Subject Care Coordination for Special Needs Basic Care (SNBC)	**Attachments** ☐ Yes ☒ No
Key words Care Coordinator, SNBC, Case Management	**AC010**
Category Business Practices (BP)	**Effective Date** 7/1/2016
Manual HealthPartners Administrative Manual	**Last Review Date** June 1, 2020
Issued By Professional Relations and Network Management	**Next Review Date** August 1,2021
Applicable Programs 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 SNBC members	**Origination Date** 7/1/2016 **Retired Date**

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 SNBC Care Coordination services.

II. Policy

The SNBC Care Coordination Program is based on the fundamentals of the Triple Aim along with the practice of cultural humility, person first principals and honoring the complexities of the members we serve.

Triple Aim:

1) Improving the health of our members

2) Delivering an exceptional experience that members want and deserve
3) Stewardship to deliver greater value, growth and financial results.

Cultural Humility:

All employees of the SNBC Programs are expected to provide services to our members in a culturally and linguistically appropriate and equitable manner. This includes at a minimum, providing effective, sensitive, non-discriminatory communication, making every effort to increase the understanding of health from the members' experience, values or perspective, and being open to the creative application of services.

Person First Principals:

All employees of the SNBC Programs are trained to work with our SNBC members demonstrating person first principals, such as:

- Each SNBC member is supported to be as healthy as possible with providers who understand the needs of this population and integrate their healthcare with their social services
- Each SNBC member is offered person-centered planning to help them design their own life using their natural supports, their own employment, and their public funds
- Each SNBC member gets the trusted partner of their own choosing to support them in navigating services
- Each SNBC member is allowed to choose the level of risk they wish to take with their life

III. PROCEDURE(S)

All HealthPartners SNBC members will receive Care Navigation services and are assigned to a Care Coordinator when their health risk assessment or other high risk triggers indicate the need for one on one assignment. 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. The Care Navigator will provide coordination of health plan benefits and collaboration/communication amongst the member's providers, county and delegated case managers and care team members.

CARE COORDINATOR/CARE NAVIGATOR ROLES AND RESPONSIBILITIES

1) Perform the duties of Care Management, Case Management or Navigation Assistant listed in the DHS SNBC contract, Article 6 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 on their caseload.

8) Coordinate with Individual Education Plan (IEP), an Individual Family Service Plan (IFSP) or Individual Community Support Plan (ICSP) including services and supports.

9) Coordinate with Case Management services provided by children's mental health collaborative, and family services collaborative and adult county mental health initiatives.

10) Coordinate with county social services and Case Management systems

11) Coordinate with transitional care for children between the ages of eighteen (18) and twenty-one (21) who require ongoing services as they transition to adult programs covered under the DHS Contract.

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

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

14) Refer Providers, county staff, family members or others requesting the contact information of the member's assigned Care Coordinator to the HealthPartners Care Navigation line at 952-967-5253 for this information.

15) Health-Risk Assessment (HRA)

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.

i) Use HealthPartners HRA tool to conduct initial, annual, and change of condition assessments. Use of alternate assessment tools and/or forms by contracted entities must be approved by HealthPartners.

ii) Complete initial HRA of SNBC members within 60 days of enrollment for all new HealthPartners members.

iii) Make best efforts to attempt to locate correct demographic information for each member as necessary in order to successfully reach each member.

iv) Offer face-to-face HRA visits to each non-waiver member. If a face-to-face visit is declined or not possible, the HRA will be completed by telephone, or by mail.

v) For members who decline an HRA, or completed an HRA by phone or mail, outreach including an offer of a face-to-face visit to non-waiver members will be completed every six months or according to a schedule as the member requests. The Care Navigator or Care Coordinator will attempt to establish a relationship with the member even if unable to complete an HRA.

vi) Complete a reassessment of SNBC members within 364 days of the previous HRA and 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 and if a face-to-face reassessment is needed.

vii) 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-waiver/non-institutional members until MnCHOICES is implemented and this information is processed automatically.

viii) Inform the member that participation in the HRA is voluntary and that the Care Navigator 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 services, the Care Navigator will continue to contact the member every six months and upon notification of a hospitalization or of the member being identified as being high risk.

16) Care Plans

i) Care Coordinators develop & implement care plans based on HRA results and developed in conjunction with the member, member's regular physician, and waiver case manager and health care specialists as 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) Act quickly upon any safety or self-preservation risks identified, whether environmental or medical.

iv) 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. Note if the member is receiving home and community-based services or is in need of a referral to the County for assessment for waiver services.

v) 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.

vi) Develop a list of health actions and/or reminders related to the member's identified needs. Members may decline having a care plan developed and/or having individual goals developed. When this occurs, the health actions are dated and documented in a manner and location such as Outlook or data base application that will trigger the Care Coordinator or Care Navigator when the follow up is due to ensure completion.

vii) Develop care plans to assist members to self-manage their unstable or newly diagnosed chronic health condition(s). If their health condition requires more specialized support, then the Care Coordinator will refer the member to HealthPartners Disease and Case Management services for additional assistance.

viii) 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.

ix) Assist the member and/or authorized family members or guardians to maximize informed choice of services and control over services and supports.

x) 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.

17) Have fast track interventions and protocols available for management of disability related conditions common among members with disabilities such as skin breakdown & urinary tract infections.

18) Provide self-management and educational materials to members with disability related conditions.

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

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

21) Provide a copy of the HRA along with a summary of the member's strengths, needs, and services HealthPartners has authorized to meet the member's identified needs when referring a member to the county for evaluation for HCBS services.

22) Collaborate with lead agencies, waiver workers, or county case managers on the authorization of medical assistance home care services 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.

23) 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.

24) 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.

25) 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.

26) 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) Preadmission screening for Home and Community Based Services (HCBS),

    iii) County Case Management for HCBS,

    iv) Child protection,

v) Court ordered treatment,

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

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

viii) Relocation service coordination,

ix) Adult protection,

x) Assessment of medical barriers to employment,

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

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

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

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

29) 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 providers who can bill Medicare when appropriate to do so, thus reducing a level of complexity for the member and responsible party.

30) 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.

31) 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. For members on a CADI or BI waiver, the County will completed the PAS process. For community members not on a waiver and members with a DD waiver, 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 and with a DD waiver.

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

33) 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.

34) Notify members under the age of 21 of the availability of Child and Teen Checkup (C&TC) screenings annually.

35) Participate in quality improvement initiatives as requested by HealthPartners.

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

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

38) Facilitate safe care transitions for members experiencing a transition due to a change in health status with emphasis on supporting safe discharges to help members prevent avoidable readmissions.

39) Refer members with serious or unstable health conditions, to HealthPartners intensive case management services if the Care Coordinator is not comfortable providing this level of service.

40) Direct providers of PMAP covered services and DME to contact HealthPartners Quality and Utilization Management department for items requiring prior authorization.

41) Follow HealthPartners defined *Benefit Exception Request* process if a Care Coordinator recommends services and equipment outside the standard benefit set.

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

43) Assist members turning 65 years old to transition out of the SNBC program to appropriate senior product.

44) HealthPartners does not use a Care Management system in which the entity providing Care Management has a financial interest in housing and may be in a position to directly influence an Enrollee's housing or employment.

IV. DEFINITIONS

Care Navigator qualification: Care Navigators ideally will have completed college level education and have experience related to working with people who have disabilities, primary care, nursing, behavioral health, social services and/or community based services. HealthPartners must review and approve work experiences prior to hiring an individual for the Care Navigator role.

Care Coordinator qualifications: HealthPartners prefers SNBC Care Coordinators to be licensed social workers, registered nurses, independently licensed behavioral health specialists, nurse practitioners, physician assistants or physicians. In lieu of these requirements, an individual with specialized expertise working with people with disabilities may be allowed to act as a care coordinator if they have a four-year degree in a closely related field and three or more years of experience in home and community based services. The individual must also be trained on assessments and consultation for long-term care services and other training required by DHS. HealthPartners must approve the individual's qualifications before they can function in a Care Coordinator capacity. The entity that hired these individuals must complete the initial and ongoing disability-related training plan for the staff working with SNBC HealthPartners members. HealthPartners requires these staff to have at a minimum 24 clock hours of training that is relevant to their role as a Care Coordinator and/or the population served every two years. It is the responsibility of the contracted entity to ensure this training occurs and to provide HealthPartners with documentation upon request.

Care Coordinator/Care Navigator Training: All Care Coordinators and Care Navigators 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 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, and 6) protocols for follow up to assure that physician visits, additional assessments or Case Management interventions are provided when indicated.

Intensive Case Management: HealthPartners provides a centralized intake line called HealthPartners Connect. This resource offers a centralized team of nurses that triage and coordinate referrals into and among all HealthPartners programs and support services available to SNBC members. Members and/or their authorized representatives, counties and providers can self-refer or refer members into any of our health care engagement or health promotion services through this phone line. For example, members may be identified for care coordination assignment if they are experiencing homelessness, need support establishing providers, need mental health support, want chemical health support, experiencing a transition of care, unmet ADL or IADL needs, medication management needs, family planning, unmanaged pain, or relocation needs.

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.

Special Needs Basic Care – The Minnesota prepaid managed care program, pursuant to Minnesota Statutes, § 256B.69, subd. 28 that provides Medicaid services and/or integrated Medicare and Medicaid services to Medicaid eligible people with disabilities who are ages eighteen (18) through sixty-four (64).

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

2020 HealthPartners and DHS Contract for Special Needs Basic Care

VIII. APPROVAL(S)

Laurel Rose
Director, Disease and Case Management

IX. ENDORSEMENT