently Asked Questions

- Housing stabilization services & relocation services are duplicative. When should I use relocation services versus housing stabilization services.
  - If a member is in an institution the ideal service would be relocation services, as the provider can bill for services while the member in institutionalized.
  - If a member has used up their 180 days of relocation services they can move onto housing stabilization services
- Where can I find a list of housing stabilization services providers?
  - You can find a list of providers on the MHCP Provider Directory here under Type: Home and Community Based Services and Sub-Type: Housing Stabilization Services.
- I work for a delegate agency that also provides housing transition or housing sustaining services. Can a member receive these services from the agency I work for?
  - This is not allowable under the CMS conflict of interest guidelines.
- How are these services billed? Is there anything the care coordinator needs to authorize?
  - These services are billed under the member's MA benefit through UCare. Care coordinators do not authorize this service. This service is not included in EW budgets.

Questions?
Email clinicalliaison@ucare.org

Mental Health and Substance Use Disorder Case Management Program

What We Do

- Crisis Intervention
- Case Management Consult
- Active Case Management
  - Shaping the care of our members
  - Advocacy
  - Improving quality of life
  - Positively impacting our members lives

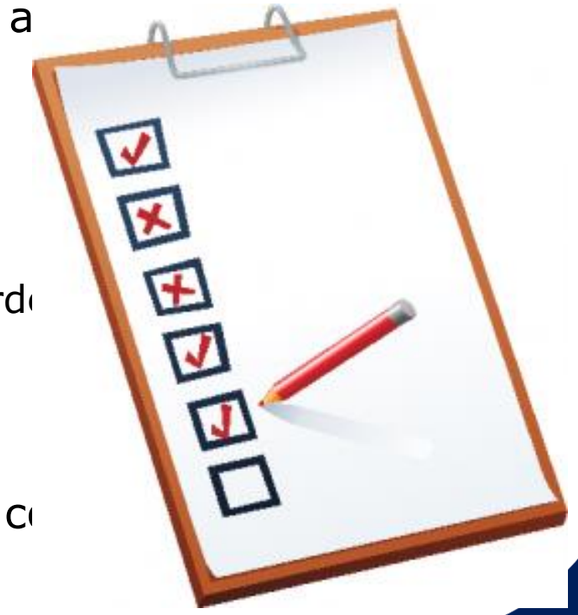
- Your role as a CC will remain critical to your members. We are there to help!!!

Referral Criteria

- Member must meet one or more of the criteria listed below to be eligible for Mental Health and Substance Use Disorder Case Management.
  - Members may have a combination of the items below to meet our criteria
- Triage Coordinators will receive the referral and screen if member meets criteria using an claims report.
- If criteria not met, will send back to referral source with option for consult with a

Criteria:

- 2 admissions in the past 12 months of the following:
  - Inpatient mental health, eating disorder, detox or substance use disorder
  - Residential treatment for mental health, substance use disorder, IRTS or eating disord
- 3 admissions in 6 months for crisis residential-
- 2 episodes in the past 12 months for partial hospitalization program
- 2 ER visits in the past 6 months for a mental health or substance use disorder c



Questions

Care Coordination Updates

Care Coordination Enrollment Rosters

The new Care Coordination Enrollment Roster’s have been sent out for 2 months now.

We want to acknowledge that this is a new process and there will be some issues as we continue with them and the process will continue to improve as time goes on.

Thank you all for your understanding as we continue to evaluate and make changes.

Residential Services Tool in MnSP

- Coordinators should have began completing residential services (RS) tools in MnSP as of August 3rd.
- All information related to RS Tools will be housed in CountyLink under Support Plan and will later be moved to the DWRS and EWRS Tool link.
- The MnCHOICES Mentors should remain available to attend the post-launch calls if they have questions for the DHS team regarding the RS tool post launch.
  - The post launch calls are scheduled for the following dates and times:
    - Thursday, September 24 –1 to 2:30pm
    - Tuesday, October 13 –10 to 11:30am
    - Thursday, October 29–1 to 2:30pm.
- As a reminder, the previous RS Tool Webinar information is on the Disability Services Division training archive page under the MnCHOICES section.
- The UCare Clinical Liaisons can assist with setting up new care coordinators to be added to the MnSP platform with UCare-[delegate] combination and password resets.

Clinical Liaison Contact

- Email
  - Clinicalliaison@ucare.org
    - When emailing please supply the following
      - Contact person’s name, phone, and email.
      - A detailed description, including:
        - Member’s name and date of birth.
        - Member’s UCare ID# or PMI #.
        - UCare product (MSHO, MSC+, Connect or Connect + Medicare).
        - Question pertaining to care coordination.

- Should you wish to have a phone conversation please email and let us know a good time and number for us to reach you at.

Thank you!