Care coordination

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Legal authority	DHS – Managed care organizations (MCO) contract information, forms and resources
Definition	**Care coordination:** A service provided by a care coordinator. The primary focus of care coordination is to promote health and wellness, provide education and manage chronic conditions. The goal of care coordination is to meet the person's health needs by coordinating efforts across different providers and services. For older adults on the Elderly Waiver (EW), the care coordinator also provides case management services.
Care coordinator qualifications	A care coordinator must be one of the following qualified professionals: • Social worker. • Licensed social worker. • Registered nurse. • Physician's assistant. • Nurse practitioner. • Public health nurse. • Physician. For Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+), all care coordinators (except physician assistants, nurse practitioners and physicians acting as care coordinators for people in nursing facilities) must be certified assessors. They provide both the assessment and ongoing case management functions for enrolled people, including support planning services.
Eligibility	To be eligible for care coordination, a person must be enrolled in one of the following programs: • MSHO. • MSC+. • Special Needs BasicCare (SNBC). For program eligibility requirements, refer to CBSM – Minnesota Medical Assistance (MA) managed care programs.
Responsibilities	Once a person is enrolled in MSHO, MSC+ or SNBC, the MCO will assign a care coordinator. A care coordinator works with the person to: • Complete a health risk assessment (HRA) to identify the person's health care needs. • Develop a person-centered support plan based on the person's assessed needs and preferences. • Help with transitions of care, including but not limited to emergency department visits and/or hospitalizations. • Keep the care team informed of the person's progress toward goals and changes in health care. • Help the person establish needed health care services. • Coordinate with counties, tribal nations, organizations, providers and others for additional services and supports the person needs. • Link the person to needed community and social services. • Evaluate and monitor services identified in the support plan. • Educate the person about health practices, medications and health conditions.

	• Help the person understand their health care options so they can make informed choices. • Educate the person about Medicare. • Encourage self-advocacy and advocate for the person when necessary. • Help the person file grievances.
Non-covered services	Care coordination services cannot duplicate other Minnesota state plan or waiver services.
Secondary information	**People age 65 and older** **Elderly Waiver (EW)** People who are enrolled in MSHO or MSC+ and request EW or state plan services receive these services through the care coordinator. The care coordinator will take the following actions: • Complete the MnCHOICES assessment, including the staying healthy section. • Provide case management and support planning. • Complete service authorizations. A single staff member serves as the certified assessor, case manager and care coordinator and is responsible to coordinate the care the person receives. The MCO is responsible for payment of services. People who live on or near the White Earth, Leech Lake, Red Lake, Mille Lacs or Fond du Lac reservations may be able to choose to get their EW services through the tribal health or human services division or through the MCO. Contact the tribal nation or the MCO with questions. **Brain Injury (BI), Community Alternative Care (CAC), Community Access for Disability Inclusion (CADI) and Developmental Disabilities (DD) waivers** People who are enrolled in managed care (MSHO, MSC+) and request a disability waiver (BI, CAC, CADI, DD) receive waiver services through a county or tribal nation. The county or tribal nation will take the following actions for the disability waiver: • Complete the MnCHOICES assessment. • Provide case management and support planning. • Complete waiver service authorizations. Fee-for-service MA (i.e., “straight MA”) pays for the waiver services. • Use MCO, County Agency and Tribal Nation Communication Form, DHS-5841 to request authorization and payment for state plan services from the MCO. State plan service providers must be in the MCO network. The county or tribal nation fulfills the roles of the certified assessor and case manager. They coordinate the care with the MSHO or MSC+ care coordinator. If the county or tribal nation fulfills the role of the case manager and care coordinator for a person receiving BI, CAC, CADI or DD waiver services, they have what is considered a “dual role.” The county or tribal nation is responsible for the above actions, and they also complete the staying healthy section in the MnCHOICES assessment as a delegate of the MCO. For more information, refer to the section about billing when in a dual role below. **People younger than age 65** People who are enrolled in managed care (SNBC or Families and

	Children) and request a disability waiver (BI, CAC, CADI, DD) receive waiver services through a county or tribal nation. The county or tribal nation will take the following actions for the disability waiver: • Complete the MnCHOICES assessment. • Provide case management and support planning. • Complete waiver service authorizations. Fee-for-service MA (i.e., "straight MA") pays for the waiver services. • Use MCO, County Agency and Tribal Nation Communication Form, DHS-5841 to request authorization and payment for home health agency services (i.e., skilled nurse visits, home health aide and home health therapies). Home health agency providers must be in the MCO network. The county or tribal nation fulfills the roles of the certified assessor and case manager, and they coordinate the care with the SNBC care coordinator. If the county or tribal nation fulfills the role of the case manager and care coordinator for a person receiving BI, CAC, CADI or DD waiver services, they have what is considered a "dual role." The county or tribal nation is responsible for the above actions, and they also complete the staying healthy section in the MnCHOICES assessment as a delegate of the MCO. For more information, refer to the section about billing when in a dual role below.
Billing when in a dual role	When one staff member is in a dual role (i.e., the person's certified assessor and care coordinator or their case manager and care coordinator), it is important to consider the following information. **Billing MCO** The country or tribal nation staff bills the MCO for supporting people to understand their health, access health care services and promote overall health care. This includes the following actions: • **Explain medical conditions and medications:** Helping people understand their medical conditions, medications and other instructions provided by health care providers is part of care coordination or care management. It involves explaining diagnoses and treatment plans, as well as educating the person to take their medications as prescribed. • **Establish needed heath care services:** Helping people locate primary care providers, dentists, eye doctors, behavioral health therapists or home health care providers is part of care coordination. This helps people access necessary health care services. • **Educate on health practices and wellness:** Providing information about health practices (e.g., annual health visits) and wellness (e.g., preventive care) is essential. Education about maintaining good health and preventing health issues contributes to the person's overall well-being. **Billing disability waiver** The county or tribal nation staff bills the disability waiver when they provide support for a person's disability-specific needs. This includes waiver support planning, which is a person-centered process that helps the person identify and access social, health, educational, vocational and other supports and services based on each person's values, strengths,

	goals, preferences and needs.
Billing for care coordination	For billing instructions when not functioning in a dual role, consult the MCO for guidance.
Additional resources	DHS – MCO contract information, forms and resources CBSM – Aging and Adult Services (AASD) eLists CBSM – Case management CBSM – Case management aide CBSM – Disability Services Division (DSD) eLists CBSM – DSD Response Center CBSM – Feedback about services for EW through MCOs CBSM – Guide to encouraging informed choice and discussing risk CBSM – Guide to support a person with a residential service termination not CBSM – Minnesota Medical Assistance (MA) managed care programs CBSM – Person-Centered, Informed Choice and Transition Protocol CBSM – Support planning for LTSS DHS – Case manager and care coordinator toolkit DHS – Person-centered practices DHS – TrainLink Disability Hub MN – Benefits planning toolkit Disability Hub MN – Housing toolkit Disability Hub MN – Informed choice toolkit Instructions for Completing and Entering the LTCC Screening Document and Service Agreement into MMIS, DHS-4625 (PDF) Moving Home Minnesota (MHM) Program Manual