Care Coordination Delegation Guidelines for Community Members

Secure Blue - MSHO
(Minnesota Senior Health Options)

2017 - September

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CONTACT INFORMATION

Care Coordination Portal
 	
www.bluecrossmn.com/carecoordination
	• Access guidelines, enrollment checklists, forms, letters, resources
	• Links to:
	  ○ Webinar training recordings
	  ○ Communiques

Blue Ride problem solving issues Transportation.liaison@bluecrossmn.com	An e-mail box to send transportation specific problems/requests. Include member name, PMI, name of transportation provider, dates of service, detailed summary of problem/issue. *Do not use for scheduling or confirming rides.
Bridgeview Company 1-800-584-9488 EWproviders@bridgeview.com https://www.bluecrossmn.com/healthy/public/bridgeview/home/	• Elderly Waiver service agreement/claims processing questions • Questions about adding/deleting security and access • EW provider billing issues
Clinical Guide Resource Team 1-866-518-8447 Clinical.guide.resource.team@bluecrossmn.com	• Member specific questions/issues • Blue Plus & community resources: i.e. formulary questions, transportation alternatives, etc. • Assist with referrals, if applicable
Enrollment Questions/Issues SecureBlue.enrollment@bluecrossmn.com	• Discrepancies with MSHO and MSC+ enrollment reports
Member Services **MSHO** 651-662-6013 or 1-888-740-6013 **MSC+** 651-662-5545 or 1-800-711-9862	• Confirm/Change Primary Care Clinics • Benefits questions • Interpreter services • Assistance finding an in-network provider
Medical Management: **Utilization Management and Intake** 651-662-5540 or 1-800-711-9868	1. Assistance w/ Prior Authorization requests 2. PCA/Home Care Prior Authorizations**/DTR** **Fax:** 651-662-4022 or 1-866-800-1655 3. Surgical/DME Prior Authorizations **Fax:** 651-662-2810 4. Assistance identifying new Care Coordination Delegate for a member being transferred
Partner Relations Consultants Partner.relations@bluecrossmn.com **Fax:** 651-662-0015 See 9.02.01 Government Programs Partner Relations map for designated representative	• Contact for general Care Coordination process questions. • Liaison for counties and care systems in the Blue Plus service area. • HRA entry/audit questions in Bridgeview
*For additional MSHO/MSC+ Resources, see Resource 9.14 Key Contact Phone Numbers under Key Contacts and Maps on the care coordination web portal	

Blue Plus SecureBlue℠ Model of Care (SNP-MOC) Policies and Procedures

The SecureBlue Model of Care ensures that Blue Plus, in partnership with its contracted providers, meets the unique needs of the SecureBlue-MSHO (Minnesota Senior Health Options) population. The Blue Plus Policy & Procedure Manual, Blue Plus Provider Manual, and Care Coordination Delegation Guidelines describe the services, practices, procedures, and systems necessary to successfully deliver coordinated care consistent with the SecureBlue Model of Care.

In accordance with the Blue Plus Provider Service Agreement, all contracted providers agree to support the implementation of the Blue Plus Model of Care by adhering to the policies and procedures contained in the Blue Plus Policy and Procedure Manual and the Blue Plus Care Coordination Delegation Guidelines. Care Coordination Delegates further agree to comply with all Minnesota Department of Human Services (DHS) requirements and Center for Medicare and Medicaid Services (CMS) rules and regulations related to the completion of a comprehensive initial health risk assessment of the beneficiary's physical, psychosocial, and functional needs, as well as annual health risk reassessment.

DEFINITIONS:

Per Blue Plus' contract with the Department of Human Services, ***Care Coordination*** *for MSHO members means "the assignment of an individual who coordinates the provision of all Medicare and Medicaid health and long-term care services for MSHO Enrollees, and who coordinates services to an MSHO Enrollee among different health and social service professionals and across settings of care. This individual (the Care Coordinator) must be a social worker, public health nurse, registered nurse, physician assistant, nurse practitioner, or physician."*

The Care Coordinator is key to supporting the member's needs across the continuum of care by leveraging member involvement, Blue Plus and County case management, and program referral processes. The Care Coordinator works closely with both the member, via face to face meetings, phone contact, and written communication and with other members of the Interdisciplinary Care Team (ICT). The ICT is unique to each member's specific needs, but at a minimum consists of the member and/or a family designated representative, and healthcare provider. This team ensures development of an individualized holistic plan of care that is member centric.

The Care Coordinator conducts the initial assessment, and periodic reassessment as necessary, of supports and services based on the member's strengths, needs, choices and preferences in life domain areas. It is the Care Coordinator's responsibility to arrange and/or coordinate the provision of all Medicare and Medicaid funded preventive, routine, specialty, and long term care supports and services as identified in the Enrollee's Care Plan whether authorized by the Care Coordinator, County, or Blue Plus. The Care Coordinator is expected to work closely with other Case Managers and agencies involved with the MSHO member. To do this, they should collect, review, and coordinate the Blue Plus Care Plan with other member care plans, as appropriate (i.e., hospice care plans and/or home care agency's care plans, etc). The member's Care Plan should be routinely updated, as needed, to reflect changes in the member's condition and corresponding services and supports. The Care Coordinator must also ensure access to an

adequate range of choices for each member by helping the member identify culturally sensitive supports and services. Care Coordinators must also arrange for interpreter services if needed.

The Care Coordinator also participates in on-going performance improvement projects that are designed to achieve significant favorable health outcomes for Blue Plus members. Finally, Care Coordinators work with Social Service Agencies and Veteran's Administration to coordinate services and supports for members as needed.

Delegate *is defined as the agency, such as counties, private agencies and clinics, that are contracted to provide Care Coordination services for Blue Plus. Delegates are responsible for periodic reporting to Blue Plus as requested and needed to meet business requirements.*

Model of Care (MOC) *is Blue Plus's plan for delivering coordinated care to SecureBlue (MSHO) members. The Center for Medicare and Medicaid Services (CMS) requires all Special Needs Plans (SNPs) to have a MOC. The Model of Care (MOC) documents the staff, systems, procedures, and improvement activities Blue Plus utilizes to simplify access to healthcare and reduce fragmentation of care delivery for SecureBlue members. The MOC also describes how Care Coordination delegates work together with Blue Plus providers and staff to coordinate access and delivery of all preventive, primary, specialty, acute, post-acute, and long term care services among different health and social service professionals and across health settings. Care Coordination delegates are required to complete annual training on the MOC included as part of Blue Plus' annual Fall Training.*

New Enrollee *is defined as member who is newly enrolled in Blue Plus. Members who switch products within Blue Plus (i.e., MSC+ to SecureBlue (MSHO) or vice versa) are considered new enrollees. All requirements related to new enrollees is applicable in all these scenarios. Note: a change in rate cell only does not mean the member is newly enrolled even if it results in a change in Care Coordination.*

Transfer *is defined as an existing (already enrolled) Blue Plus member who has been transferred to a new Blue Plus delegate.*

Required Caseload per worker *for Community Well, Nursing Facility, and Elderly Waiver is as follows: Elderly Waiver/Community Well mix =* ***40-70****, Nursing Facility only =* ***90-120****, and Community Well only =* ***75-100****.*

PERSON-CENTERED PRACTICE & PLANNING REQUIREMENTS

The implementation of person-centered values, principles and practices is a requirement of several state and federal authorities. It is our expectation that all members receiving Home and Community Based Services have the same access and opportunity as all other members. A member's unique life experiences such as culture, ethnicity, language, religion, gender and sexual orientation should be embraced in the planning process to enhance the member's quality of life.

Person-centered requirements apply to all but not be limited to:

- Assessment/reassessment
- Planning process
- Creation of service plans
- Review of services plans and collaborative care plans
- Transitions

Members and or authorized representatives should be encouraged to:

- Direct their own services and supports, when desired
- Include preferences, strengths, skills, and opportunity to promote dignity and respect
- Include community presence, participation and connections

INTAKE PROCESS

Delegate Responsibilities upon Notification of Enrollment

Blue Plus is notified of enrollment by Department of Human Services (DHS) twice a month via enrollment tapes. Blue Plus then generates the following reports via Bridgeview to communicate enrollment with our Care Coordination Delegates. Delegates will receive an e-mail notifying them that the reports are available from the SecureBlue enrollment e-mail box.

1. New CAP: List of members who are newly enrolled to MSHO or MSC+ and is available in Bridgeview the first week of each month. Occasionally this report is ready a few days prior to the enrollment month. Do not start care coordination activities until on or after the 1st of the enrollment month.
2. Full Detail: A comprehensive list of all members assigned to the Delegate agency for the month and includes the following flags:
    - New: Enrollees who enrolled after the DHS capitation
    - Reinstated: Members who were going to term but were reinstated with no lapse in coverage
    - Termed: Coverage termed
    - Product changes: Changed from MSC+ to MSHO or vice versa (these members are treated as brand new enrollees and will need a new HRA)
    - Transfer: Existing enrollee who transferred to you. Official notification is via form 6.08 Transfer in Care Coordination Delegation.
    - Future Term Dates: Lists Month/Year. Member will be termed at the end of the month listed. CC should follow up to determine if the reason for disenrollment requires mediation (i.e., MA paperwork not submitted yet).
3. Daily Add: Includes new enrollees who were retroactively enrolled by DHS after both the New CAP and Full Detail reports were processed.

Upon notification the Delegate:

1. Reviews the "New CAP" list to check for discrepancies (For example, member is incorrectly assigned to your agency) and reports them to

secureblue.enrollment@bluecrossmn.com no later than the 15th of the enrollment month.

2. Compares the "Full Detail" list to the previous months Full Detail list to check for discrepancies and reports them to secureblue.enrollment@bluecrossmn.com no later than the 15th of the month the report was received. (For example, a name may appear or disappear and the Delegate was unaware of any move/change. Care Coordinators should then refer to the Transfers of Care Coordination section of the guidelines for proper transfer of the case).
3. Reviews the Daily Add report for discrepancies and reports them to SecureBlue.Enrollment@bluecrossmn.com no later than 15 days from notification. The Delegate will receive an email if there's a Daily Add report and be directed to log into Bridgeview to access it. Please treat these as new enrollees for the month and follow the Guidelines for seeing these members within 30 or 60 days of notification as applicable.

   Note: For discrepancies **not** reported by the 15th of the enrollment month, the assigned care coordination delegate must initiate care coordination and is responsible to complete all applicable BluePlus Care Coordination tasks prior to transferring the member the first of the following month.

4. Assigns a Care Coordinator per Delegate's policy
5. Informs the member of the name, number, and availability of the Care Coordinator within 10 days of notification of enrollment
6. Enters the name of the care coordinator assigned in Bridgeview.
7. Documents any delays of enrollment notification in case notes

Blue Plus members living in a Veteran Administration Home (Nursing Home)

For MSHO members living in a Veteran's Administration Nursing Home, the care coordinator should follow the processes and timelines outlined in the Care Coordination Guidelines for Members in the Nursing Home.

Note: Please be aware that these members are designated by DHS as a Rate Cell A (Community Well) and thus will show up as a Rate Cell A on your enrollment reports. In other words, they will not show up on your enrollment lists as a Rate Cell D like other members in the nursing home. The Delegate should be aware of this and proceed as they would other Rate Cell D nursing home members.

Relocation Targeted Case Management

As part of their usual role, Care Coordinators provide relocation services to members planning on returning to the community from a Nursing Facility. However, if a new member has been receiving Relocation Targeted Case Management services at the time of initial enrollment to Blue Plus, the

member must be given the choice to continue to work with their current Relocation Targeted Case Manager. If the member chooses to continue to work with this individual, the Care Coordinator is expected to work with the Relocation Targeted Case Manager on the member's plan of care. It remains the Care Coordinator's responsibility to ensure all activities included in the Care Coordination Guidelines are completed within the necessary timeframes. If a member does not wish to work with their Relocation Targeted Case Manager the Care Coordinator will provide all necessary relocation service coordination.

General Contact Requirements—Member (September updates)

1. Contact as needed per significant change in member's health status.

2. Community Well - One face-to-face visit & one 6-month phone contact, at minimum, per year.
   CW Refusals: If the member refuses a face-to-face assessment, the Care Coordinator should:
   1. Offer the option of a telephonic health risk assessment. If the member agrees to a telephonic assessment the CC should follow the process outlined in the Telephonic Health Risk Assessment for CW Refusing a face-to-face Health Risk Assessment section of the guidelines
   2. If the member refuses both telephonic and face-to-face assessment the CC should do the following:
      a. Document in the member record a case note stating that the member refused the health risk assessment.
      b. Enter a SD using the Refusal code in MMIS
      c. Enter the refusal in Bridgeview following instructions found in the Bridgeview manual located on their website (See Contact Information) and
      d. Continue to reach out at minimum, every six months either by mail or phone.

   CW Unable to Reach: The Care Coordinator must:
   1. Attempt three phone contacts, then if unable to reach;
   2. Mail an 8.40 Unable to Contact Letter to the member;
   3. Document your attempts following the process outlined in Assessment and Refusal Tracking Process section.
   4. **For activity type date of September 1, 2017 or after, enter a screening document "H" with new assessment value "50" within 45 days of the enrollment date** or within 365 days of the previous attempt.
   5. Continue to reach out, at minimum, every six months either by mail or phone

3. Elderly Waiver—Two face-to-face visits per year at minimum.

*For all 6-month visits/contacts the Care Coordinator should evaluate and update any changes to the member's condition and corresponding services and supports. Care Coordinators are expected to monitor and document progress of the member goals and enter the date on the care plan. For details refer to the Comprehensive Care Plan section of the guidelines and 6.02.02 Final Instructions for the Collaborative Care Plan.

General Contact Requirements—Physician

The Care Coordinator must communicate with the member's primary care physician:

1. Within 90 days of enrollment the Care Coordinator shall send 8.28 Intro to Doctor Letter even if unable to contact the member.
2. Initially, annually, and when there is a significant change, the Care Coordinator will complete and send 8.29 Care Plan Summary Letter to Doctor or send a copy of the care plan (not required for members who have refused an HRA).
3. As needed for Transitions of Care (See page 34), assessment, and care planning

INITIAL CONTACT WITH NEW MSHO ENROLLEE

1. The Delegate is responsible to verify member's eligibility prior to delivering Care Coordination services
2. Use the following optional checklist: 6.12 CW EW Checklist SB
3. Delegate will inform the member of the name, number, and availability of the Care Coordinator within 10 calendar days of notification of enrollment
4. Welcome call/letter (8.22 Intro Letter) to member within 30 calendar days after notification of enrollment
5. Explanation of Care Coordinator's role. Optional resource: 6.01 Welcome Call Talking Points.
6. Explain supplemental benefits with member using the resource 6.26 Explanation of Supplemental Benefits. Document this discussion on the checklist(s) or in your case notes.
7. Discuss In-Home Assessment Program. (See page 14 for details on this program)
8. Confirm the correct Primary Care Clinic (PCC). The PCC is listed on the enrollment list received from Blue Plus. A PCC may have been chosen by the member or auto-assigned if one was not indicated at the time of enrollment.
    - To change a member's PCC:
      The Care Coordinator must update the PCC field in Bridgeview. The field includes a list of all PCC's from our Primary Care Network Listing (PCNL) in a drop-down format. You must choose a clinic from one that is listed. If the member's PCC is not listed in Bridgeview, it may not be in our Primary Care Network. Please contact Member Services or your Partner Relations Consultant with any PCC network questions.
    - Determine if Change in PCC requires a transfer in Care Coordination:
      If the member's PCC is contracted with Blue Plus to provide care coordination (See list below), the change in PCC may also trigger a change in who provides Care Coordination for the member. Changing the PCC in Bridgeview alone will not transfer care coordination. You are still required to either send notification to SecureBlue.Enrollment@bluecrossmn.com for enrollment miss-assignments or follow the process outlined in section titled, Transfers in Care Coordination to

another Delegate. This will include sending in form 6.08 Transfer in Care Coordination Delegation.

The following PCC's currently provide care coordination:

- Bluestone Physicians (select customized living facilities only)
- Fairview Partners (select customized living and nursing home)
- Essentia Health
- HealthEast
- Genevive (MSHO only in select nursing facilities)
- Lake Region Health Care Clinic (**MSHO members in** select Nursing Facilities in Otter Tail County)

9. The Care Coordinator will make arrangements to complete the Health Risk Assessment within 30 calendar days of enrollment date OR if delegate receives late notice of enrollment, within 30 calendar days of this notification

HEALTH RISK ASSESSMENT

Member Request for assessment

Health Risk Assessment for enrolled members who are requesting an HRA for determination of EW eligibility is required to be completed within 20 calendar days of the member's request.

Health Risk Assessment requirements for new enrollees

Health Risk Assessment (HRA) must be completed for all members within 30 calendar days of enrollment date OR if delegate receives late notice of enrollment, within 30 calendar days of this notification The Care Coordinator will make a determination about which type of HRA to do based on the definitions below.

Initial Assessment—Health Risk Assessment for newly enrolled members who have not had a LTCC within 365 days of enrollment.

Transitional HRA—Health Risk Assessment for newly enrolled members who have had a LTCC or MNCHOICES Assessment within 365 days of enrollment and who have not experienced a significant change.

HRA for other waiver, ICF/DD or DD member in community—Health Risk Assessment for members who are on other waivers (CAC, CADI, DD, BI) or members in an ICF/DD or DD case managed.

Initial Assessment

The Care Coordinator will schedule a face-to-face assessment Health Risk Assessment (HRA) for all members within 30 calendar days of enrollment date OR if delegate receives late notice of enrollment, within 30 calendar days of this notification.

1. The Care Coordinator will thoroughly complete all sections of the Minnesota Long Term Care Consultation Services Assessment Form (LTCC) [DHS-3428].
   As a result of the LTCC Assessment, if the member is determined to be at risk, or needs referrals for specialty care and other home care services or assessments, the Care Coordinator will make all appropriate referrals. For example, if the member is at risk for falls, a PT referral can be completed. If the member experiences incontinence, a referral to their primary physician should be completed. If the MSHO member needs to increase physical activity, enrollment into Silver & Fit may be appropriate.
2. Document any delays in scheduling of the assessment
3. Documents any delays of enrollment notification in case notes
4. Enter the assessment type and date into the Bridgeview Company's web tool (see section, Assessment and Refusal Tracking Process) by the 10th of the following month.
5. Enter a LTC Screening Document in MMIS (see page 15)
6. Reassessment is due within 365 days of the date of this LTCC.

Transitional HRA (September updates)

Health Risk Assessment (HRA) must be completed for all members within 30 calendar days of enrollment date OR if delegate receives late notice of enrollment, within 30 calendar days of this notification. This Transitional HRA process can only be used when a LTCC/MnCHOICES assessment has been completed within 365 days of enrollment**. This process can be used for members who switch products within Blue Plus (i.e., MSC+ to SecureBlue (MSHO) or vice versa) as they are considered new enrollees.** The Care Coordinator can meet the HRA requirement without doing a new LTCC by reviewing the current LTCC or MnCHOICES Assessment information and care plan/community support plan/collaborative care plan from the member's previous Health Plan or county.

1. The Care Coordinator should review the LTCC or MnCHOICES Assessment information and care plan/community support plan/collaborative care plan with the member, either telephonically or in person, to ensure that the assessment information hasn't changed and that the care plan is addressing the member's needs. **Note: If any portion of the paired documents are missing or unsigned, the Care Coordinator is responsible for obtaining the missing information. If unable to obtain the missing information, the Care Coordinator must follow the process for conducting an HRA as outlined in section titled, Initial Assessment.**
2. The Care Coordinator documents these activities by completing the 6.28 Transitional Health Risk Assessment Form.
3. Documents any delays of enrollment notification in case notes

4. Enter the assessment information from the previous LTCC/MNChoices by the 10th of the following month into the Bridgeview Company's web tool (see Bridgeview Care Coordination Delegate User Guide, section titled, Fee For Service LTCC/MN Choices completed prior to enrollment (Transitional HRA).
5. Enter the Transitional HRA assessment information into the Bridgeview Company's web-tool by the 10th of the following month (see Bridgeview Care Coordination Delegate User Guide section titled, Fee For Service LTCC/MNChoices completed prior to enrollment (Transitional HRA).
6. A LTC Screening Document must be updated in MMIS (see page 15)
7. Reassessment is due within 365 days of the date of the LTCC/MNChoices assessment not the date of the Transitional HRA.

HRA for other waiver, ICF/DD or DD member in community (September updates)

Health Risk Assessment (HRA) must be completed for all members within 30 calendar days of enrollment date OR if delegate receives late notice of enrollment, within 30 calendar days of this notification. For CW (non-waivered) MSC+ members, the HRA must be completed within 60 calendar days of enrollment. If the delegate receives late notice of enrollment, the HRA can be completed within 30 or 60 calendar days of this notification. Follow this process for members who are on non-EW waivers; are living in an ICF/DD; or a DD member in the community. These members already benefit from intensive assessment and care planning by the HCBS waiver or DD case manager. While, the primary case management responsibility will remain with the HCBS waiver or DD case manager, the MSHO/MSC+ Care Coordinator must carry out all Care Coordination responsibilities such as contacts with member and physician, health risk assessments, care planning, transition of care activities, reassessments and all other responsibilities and timeframes as outlined in these guidelines.

Is there a current assessment/care plan from the HCBS waiver/DD case manager (completed within previous 365 days) that you have to review?

No→

- Complete an LTCC and CCP within 30 (or 60 for CW non-waivered MSC+ members) calendar days of enrollment as outlined in Initial Assessment section

1. Document progress and achievement of goals on the CCP during the 6 month contact and/or as needed throughout the year.

Reassessments:

1. Complete annual reassessment using the LTCC and CCP within 365 days of the previous assessment.

Yes→

- Obtain a copy and review other case manager's assessment and care plan

- Complete 6.17 ICF/DD and HCBS Waiver Health Risk Assessment and Care Plan Supplement within 30 (or 60 for CW non-waivered MSC+ members) calendar days of enrollment
- Attach the other case manager's assessment/care plan to 6.17 ICF/DD and HCBS Waiver Health Risk Assessment and Care Plan Supplement and file in member's MSHO/MSC+ file.
- Enter health related information onto form 6.17 in Section II.
- Document progress and achievement of goals during the 6 month contact and/or as needed throughout the year.
- Document preventive care discussion in Section III of form 6.17.
- Sign and date form 6.17
- Provide a copy of form 6.17 to the member and other Case Manager
- Provide a copy of 6.17 or a care plan summary letter to the physician.
- Document any delays of enrollment notification in case notes
- Enter the assessment type and date into the Bridgeview Company's web tool by the 10th of the following month. (See section: Assessment and Refusal Tracking Process and see also Entering Health Risk Assessment Information Assessment and Refusal Tracking Process in Bridgeview's Web Tool User Guide)
- **Effective September 1, 2017 enter Screening Document following the directions as outlined in DHS Instructions for Completing and Entering the LTCC Screening Document in MMIS for the MSHO and MSC+ Programs (DHS-4669)**
- For members on other waivers, do not enter service agreements into Bridgeview.

Reassessments:

1. Complete a new form 6.17 within 365 days following the date listed from the previous year in the "Assessment and Care Plan reviewed date" field. Follow all steps above.

Refusals:

- Refusals by the member or responsible party: Refusals of the ICF/DD and HCBS Waiver HRA should be documented on form 6.17 ICF/DD and HCBS Waiver Health Risk Assessment and Care Plan Supplement in the Date Assessment and Care Plan Reviewed field. This date should also be entered into Bridgeview to document the refusal date.

Telephonic Health Risk Assessment for CW Refusing a face-to-face Health Risk Assessment

Blue Plus has created an option for a telephonic Health Risk Assessment for use in cases where a member refuses to allow a Care Coordinator to complete a face-to-face assessment. This assessment is only for use with Community Well members (Rate Cell A) who refuse a face-to-face assessment and who are not receiving home care services. Care Coordinators must **still offer** a face-to-face HRA as described in the above section. This is the preferred HRA option and is the only way to access home care services or EW services. Contact the member and offer

the member their required Health Risk Assessment. Using motivational interviewing or other techniques, explain to them the value of an in-home assessment and the opportunity to access additional programs if eligible (such as EW).
If the member still refuses to be seen in person, the Care Coordinator should ask if they would be willing to consent to a telephone health risk assessment instead.
If the member agrees the Care Coordinator should do the following:

1. A case note should be entered into the member's record stating that the member refused a face-to-face health risk assessment.
2. Complete form 6.40 My Health Risk Assessment and Care Plan – telephonic version.
3. Mail a copy to the member for their records.
4. Enter the HRA date into Bridgeview recording the date you completed the telephonic HRA and select Telephonic HRA from the HRA Form Used drop box.
5. Complete a MMIS LTC Screening Document – dhs-3427, entering a 01 Activity Type (telephone screening) and an assessment result 35 for the health risk assessment. The instructions for required fields can be found on page 63 in DHS – 4669 Instructions for Completing and Entering the LTCC Screening Document into MMIS For the MSHO and MSC+ Programs.

In-Home Assessment Program (September updates)

****In home assessment program is temporarily on hold. New in-home assessment coming later in 2017****

Entry of LTC Screening Document information into MMIS (September updates)

Follow the directions as outlined in the DHS Instructions for Completing and Entering the LTCC Screening Document in MMIS for the MSHO and MSC+ Programs (DHS-4669).

Timeline for entry:

MSHO-CW: Enter a screening document within 45 days of enrollment date

For CW members on another Waiver (CADI, CAC, BI, DD):

- **For activity type date September 1, 2017 or after enter Screening Document type "H".**
- Do not enter a screening document **for activity type dates prior to September 1, 2017**.

CW Refusals : Enter a screening document using the refusal code in MMIS within 45 days of the enrollment date.

Unable to Reach: For activity type date of September 1, 2017 or after, enter a screening document "H" with new assessment value "50" within 45 days of the enrollment date.

EW: Enter screening document by the cut-off date below

When the First Month of the Eligibility Span is:	Last Day to Enter Screening Document timely is:
January	12/21/16
February	1/23/17
March	2/20/17
April	3/23/17
May	4/20/17
June	5/22/17
July	6/22/17
August	7/21/17
September	8/23/17
October	9/21/17
November	10/23/17
December	11/20/17
January 2017	12/20/17

Instructions for updating MMIS Entry for Transitional HRA or Transfers only:

The delegate is responsible for updating an existing LTC Screening Document in MMIS for either Elderly Waiver (EW) or Community Well (CW) populations when the member:

- moves from another Health Plan to Blue Plus
- switches products within Blue Plus (i.e., MSC+ to SecureBlue (MSHO))
- moves from FFS to Blue Plus
- when there is a change in care coordinator.

Scenario	**Transitional HRA for New Enrollee**	**Transitional HRA for New Enrollee**	**Change in Care Coordinator**	**Change in Care Coordinator**
	Community Well	**Elderly Waiver**	**Community Well**	**Elderly Waiver**
Activity Type:	05	05	05	05
Activity Date:	Date Transitional HRA is completed	Date Transitional HRA is completed	Date delegate assumed Care Coordination responsibility	Date delegate assumed Care Coordination responsibility
LTCC CTY	BPH	BPH	n/a	n/a
Case Managers Name and	Use your MCO UMPI number	Use your MCO UMPI number	Use your MCO UMPI number	Use your MCO UMPI number

UMPI Number				
Assessment Result:	98	98	n/a	n/a
Effective Date:	Date Transitional HRA is completed	Date Transitional HRA is completed	n/a	n/a
Program Type **Note: program type cannot be changed with 05 SD**	18	03 or 04	n/a	n/a

COMPREHENSIVE CARE PLAN

Care Coordinators shall develop a comprehensive care plan in collaboration with the member, caregiver, and/or other interested persons, as appropriate within 30 calendar days of the LTCC assessment using 6.02.01 Collaborative Care Plan. Instructions for the Collaborative Care Plan are available as form 6.02.02. (For members on other disability waivers, in an ICF/DD or DD member living in the community, see section on Page 12)

With the exception of Community Well members who have refused an assessment, all of the following apply:

1. The member must sign the collaborative care plan
2. The Care Coordinator must sign the collaborative care plan
3. A copy of the collaborative care plan including budget worksheet must be given to the member. Optional 8.25 Care Plan Cover Letter SB MSC+ may be used if mailing the copy to the member.
4. A copy of the Members Bill of Rights, Form 6.02.03 Medicare/Medicaid Member Rights must be given to the member
5. A copy of the care plan or care plan summary (8.29 Care Plan Summary Letter) must be sent to member's physician
6. Person-centered goals, target dates, should be addressed and documented at a minimum at the 6-month visit. (Refer to 6.02.02 Final Instructions for the Collaborative Care Plan)

The Care Plan must employ an interdisciplinary/holistic approach incorporating the unique primary care, acute care, long term care, mental health and social services needs of each individual with appropriate coordination and communication across all Providers and at minimum should include:

- Case mix/caps

- Collaborative input with the Interdisciplinary Care Team which, at a minimum consists of the member and/or his/her representative; the Care Coordinator, and the primary care practitioner (PCP).
- Assessed needs
- Member strengths and requested services
- Accommodations for cultural and linguistic needs
- Care Coordinator/Case Manager recommendations
- Formal and informal supports
- Person-centered goals and objectives, target dates, on-going monitoring of outcomes through regular follow-up.
- Preventive discussions
- Identification of any risks to health and safety and plans for addressing this risks. Including Informed Choices made by members to manage their own risk. Member Plan that includes; community-wide disaster plan; Emergency plan; and, if applicable; Essential services back-up plan and risk plan for services refused.
- Personal Emergency Response Systems documentation can be included in the free form field labeled 'Additional Case Notes'
- Blue Plus offers Medical Management telephonic programs to address members' current health concerns. Members or their caregivers have access to a dedicated Health Coach to receive education and support. Health Coaches can provide short-term case management services in complex situations involving catastrophic illness, high medical costs, frequent hospitalizations, out-of-state providers, or when additional education or support is requested by a member's caregiver. Make a referral to these programs using 6.09 Medical Management Referral form.
- Advanced Directives discussions. The care coordinator can also use the optional resource 9.19 BCBSMN Advance Directive and cover letter 8.27 Advanced Directive Letter to Member
- Care Coordinators can consult with Blue Plus Health Plan resources if needed
- Educate and communicate to member about good health care practices and behaviors which prevent putting their health at risk.
- Documentation that member has been offered choice of HCBS and nursing home services.
- Documentation that member has been offered choice of HCBS providers.

Home Health Care Authorizations

Medicare skilled home care services and Medical Assistance state plan home care services must be provided by a Blue Plus participating provider.

This section will cover the process for home care service authorizations except PCA. See PCA Authorization Processes section for more information.

Medicare Skilled Home Care Services:

Medicare billable skilled home care services do not require prior authorization or notification to Blue Plus UM. The home care agency determines if the member qualifies for Medicare covered skilled home care services. If Blue Plus is notified of Medicare eligible skilled home care services, Blue Plus will advise the home care agency to contact the Care Coordinator to assure continuity of services.

Medical Assistance State Plan Home Care Services:

The following information relates to all members receiving Medical Assistance state plan home care services, including those on a home and community based service waiver. Care Coordinators may approve a prescribed amount of state plan home care services which requires a Notification *only* to Blue Plus. Amounts exceeding what is allowed for Care Coordinator approval will require a Prior Authorization from Blue Plus.

State plan home care services include:

- Skilled Nurse visits (SNV)
- Home Health Aide visits (HHA)
- Private Duty Nursing (PDN)
- Physical, Occupational, Respiratory, and Speech Therapy
- Personal Care Assistance (PCA)

State plan home care claims should be submitted to Blue Plus.

Care Coordinator Role:

1. *Coordinate* service needs with the provider including initial authorizations, acute changes in a member's condition requiring additional services, or at reassessment.
2. *Send* **6.04.03 MA Home Care Services Notification-Prior Authorization Request** form to Blue Plus following the below processes **prior to the start of home care services.** All home care claims submitted without notification or prior authorization requests will be denied, which may result in providers having to appeal.
3. *Consider* the following in your home care decision making process:
    a. Follow the guidelines outlined in the Home Care chapter of the Community Based Services Manual (CBSM).
    b. If a member is on another waiver (CAC, CADI, DD, or BI) the Care Coordinator shall coordinate any home care authorizations with the other case manager.
    c. Authorization should coincide with the member's current waiver span or assessment year if not on a HCBS waiver.

Blue Plus will **not accept requests for authorization of services received directly from a home care provider. The provider will be advised to contact the Care Coordinator to review and make the request following the processes outlined below.

Process for Notification and Prior Authorization of Medical Assistance State Plan Home Care Services:

Care Coordinator *Notification* Process:

Care Coordinators may approve up to the following prescribed amounts by notifying Blue Plus using form **6.04.03 MA Home Care Services Notification-Prior Authorization Request** form:

- Up to 52 Skilled Nurse Visits per year (not to exceed 2 visits per week)
- Up to 156 Home Health Aide visits per year (not to exceed 3 visits per week)
    a. if the member does not live in Adult Foster Care or Customized Living
    b. if the member is not receiving PCA services
- Up to 20 visits per discipline per year of non-maintenance home therapy: physical, occupational, speech, or respiratory therapy

Note: For an initial assessment done by the home care provider to determine home care service eligibility, the Care Coordinator can wait until *after* the initial visit to submit **6.04.03 MA Home Care Services Notification-Prior Authorization Request** form. This visit should be included with the total number of visits needed in addition to any PRN (as needed) visits.

Blue Plus UM will:

- Enter authorization into Blue Plus system for payment purposes
- Notify member and home care provider of the authorization via letter
- Notify Care Coordinator via email

Prior Authorization Request process:

Blue Plus requires prior authorization to determine medical necessity for home care service amounts listed below by notifying Blue Plus using form **6.04.03 MA Home Care Services Notification-Prior Authorization Request** form:

- Skilled Nurse visits exceeding 52/year or 2 per week
- Home Health Aide visits exceeding 156/year or 3 per week
- Home Therapy (physical, occupational, speech, or respiratory therapy) exceeding 20 visits per discipline per year
- Home Health Aide visits for members in Customized Living or Adult Foster Care
- Home Health Aide in conjunction with PCA Services
- Private Duty Nursing
- Acute changes in condition requiring more visits than currently authorized if they are beyond the limits or scope of what the Care Coordinator may authorize

**For members residing in Customized Living or Adult Foster Care, document this information in the summary section on form 6.04.03. Please include a copy of the member's Residential Services tool.

Upon receipt of the prior authorization request, Blue Plus will:

- Conduct a medical necessity/clinical review following the guidelines outlined in the Home Care chapter of the CBSM and applicable State Statutes. Per statute, authorization is based upon medical necessity and cost-effectiveness when compared with other options.
- Request any necessary medical information needed directly from the home care agency. Submitting clinical documentation is the home care agency's responsibility.
- Contact the Care Coordinator if additional input from the Care Coordinator is required
- Make a coverage determination within 10 business days or 14 calendar days
- Enter decision into Blue Plus system for payment purposes
- Notify member and home care provider of the decision via letter
- Notify Care Coordinator via email

New enrollees with previously approved state plan home care services:

If the member is new to Blue Plus with previously approved state plan home care services, for continuity of care, the CC should honor the current authorization until a new assessment is completed. The CC should notify Blue Plus by:

1. Sending **6.04.03 MA Home Care Services Notification-Prior Authorization Request** form
2. Including a copy of the county or health plan's authorization

Members on Elderly Waiver receiving state plan home care services:

For members open to Elderly Waiver, the following state plan home care services must count towards and fit under their EW cap:

- Personal Care Assistance (PCA)
- Home Health Aide (HHA)
- Skilled Nurse Visit (SNV)
- Private Duty Nursing

The following state plan home care services do NOT need to fit under the EW cap:

a) Physical Therapy (PT)
b) Occupational Therapy (OT)
c) Speech Therapy (ST)

State plan home care services need to be included in the grand total of all the Medicaid services that count toward case mix cap and are entered in the Bridgeview Company's web tool under MA Plan Services in the LTCC & Case Mix section.

See Bridgeview Manual for how to enter state plan home care service amounts into the EW service plan budget or ask your Partner Relations Consultant.

Elderly Waiver Extended Home Care Services

To be eligible for extended home care services, the member must be accessing state plan home care service benefits under Medical Assistance. If they need additional services than what is allowed under state plan, the Care Coordinator may approve extended home care services under EW. The Care Coordinator may only use extended services for the same services already authorized under the medical benefit (i.e., Home Health Aide is approved under the medical benefit, then the EW extended home care service must also be Home Health Aide). Extended home care services are not subject to Blue Plus prior authorization and notification guidelines.

Extended home care claims should be submitted to Bridgeview Company.

Denial, termination, or reduction of state plan home care or EW extended home care services:

Refer the processes outlined in the section: DTRs - Coordination of Potential Denials, Terminations, and Reduction of Services.

PCA Authorization Processes

Blue Plus will review all PCA requests for medical necessity. A member is entitled to up to two PCA evaluations per year. Care Coordinators should contact Blue Plus if additional evaluations are needed.

All Secure Blue (MSHO) and MSC+ members receiving or requesting PCA services will be required to be assessed using the DHS tool, Personal Care Assistance (PCA) Assessment and Service Plan (DHS-3244-ENG), or if an LTCC is present, use the DHS tool Supplemental Waiver Personal Care Assistance (PCA) Assessment and Service Plan (DHS-3428D-ENG).

Note: Blue Plus will not accept the LTCC Assessment tool without the supplemental form for determination of PCA services.

Assessors may be a Care Coordinator only when doing the LTCC and 3428D forms. If completing the Personal Care Assistance Assessment and Service Plan (DHS 3244) the assessor must be an RN or PHN.

1. Blue Plus Utilization Management (UM) will review all PCA requests to determine the number of units the member is eligible for under state plan services and has up to **10 business days** to make a decision.

2. Once a decision is made, UM will notify the member, PCA provider, and Care Coordinator of the decision.
3. Blue Plus will send any letters (approval or denial) to the member and agency via mail and the care coordinator via fax.
4. If Blue Plus has questions regarding an assessment, UM may contact the Care Coordinator or the PHN assessor to discuss.

New enrollees with existing PCA authorizations

1. Determine if the PCA provider is in the Blue Plus network by verifying with the PCA provider directly or calling Member Services (See CONTACT INFORMATION).
2. If in network, the Care Coordinator must fax a copy of the previous PCA authorization with form 6.04.05 PCA Authorization Request to Blue Plus Utilization Management.
3. For PCA providers not in our network, Blue Plus UM may add a temporary authorization for up to 120 days. CC should work with the member to transition to an in network provider before the temporary authorization expires.
4. If a MnCHOICES assessment was completed prior to enrollment with a determination of PCA service needs, the Care Coordinator should send the MnCHOICES Assessment Report and Full Eligibility Summary Report to Blue Plus with form 6.04.05.

New PCA authorization requests for current enrollees

1. Upon completion of the PCA assessment, the CC/assessor is responsible for providing a copy of the completed PCA Assessment and Service Plan to the member and PCA provider within 10 days of the assessment.
2. Current enrollees must use an in network PCA provider. Determine if the PCA provider is in the Blue Plus network by verifying with the PCA provider directly or calling Member Services (See CONTACT INFORMATION).
3. Prior to starting services, the CC/assessor must fax form 6.04.05 PCA Authorization Request with the PCA assessment and Service Plan to Blue Plus for coverage determination and final authorization.
4. The Care Coordinator may align the PCA date span with the EW date span by indicating so in the start and end dates on the request form.

Re-assessment PCA authorization requests

1. Complete the PCA Assessment and Service Plan prior to the end of the authorization period
2. Provide a copy of the completed PCA Assessment and Service Plan to the member and PCA provider within 10 days of the assessment.
3. At least 10 business days prior to the end of the current authorization, the CC/assessor must fax the form 6.04.05 along with the PCA assessment to Blue Plus for coverage determination and final authorization.
4. The Care Coordinator may align the PCA date span with the EW date span by indicating so in the start and end dates on the request form.

Change in PCA Provider

1. If member has a current PCA but wishes to change PCA providers, the CC must confirm the new PCA provider is in network by verifying with the PCA provider directly or calling Member Services (See CONTACT INFORMATION).
2. If the new provider is in network, CC must fax form 6.04.05 providing the new agency information, the current authorization number, and the effective date of change.

PCA Temporary Start/Temporary Increase

1. If member has immediate or acute PCA needs prior to being assessed or re-assessed, Care Coordinators can authorize up to 45 days of PCA. CC must fax form 6.04.05 completing the applicable PCA provider information and the section for temporary authorization.

PCA Denial, Termination, Reduction (DTR)

1. As a reminder, reduction or termination in services requires a **10 day** notice prior to the date of the proposed action.
2. If the DTR notification is due to a PCA reassessment indicating a need for fewer hours, include a copy of the PCA Assessment or MnCHOICES Assessment Report & Full Eligibility Summary Report, the PCA provider's name and contact information and the number of units approved when submitting form 6.05 Notification of Potential Denial Termination or Reduction of Services to Blue Plus.
3. If services are reduced, the current authorization will be extended to accommodate the **10 day** notification period. A new authorization will be entered for services beyond the **10 days** with the new number of units approved.
4. Blue Plus will send any letters (approval or denial) to the member and agency via mail and the care coordinator via fax.

Extended PCA Requests for members on EW

For Blue Plus members open to EW, extended PCA hours may be authorized by the Care Coordinator. Extended PCA services cannot be a "stand-alone" PCA service. To be eligible for extended PCA, the member must first be accessing PCA services under their medical benefits. If the medical benefits alone do not meet the member's care needs, extended PCA services may be authorized by the Care Coordinator as allowed within the member's EW budget. The Care Coordinator should assess for appropriateness of extended PCA. Blue Plus does not need to review as extended PCA is not based on medical necessity criteria.

Notes related to billing of state plan and extended PCA services:

- Extended PCA services, state plan PCA services and PCA Temporary Start/Increase counts towards CAP if member is on EW
- Extended PCA services need to be included on the **Bridgeview Company's EW** Service Agreement
- **For EW,** all state plan PCA services need to be included in the grand total of the Medicaid services that count toward case mix cap and are entered into Bridgeview Company's web-tool under MA Plan Services in the LTCC & Case Mix section.

- Extended PCA claims should be submitted to Bridgeview Company.
- State Plan PCA claims should be submitted to Blue Plus

ELDERLY WAIVER AUTHORIZATIONS

When authorizing an EW service, the Care Coordinator is expected to be compliant with all EW program rules, follow all appropriate bulletins related to MSHO/EW, and follow directions found in the Provider Manual Chapter 26A: Elderly Waiver and Alternative Care.

- A link to the MHCP Manual is located in the Resource section of the Care Coordination web-portal.

- Links to two DHS Supplies and Equipment grids are located in the Resource section of the Care Coordination web-portal

MHCP Enrolled Providers

Most EW services must be provided by a provider enrolled with Minnesota Health Care Programs (MHCP) (formerly Tier 1 services). A group of basic EW services can be delivered by an MHCP-enrolled provider or a qualified vendor approved by a lead agency. These are referred to as Approval-Option Services (formerly Tier 2 and Tier 3 services). See below for more information.

Care Coordinators must ensure members are given information to enable them to choose among available providers of HCBS. Care Coordinators may share with members the statewide listing of enrolled HCBS providers from the Minnesotahelp.info website. If the Care Coordinator uses a local list of Elderly Waiver providers, the list must indicate that additional providers from other areas of the state are available and include the phone number of the Care Coordinator to call for assistance.

Blue Plus is not contracting directly with any Elderly Waiver providers. Providers are being asked to enroll directly with DHS to ensure EW payment for Blue Plus members. Care Coordinators should ensure EW providers are enrolled with DHS prior to authorizing services. For information on accessing provider enrollment status, please refer to the DHS website:

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_181451

Approval-Option Service Providers (formerly known as non-enrolled Tier 2 and 3 providers)

Blue Plus contracts with Delegates who have agreed to bill in a “pass-through” capacity for approval-option service providers (direct delivery services and purchased item services). We

expect the need for this would be very limited. An example might be a chore service such as a neighbor snow shoveling or an environmental modification contractor. For more information on becoming a pass-through entity, contact your Partner Relations Consultant.

See the Bridgeview manual on how to enter service agreements for Approval-Option Services.

See the DHS CBSM for more information about Approval-Option Services and lead agency requirements.

Service Agreements

Bridgeview Company, processes all Elderly Waiver provider claims and Service Agreements for MSHO/SecureBlue and MSC+/Blue Advantage.

Care Coordinators will enter Service Agreements directly into Bridgeview Company through their web-based tool and are responsible to become familiar with this web-tool and the Bridgeview manual. Care Coordinators are also responsible for EW Provider inquiries related to their Service Agreement entries.

State Plan Home Care Services, Care Coordination and other services included in Case Mix Cap

- Care Coordinators must calculate the monetary total of services listed below that are being rendered to the member during the waiver span and are counted against the member's monthly case mix service cap:
    - home care services (X5609-PCA, HHA, SN, PDN),
    - care coordination,
- This total amount must be entered in the Bridgeview Company web tool under the LTCC/Case Mix section.
- **The LTCC/Case Mix section needs to be updated as these services increase or decrease in the member's service plan.**

Waiver Obligation

Information regarding a member's waiver obligation, if they have one, is listed at the bottom of the Service Agreement summary page within the web tool. The beginning date, end date, and dollar amount is included. Please keep in mind that waiver obligations may change retroactively based upon the work completed by the member's financial worker. Questions regarding waiver obligation amounts are to be directed to the member's financial worker. Questions regarding which provider was assigned the waiver obligation for a specific month may be directed to Bridgeview Company.

When completing the Service Agreement, each Extended Supply and Equipment item authorized should be listed on a separate line with a narrative description of what is being authorized, the number of units, and the specific rate per unit. Inquiries related to EW claims and Service Agreements should be directed to Bridgeview Company:

https://www.bluecrossmn.com/healthy/public/bridgeview/home/
1-800-584-9488
Or e-mail:
EWProviders@bridgeviewco.com

ELDERLY WAIVER SERVICES

Consumer Directed Community Supports (CDCS) (September updates)

CDCS is a service option available under the Elderly Waiver which gives members more flexibility and responsibility for directing their services and supports including hiring and managing direct care staff. Refer to the Department of Human Services website http://mn.gov/dhs/people-we-serve/people-with-disabilities/services/home-community/programs-and-services/cdcs.jsp for additional information regarding CDCS.

Choosing CDCS does not change the Care Coordinator's responsibilities under the health plan. The Care Coordinator remains responsible for the completion of the Health Risk Assessment (LTCC) and collaborative care plan within the required timeframes. The collaborative care plan should coordinate with the community support plan created by the member or their representative. **When selecting CDCS, remember to include the MA Plan Services amount when you calculate CDCS services towards the member's CDCS case mix cap.**

The Bridgeview Service Agreement web-tool contains two fields specific to CDCS: CDCS Eligible and CDCS Monthly Amount. As a reminder, CDCS Background Checks **and Required Care Management Units** should be a separate line item from the CDCS service line item in the Bridgeview Service Agreement. Background checks are not included in the member's CDCS budget. Please refer to the web tool user guide for complete details regarding these fields and contact Bridgeview directly with questions.

Home and Vehicle Modifications (September updates)

The Care Coordinator may authorize Home and Vehicle Modifications under EW without submitting a prior authorization request to Blue Plus. The Care Coordinator must follow the guidelines as outlined in the Environmental Accessibility Adaptations chapter of the MHCP manual. A few highlights to keep in mind are as follows:

- Adaptations and modifications are limited to a combined total of **$20,000.00** per member waiver year and must fit within member's EW budget cap.
- Care Coordinators must use an enrolled HCBS provider or have a county contract with Blue Plus to act as a billing "pass-through" for non-enrolled Tier2/Tier 3 providers.
- It is recommended that the Care Coordinator obtains bids from a minimum of two contractors or vendors.
- All services must be provided according to applicable state and local building codes. If the Care Coordinator determines that all criteria are met and the bid for the work is reasonable, they should enter a line item and amount on the member's service agreement in Bridgeview.

EW Specialized Equipment and Supplies (T2029) (Section revised September)

Prior to the Care Coordinator authorizing Specialized Supplies and Equipment under Elderly Waiver, the CC must determine that EW is the appropriate payor. For coverage determination complete the following:

- Review DHS-3945 Long-Term Services and Supports Service Rate Limits to ensure item fits within member's assessed case mix cap
- Review MHCP Supplies/Equipment Coverage Guide
- Review Medicare.gov for coverage determination.
- If an item can potentially be covered under Medicare/MA, the Care Coordinator must assure that the DME Provider has submitted the item for coverage review through insurance before considering it for coverage under EW.
- Refer to the Elderly Waiver Services Specialized Supplies and Equipment (T2029) Eligibility Coverage Guide (also known as EW T2029 Guide). This tool is to be used as a resource for determining EW coverage and primary payer source. **This Guide is not all inclusive** and is updated regularly. It is available on the Bridgeview Company website: https://www.bluecrossmn.com/healthy/public/bridgeview/home/

If an item is not listed on the EW T2029 Guide and the Care Coordinator is uncertain if it meets the EW Service Criteria as outlined in the MHCP Manual, contact the Clinical Guide team at 1-866-518-8447 or Clinical.Guide.Resource.Team@bluecrossmn.com or your Partner Relations Consultant.

For items that are never covered or have been denied by Medicare/MA, see authorization processes below.

EW T2029 Authorization Process for: Single EW items *less than* $500

Review the EW T2029 Guide.

If an item is listed on the EW T2029 Guide as **YES** to Elderly Waiver, *and* the single item is **less than $500** *and* the Care Coordinator agrees that the item is medically or remedially necessary for the member, the Care Coordinator should enter a Service Agreement in Bridgeview and document the item on the member's Collaborative Care Plan.

If the single item less than $500 is listed on the EW T2029 Guide as **NO** to Elderly Waiver the Care Coordinator must:

1. Submit 6.05 Notification of Potential DTR if the CC agrees that the item does not meet EW coverage criteria *OR*
2. Request an exception by completing and submitting 6.06 Elderly Waiver Prior Authorization Request to Blue Plus UM if the CC would like to have the item reviewed for authorization under EW. Blue Plus UM will make the final EW coverage determination (see process below). **Do not enter a Service Agreement until the item has been approved by Blue Plus UM.**

For items **not** listed on the EW T2029 Guide:

- As a care coordinator use your professional judgement to determine if the item is medically or remedially necessary. If needed, you may contact the Clinical Guide team at 1-866-518-8447 or Clinical.Guide.Resource.Team@bluecrossmn.com or your Partner Relations Consultant.
- If CC approves, is single item *under* $500?
    - If YES, enter SA in Bridgeview.
    - Document on Member's Collaborative Care Plan budget worksheet
- If CC does not approve item, submit 6.05 Notification of Potential DTR to Blue Plus

T2029 Exceptions Process for: Single EW items *over* $500 and/or Exceptions to EW T2029 Coverage Guide

For EW T2029 single items over $500 or items listed as **NO** on the EW T2029 Guide, the care coordinator must use professional judgement to determine if the item is medically or remedially necessary. If needed, you may contact the Clinical Guide team at 1-866-518-8447 or Clinical.Guide.Resource.Team@bluecrossmn.com or your Partner Relations Consultant.for a case consultation. **Do not enter a Service Agreement in Bridgeview until item is approved by Blue Plus UM.**

A prior authorization request is required for any single EW T2029 item over $**500** or for those items listed as 'NO' for EW eligibility on the EW T2029 Guide and the Care Coordinator feels that the item is medically or remedially necessary and wants to request an exception.

- The Care Coordinator must fax a completed 6.06 Elderly Waiver Prior Authorization Request form including all the following information to Blue Plus Utilization Management for review at 651-662-4022 or 1-866-800-1665:
- Description of extenuating circumstances that warrant an exception to the EW T2029 Guide.

- Description of how the item will prevent institutional placement.
- Documentation of how the item is the most cost-effective alternative.
- Description of other alternatives that have been tried and failed or considered prior to this request.

Blue Plus will make a coverage determination within 10 business days and notify the Care Coordinator and Bridgeview Company via secure e-mail.

If the item is approved by Blue Plus UM,

- The Care Coordinator is responsible to notify the member of the approval and
- Enter all approved EW items in Bridgeview Company service agreement web tool and
- Enter the item on the member's Collaborative Care Plan budget worksheet.

If the single EW item over $500 or Exception requested item is denied, Blue Plus UM will issue a DTR to the member and e-mail a copy to the Care Coordinator.

Prior Authorization Process for Lift Chair and Mechanism

DME Providers, Care Coordinators and Blue Plus Utilization Management (UM) all have a role in the process of obtaining authorization for lift chairs for members on EW. Coordination and communication is key.

- DME Provider submits a prior authorization request for Medicare coverage of the lift mechanism.
- Blue Plus UM clinicians review requests for prior authorization of:
    - lift mechanism for coverage under the Medicare benefit
    - chair portion of the lift chair if it costs $801 or more for coverage under EW
- Care Coordinator authorizes under Elderly Waiver (EW):
    - Chair portion of the lift chair if it is under $800
    - lift mechanism under EW if it is denied under the Medicare benefit

Lift Mechanism Process

To request authorization for a lift chair for a member on EW, the DME Provider must follow their usual process for submitting a prior authorization request to Blue Plus. The Provider will follow the medical necessity review process as outlined in the Blue Plus Provider Policy and Procedure Manual. Providers have been notified of the requirement for prior authorization of chair/seat lift mechanism.

Blue Plus UM will review the request and make a coverage determination within 10 business days and notify the appropriate parties of the approval or denial determination as follows:

- If *approved* under the Medicare benefit:
    1. Notification will be sent to:
        - The member
        - Durable Medical Equipment Provider
        - Care Coordinator

2. Blue Plus UM will enter an authorization into the claims payment system.

- If *denied* under Medicare benefit:
    - Blue Plus UM will send a DTR to the member and the provider and will notify the Care Coordinator via secure email.
    - The Care Coordinator may review for authorization of the lift mechanism under the EW benefit.
    - If the Care Coordinator approves the lift mechanism under EW, **the lift mechanism and chair portion should be entered as separate service agreements**.
    - If the Care Coordinator deems it is ineligible for coverage under EW, the Care Coordinator should submit 6.05 Notification of Potential DTR to Blue Plus per usual process.

Chair portion under $800

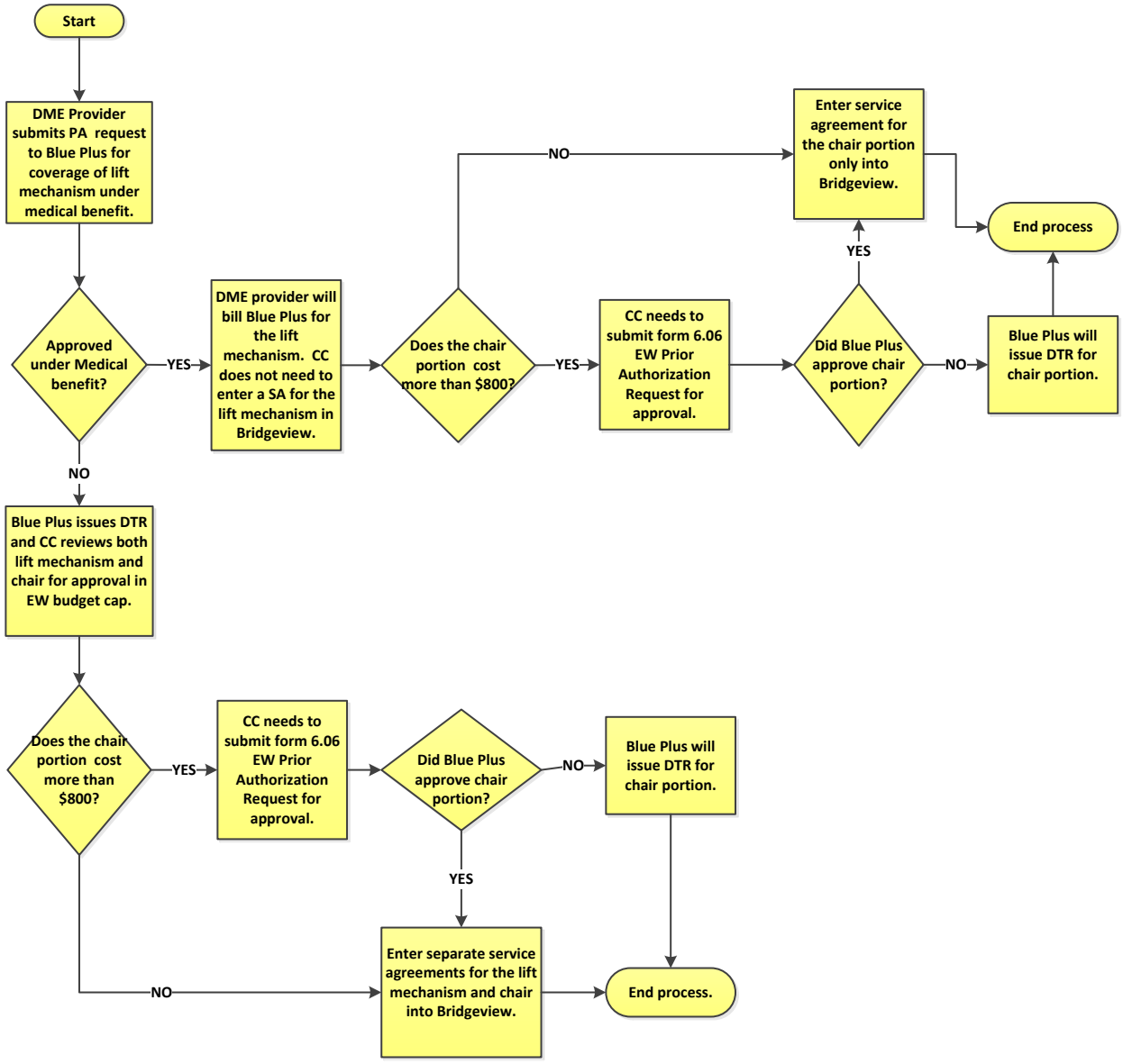
The Care Coordinator can authorize the chair portion under EW without submitting a prior authorization request to Blue Plus. The authorization should be entered as a Service Agreement in the Bridgeview web-tool. No form or documentation needs to be submitted to Blue Plus unless the cost of the furniture portion will be over $800 (see section below).

Chair portion over $800

The Care Coordinator must request prior authorization from Blue Plus. Do not enter Service Agreements until approval is received. Blue Plus UM will review the request and make a determination within 10 business days of receipt of all necessary documentation.
Fax the following to Blue Plus UM at 651-662-4022 or 1-866-800-1665:

- A completed 6.06 Elderly Waiver Prior Authorization Request form, and
- The DME Provider's written quote that separates out:
- the cost of the chair vs. the lift mechanism and
- includes a description of any specialized chair features
- If approved, Blue Plus will notify both the Care Coordinator and Bridgeview.
    - Care Coordinator enters the service agreement into Bridgeview web tool.
- If denied, Blue Plus will send the DTR to both the member and the Care Coordinator.

Lift Chair/Mechanism Process Flow



Residential Services /Foster Care Process (Formerly Customized Living Process) (September updates)

The Care Coordinator will assist members who are moving to a registered Housing with Services establishment obtain a verification code. MMIS auto-generates the necessary verification code

Blue Plus uses the DHS Residential Services Workbook (RS Tool). Care Coordinators are required to use the tool for service planning and rate-setting for adult foster care and customized living services. Refer to DHS website below for the details including DHS bulletins, most recent versions of the tool, and instructions for completion and submission of the tool.

https://mn.gov/dhs/partners-and-providers/policies-procedures/aging/elderly-waiver-residential-services/

The Care Coordinator, with the individual's permission, must send the completed Residential Services Tool to the provider after completion.

REASSESSMENTS

The following steps are to be completed with each reassessment for EW and CW:

1. The Delegate is responsible to verify member's eligibility prior to delivering Care Coordination services.
2. Within **365*** days of the last assessment, the Care Coordinator will thoroughly complete all sections of the Minnesota Long Term Care Consultation Services Assessment Form (LTCC) [DHS-3428]. (For members on other disability waivers, in an ICF/DD or DD member living in the community, follow process outlined on Page 12)
    a. The same LTCC tool should be used for no more than three assessments.
3. Review Supplemental MSHO Benefits using the resource 6.26 Explanation of Supplemental Benefits. Document this discussion on the checklist(s) or in your case notes.
4. The Care Coordinator shall complete the 6.02.01 Collaborative Care Plan within 30 calendar days of the LTCC (refer to section: Comprehensive Care Plan).
    a. Document on-going monitoring of goals, interventions, and target dates
    b. The member must sign the Collaborative Care Plan.
    c. A copy of the care plan, including the budget worksheet and the Member Bill of Rights, Form 6.02.03, must be given to the member.
5. Enter the assessment type and date into the Bridgeview Company's web tool (see section, Assessment, Refusal, and Unable to Reach Tracking Process) by the 10th of the following month.
6. The Care Coordinator will complete 8.29 Care Plan Summary Letter to Doctor or send a copy of the care plan.
7. If state plan home care services are needed, the Care Coordinator shall fax in the applicable home care services form as outlined in section: Home Health Care Authorizations.
8. If the member was on Elderly Waiver and a reassessment comes due during a 90-day period in which the member is waiting for their Medical Assistance to be reinstated, the Care Coordinator must do the reassessment on schedule and enter the appropriate screening document when MA is reinstated. See DHS Bulletin 15-25-10 Scenario 10 for more details about this requirement.

***If member is temporarily in nursing home or hospital at the time reassessment is due, a HRA is still required within 365. CC should use professional judgement to complete an assessment within the timeframes. Document any delays in reassessments.**

Entry of Reassessment LTC Screening Documents into MMIS **(September updates)**

Follow the directions as outlined in the DHS Instructions for Completing and Entering the LTCC Screening Document in MMIS for the MSHO and MSC+ Programs (DHS-4669).

EW: Enter screening document by the cut-off date below

When the First Month of the Eligibility Span is:	Last Day to Enter Screening Document timely is:
January	12/21/16
February	1/23/17
March	2/20/17
April	3/23/17
May	4/20/17
June	5/22/17
July	6/22/17
August	7/21/17
September	8/23/17
October	9/21/17
November	10/23/17
December	11/20/17
January 2017	12/20/17

Unable to Reach: For activity type date of September 1, 2017 or after, enter a screening document "H" with new assessment value "50" within 45 days of the enrollment date.
CW Refusals : Enter a screening document using the refusal code in MMIS
For members on another Waiver (CADI, CAC, BI, DD):

- **For activity type date September 1, 2017 or after enter Screening Document type "H". or**
- Do not enter a screening document **for activity type dates prior to September 1, 2017**.

Nursing Facility Level of Care Change

Effective January 1st, 2015 Care Coordinators must follow the updated Nursing Facility Level of Care Determination Requirements as outlined in DHS Bulletins 14-25-09, 14-25-10, and 14-25-12.

Only a face-to-face assessment can make the final determination of NF LOC. For Blue Plus members, this assessment is the LTCC.

If a member loses NF Level of Care, which determines EW eligibility, the NFLOC statute requires a minimum of 30 days advance notice for termination of services. The Care Coordinator

will follow the instructions outlined in section: DTRs—Notification of Potential Denials, Terminations, and Reduction of Services section.

Members that lose level of care should be offered alternative services including: state plan home care or state plan PCA, if they are eligible.

Essential Community Supports

Please refer to DHS Bulletins 14-25-13, 14-25-13C for a complete description and instructions for Essential Community Supports.

Care Coordinators may continue to have members who qualified for ECS program following the NF LOC changes effective January 1, 2015. Members can participate in ECS as long as they continue to meet ECS criteria and do not exit the ECS program.

Members may not receive ECS services if they are eligible for personal care assistance (PCA) services. A member must live in their own home or apartment as ECS cannot be provided in Board and Lodge; Non-certified boarding care or corporate or family foster care.

Services provided through ECS include: Homemaker, chore, caregiver training and education, PERS, home-delivered meals, service coordination, community living assistance (CLA), adult day services.

ON-GOING CARE COORDINATION RESPONSIBILITIES

****The Delegate is responsible for confirming member's eligibility before providing Care Coordination Services**

Special Needs Plans Model of Care (SNP-MOC) Training

The Centers for Medicare & Medicaid Services (CMS) requires all providers and appropriate staff who see beneficiaries of a Fully Integrated Dual Eligible Special Needs Plan (SNP) on a routine basis to complete initial and annual Special Needs Plan-Model of Care (SNP-MOC) training. Providers and appropriate staff required to complete the training include anyone who may participate in a SecureBlue member's Interdisciplinary Care Team, be responsible for implementation of the member's Collaborative Care Plan, or manage planned or unplanned transitions of care.

Blue Plus utilizes annual, in-person Fall Training to meet the CMS SNP-MOC training requirement for Care Coordination delegates. Care Coordinators are expected to attend training in person or by sending delegates from each county or care system to attend the training and then train the remaining Care Coordinators that did not attend. Additionally, Care Coordination delegates are responsible for ensuring all newly hired Care Coordinators complete training on the SNP-MOC.

Blue Plus will maintain attendance records for in-person training. Care Coordination delegates must document and maintain MOC training completion records for those Care Coordinators who did not attend the in-person training. At a minimum, training completion records must include the Care Coordinator's name and the date the training was completed. Upon request, Care Coordination delegates must provide training completion records to Blue Plus to validate that the SNP-MOC training has been completed.

The SecureBlue SNP-MOC Fall Training is available online as a PowerPoint presentation at: https://www.bluecrossmn.com/carecoordination/public/msho_training.html.
To complete the training, simply review the presentation.

Blue Plus is committed to maintaining strong, collaborative partnerships with our care coordination delegates to ensure they have easy access to the information and tools necessary to provide the highest quality, evidence-based care. We therefore work with our delegate partners to validate that mandated and regulated activities such as Model of Care Training occur and assist providers in identifying and overcoming any barriers to training completion. Your Blue Plus Provider Service Agreement reflects these commitments. Because compliance is critical, if a provider fails to complete the CMS required training and remains noncompliant, they may be required to develop a Corrective Action Plan or be subject to other remediation activities.

Primary Care Clinic (PCC) Change

Blue Plus must be notified when a member changes their Primary Care Clinic. This is especially important if the PCC change also results in a change in Care Coordination Delegation.

1. To change a member's PCC:
   The Care Coordinator must update the PCC field in Bridgeview. The field includes a list of all PCC's from our Primary Care Network Listing (PCNL) in a drop-down format. You must choose a clinic from one that is listed. If the member's PCC is not listed in Bridgeview, it may not be in our Primary Care Network. Please contact Member Services or your Partner Relations Consultant with any PCC network questions.

2. Determine if Change in PCC requires a transfer in Care Coordination:
   If the member's PCC is contracted with Blue Plus to provide care coordination (See list below), the change in PCC may also trigger a change in who provides Care Coordination for the member. Changing the PCC in Bridgeview alone will not transfer care coordination. You are still required to either send notification to SecureBlue.Enrollment@bluecrossmn.com for enrollment miss-assignments or follow the process outlined in section: Transfers in Care Coordination to another Delegate, which includes sending in form 6.08 Transfer in Care Coordination Delegation.
   The following PCCs currently provide care coordination:
   - Bluestone Physicians (select customized living facilities only)
   - Fairview Partners (select customized living and nursing home)
   - Essentia Health

- HealthEast
- Lake Region Health Care Clinic (**MSHO members in** select Nursing Facilities in Otter Tail County)
- Genevive (MSHO only in select nursing facilities)

Transitions of Care (TOC)

The Blue Plus Care Coordinator is key to supporting the member's needs across the continuum of care. Regular engagement and contact with the member and their service providers allows the Care Coordinator to be informed of health care service needs and supports, thus allowing active management of planned and unplanned transitions. The goal of the TOC process is to reduce incidents related to fragmented or unsafe care and to reduce readmissions for the same condition. *******Transitions of Care engagement and follow up is required regardless of how or when the Care Coordinator learns of the transition. One way the CC may learn of the transition is through Blue Plus notice of inpatient admissions, which is sent to Delegates via secure e-mail 24 hours after notification from the facility.

The Blue Plus Care Coordinator assigned to the member is responsible for completing all required tasks related to the transition(s) of care. If the member has an additional case manager (i.e. CADI waiver case manager), the Blue Plus Care Coordinator may communicate applicable information about the transition(s), or any updates as a result of the transition(s), with the other case manager(s).

Definitions:

Transition: Movement of a member from one care setting to another as the member's health status changes. Returning to usual setting of care (i.e. member's home, skilled nursing facility, assisted living) is considered a care transition and the required tasks need to be completed.

Care Setting: The provider or place from which the member receives health care and health-related services. Care settings may include: home, acute care, skilled nursing facility, and rehabilitation facility, etc.

Planned transition: Planned transitions include scheduled elective procedures, including outpatient procedures performed in a hospital or outpatient/ambulatory care facility; discharges from the hospital to long-term care or rehabilitation facility; or a return to the member's home (usual care setting) after an unplanned transition. Change in level of care (i.e. move from SNF to customized living) is also considered a planned transition of care.

Outpatient procedures which have been identified by Blue Plus as requiring transition activities are: Knee Arthroscopy, Virtual colonoscopy, Capsule Endoscopy, Radiofrequency Neuroablation for Facet Mediated (Back & Neck Pain) Joint Denervation, Phototherapeutic Keratectomy (PTK).

Unplanned transition: Unplanned transitions are most often urgent or emergent hospitalizations.

Care Coordination TOC Responsibilities

Documentation for TOC Activities

1. The Care Coordinator will document transition services on the 6.22 TOC Log. Use 6.22.01 Transitions Log Instructions for detailed information on the completion of the log. One log can be used to document up to three transitions. The TOC Log (s) should be kept in the member's file along with additional case note documentation as appropriate.

2. If the Care Coordinator finds out about all of the transition(s) 15 calendar days or more after the member has returned to their usual care setting, no TOC log will be required. However, the Care Coordinator should follow-up with the member to discuss the care transition process, any changes to their health status and plan of care, and provide education about how to prevent future admissions. Document this discussion in case notes.

   Caution: This applies only if the CC learns about all of the transitions 15 calendar days after the member has returned to the usual care setting. If the CC learns of a transition while the member is still in any phase of the transition process, CC TOC activities outlined below and completed TOC log(s) are still required. Also, if CC begins TOC interventions/log, they should complete the process through to discharge back to usual care setting even if the CC learns of the discharge back to the usual care setting 15 calendar days or more after it occurred.

Planned Transitions

The Care Coordinator should contact the member prior to the admission day to ensure they have the Care Coordinator's phone number and understand how the Care Coordinator will assist during the member's care transitions.

Member is Admitted to New Care Setting

1. Share essential information with the receiving facility (discharge planner, Social Worker, etc.) within 1 business day of learning of the admission. Examples of essential information include but are not limited to:
   a. services currently received by the member and who provides them;
   b. the name of the Primary Care Provider/Specialty Care Provider to use as a resource for current medications, chronic conditions, and current treatments;
   c. The Care Coordinator contact information and a brief explanation of their role in assisting the member with care transitions.
   d. Work with the discharge planner to ensure continuity in home care and home and community based services, if needed, upon discharge.
   e. Refer to 9.16 TOC Talking Points for Hospital staff.

NOTE: If the member's usual care setting is a long term care facility or other supportive living setting, staff at this setting usually shares relevant care plan information with the receiving facility. However, it is the Care Coordinator's responsibility to confirm this task has been completed by the facility staff and document the date they confirmed it on the transition of care log. If sharing of information has not been completed by the facility, the Care Coordinator must facilitate the completion of this task and document the date this was done on the transition of care log.

2. Notify the Primary Care Physician and/or Specialty Care Physician of all transitions including the transition to home, within 1 business day of learning of the transition. Optional fax form: 6.22.02 Fax Notification of Care Transition-Optional is available for this communication. If the admitting physician is the member's primary physician document this by checking the appropriate check box on the transition of care log.

Member Returns to Usual Care Setting

The Care Coordinator is required to reach out to the member or authorized representative within one business day after the member returns to their usual care setting or "new" usual care setting, (i.e., a community member who decides upon permanent nursing home placement) or within 1 business day of learning of the transition and should discuss the following:
NOTE: Communication with the Customized Living or Nursing Facility staff does not replace the requirement to contact the member/member's representative.

1. Discuss care transition process including the role of the Care Coordinator
2. Discuss changes to health status. Suggested topics to review: medication changes/new prescriptions filled; DME/supply needs; transportation or other service needs; changes in functional needs (bathing, eating, dressing, transfers, etc.),
3. Discuss changes to plan of care. The Care Coordinator should update the member's plan of care with any applicable changes. This may include but is not limited to, addressing and documenting any newly identified medical issues and documenting any updates to applicable sections of the collaborative care plan. If the member's usual care setting is a nursing facility, the Care Coordinator should confirm that necessary changes were applied to the care plan and offer input, if applicable, and provide support/reinforcement of the updated care plan.
4. The Care Coordinator shall address the "Four Pillars for Optimal Transition: Care Coordinators should refer to 9.12 TOC Resource Tool kit for information on the four pillars:
    a. Timely follow up appointment. The Care Coordinator should stress the importance of the appointment, ask if the member has scheduled it or needs assistance and inquire if they need help getting to the appointment**. For mental health hospitalizations—the follow up appointment should be within 7 days following the return to the usual care setting.**
    b. Medication Self-Management. The Care Coordinator should inquire if the member or responsible party understands their current medication regime and should discuss whether there were any changes to the regime, do they have the

medications, do they remember to take them, do they need help setting them up, do they have any questions or concerns.

c. Knowledge of red flags. The Care Coordinator should discuss with the member or responsible party if they are aware of symptoms that indicate problems with healing or recovery such as warning signs and symptoms, what action should be taken if the symptoms appear, who and when to call with questions/concerns, and are those phone numbers available.
d. Use of a Personal Health Record. The Care Coordinator should discuss the use of a personal health record to document their medical history and medication regime and bring to appointments. The use of a Personal Health Record increases the member engagement and self-management.

5. Provide education about how to prevent unplanned transitions/readmissions. This education should be tailored to the member's specific needs, diagnoses, health issues, etc. and should be in a format that best works for the member based on their abilities. Members with chronic conditions who are frequently hospitalized can still benefit from educational discussions about their conditions, appropriate care, treatment options and relationship building with the Care Coordinator. Members in a nursing facility can benefit from an opportunity to reinforce or develop what is in their nursing facility plan of care.
   Educational examples include (but are not limited to):
   - Discuss the member's understanding of what to do if their condition worsens.
   - Discuss how to maintain their health and remain in the least restrictive setting.
   - Use of written materials related to a member's medical condition. (These can be found in the Resource Management section of the Care Coordination web portal.)
   - A referral to Disease Management
   - A referral to Medication Therapy Management (Medicare recipients can receive this through a local pharmacy, or directly from a Blue Plus Pharmacist – see Key Contact List)
   - Falls risk education
   - Caregiver support/training
   - Discussion with member (or authorized representative) during a nursing facility care conference

Pre-Admission Screening activities

Effective 11/1/2013, MSC+ and MSHO members have Pre-Admission Screening activities completed by their health plan. Secure Blue (MSHO) and Blue Advantage (MSC+) members (CW) will be screened by an internal team at Blue Plus.

A referral for all members discharging from a hospital to a nursing home for any length of time must be made by the hospital to the Senior Linkage Line. The Senior Linkage Line (SLL) identifies that the person is a Blue Plus member and forwards the referral to Blue Plus for processing.

For CW members entering a nursing facility:

- Delegate will be sent secure email notification that a PAS was completed on CW members that are referred to Blue Plus by the Senior Linkage Line. (Blue Plus will send the OBRA I and required documents to the NF.)

For EW members entering a nursing facility:

- Delegate will be contacted via secure email by Blue Plus with instructions to send a completed OBRA Level I to the designated NF if an EW member is being discharged to a nursing facility for ANY length of stay (including short rehab stays).

In the event that Blue Plus staff is unable to determine level of care based on the information obtained by the hospital, the delegate will be contacted with instructions that a face-to-face LTCC/MnCHOICES assessment is required. The assigned Care Coordinator or back-up staff will conduct the face-to-face assessment before discharge to the NF.

The OBRA II referral process is unchanged. Members whose need for a OBRA level II evaluation is determined will be referred by Blue Plus for CW members. For EW members the CC should make a referral for OBRA level II evaluation if they determine a referral is appropriate.

Please refer to DHS Bulletin #13-25-15 for complete details of the PAS process and changes made as of 11/1/2013.

Communications from Utilization Management (UM)

Blue Plus UM notifies Care Coordinators of health plan prior authorization request approvals and denials for behavioral health and medical services via secure email. Examples of potential notifications include, but are not limited to, surgical procedures, durable medical equipment, and Medicare skilled days in a nursing facility. The purpose of the notification is to support the Care Coordinator's expanded role of coordination of all Medicaid and Medicare funded preventive, routine, specialty, and long term care supports and services, whether authorized by the Care Coordinator or Blue Plus.

Follow up with a member after receipt of authorization notification may be required. For example, if the notification is for a surgical procedure, transition of care documentation and follow up would be required as a "planned" transition. The same holds true if it is a nursing facility transition. You may also be notified of Medicare covered days in a nursing facility for a current nursing facility resident that did not follow a hospital stay. In this case, transition of care activities are not required. You should be aware of Durable Medical Equipment needs, but the authorization lets you know the member is able to get the needed equipment under their medical benefit.

Communications from Consumer Service Center

Member and provider appeals received by Blue Plus are managed by our Consumer Service Center (CSC). CSC will notify care coordination delegates, via email, of appeal determinations for the following situations:

- Appeal Determinations prior to services being rendered—Informational only
- State Fair Hearing. While this is intended as an informational communication, a Care Coordinator may contact CSC to participate in the hearing. CSC contact information will be included in the notice.
- State Fair Hearing Determinations—Informational only

Transfers

Transfers of Care Coordination to Another Delegate

When a care coordinator becomes aware that a member is moving from their service area or the member chooses a Primary Care Clinic (PCC) that is contracted with Blue Plus to provide care coordination, it is important to notify Blue Plus via form 6.08 Transfer in Care Coordination Delegation. Once received and processed, Blue Plus will provide official notification of the transfer to both Delegates via email. The change in Care Coordination will be effective on the first of the month following the date of notification unless previous agreed upon with Blue Plus enrollment staff. It is expected that the current and receiving care coordinator work together to alleviate gaps in care during the transition.
Important: If it is known the member's MA is terming and the member will not be reinstated, do not transfer the case. The current care coordinator should continue to follow the member until the member's coverage terminates.

The following process should be done to expedite communication between the old and new care coordinator and provide our member with a smooth transfer of care coordination services. For a list of all tasks associated with a transfer, refer to form 6.08.01 Transfer in Care Coordination Delegation Checklist as resource if needed.

NOTE: If the CC needs to confirm who the new Care Coordination Delegate will be, including where to send assessment information, please contact Medical Management Intake at 651-662-5540 or 1-800-711-9868 or your Partner Relations Consultant.

Responsibilities of the Care Coordination Delegate who is <u>initiating</u> the transfer:

1. Confirm the current and/or new PCC with the member, authorized rep, or customized living/nursing facility. This is especially important if the change in PCC triggers a change in care coordination delegation. For example, the following PCCs also provide care coordination to our members:

- Bluestone Physicians (customized living facilities only)
- Fairview Partners (customized living and nursing home)
- Essentia Health
- Health East
- Genevive (MSHO only in select nursing facilities)
- Lake Region Health Care Clinic (**MSHO members in** select nursing homes in Otter Tail County)

2. If the PCC needs to be changed, follow the PCC change process as outlined in the Primary Care Clinic (PCC) Change section of these Guidelines.
3. Notify Blue Plus Medical Management Intake of the transfer by completing and faxing form 6.08 Transfer in Care Coordination Delegation. **Note:** The official transfer of care coordination assignment is the first of the month following the notification date on this form unless previously agreed upon with Blue Plus enrollment staff.

Responsibilities of the <u>Transferring</u> Care Coordination Delegate:

1. The **transferring** Care Coordinator is required, at a minimum, to share the following **directly** with the new delegate:
   - Completed DHS-6037 HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form. Refer to DHS Bulletin 15-25-10 for complete details.
   - The next face-to-face assessment date (within 365 days of previous assessment)
   - Send the following documents, if applicable:
     - Long Term Care Consultation (LTCC)/MnCHOICES assessment/summaries
     - Plan of care information including the completed signature page
     - A copy of the Residential Services tool
     - Any state plan service authorization information and
     - My Move Plan Summary
     - 6.15 NH Member Annual Assessment-Care Plan Reviews.

2. The **transferring** Care Coordinator should communicate the following to the member's financial worker:
   - Address change
   - EW eligibility

3. If the member is open to EW, the **transferring** Care Coordinator should:
   - Keep the waiver span open in MMIS if the member remains eligible for EW
   - Keep all active service agreement(s) in Bridgeview open, if services will continue with the same provider. Be sure to share this information with the new delegate.
   - Close service agreement(s) that are no longer applicable.

4. If a member enters an inpatient setting such as a hospital, Residential Treatment Center, etc. outside of the county the member resides in, the Care Coordination responsibility continues with the current Care Coordinator. Once it is determined the member will not be returning to the original county, the transferring Care Coordinator should proceed with completing and faxing form 6.08 Transfer in Care Coordination Delegation and changing the PCC (if applicable). Blue Plus will securely email form 6.08 to both Delegates

5. Transitions of Care responsibility: If this transfer of Care Coordination is the result of a change in level of care (i.e. a permanent move from SNF to Customized Living, etc.), the **transferring** delegate will need to finish up the Transitions of Care (TOC) responsibilities as outlined on page 34 of the guidelines. This includes documenting this move on the form 6.22 Individual Transitions Log.

Responsibilities of the Care Coordination Delegate who is receiving the transfer:

Regardless of how a Delegate is notified, the **receiving delegate:**

1. Must assign a Care Coordinator and notify the member by the 10th of the month the change is effective. The 8.30 CM Change Intro letter may be used to notify the member of a change in Care Coordinator.
2. Enter the name of the assigned Care Coordinator in Bridgeview following the process outlined in the Bridgeview manual.
3. Must update the Screening Document to reflect the change in Care Coordinator, if applicable.
4. Notify the financial worker of the assigned Care Coordinator's name.
5. Notify the physician using 8.28 Intro to Doctor Letter.
6. Confirm the PCC is correct in Bridgeview. If not, please update following the process outlined in the Primary Care Clinic (PCC) Change section of these Guidelines.
7. The Care Coordinator is now responsible for the content of the transferred assessment and care plan. The CC must review the assessment and care plan received from the previous Delegate. If applicable, document any updates and complete any areas that are not complete.
8. Follow the process for completing the health risk assessment and care plan if no current Health Risk Assessment/Care Plan is received from the transferring Delegate.
9. Keep copies of all forms and letters related to the transfer for your records.

Optional: Either Delegate may update the address and County of Residence in Bridgeview. This will be done automatically after the Financial Worker makes their changes, however those changes may take up to a month to reach Bridgeview. Changing the address and county of residence manually will update the current month's enrollment report. Follow the process outlined in the Bridgeview manual to make these manual changes. Note: Manual changes made to the member information except the PCC in Bridgeview are saved for only 90 days. You must notify the financial worker to permanently change the member's information.

Moving out of the Blue Plus service area

Do not send form 6.08 Transfer in Care Coordination Delegation to Blue Plus. Instead, please communicate directly with the new Care Coordinator to send appropriate documentation.

Implications of a move outside Blue Plus service area should be discussed with the member ahead of time if possible. Resource 9.01 Blue Plus Service Area Map can be used to determine if a move will take the member out of our service area. Member questions related to selecting a new health plan and/or Part D plan can be directed to either the member's county financial worker or the Senior Linkage Line at 1-800-333-2433.

Important:

- Blue Plus will continue to pay for services, including Customized Living, until the member's disenrollment.
- The Blue Plus care coordinator is responsible for all care coordination activities until the case is transitioned and until the member is disenrolled from Blue Plus. This includes all assessments, care plans, CL tools, service agreement entry, and TOC activities unless coordinated in advance with the receiving county/agency.
    - If the Blue Plus care coordinator needs assistance with determining who to contact to coordinate the transition at the new county, contact your Partner Relations Consultant for assistance.

The following process should be followed to provide our member with a smooth transfer of care coordination services for transfers outside of the Blue Plus service area:

1. The **transferring** Care Coordinator is required, at a minimum, to share the following **directly** with the Care Coordinator:
    - Completed DHS-6037 HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form. Refer to DHS Bulletin 15-25-10 for complete details.
    - The next face-to-face assessment date (within 365 days of previous assessment)
    - Send the following documents, if applicable:
        - Long Term Care Consultation (LTCC)/MnCHOICES assessment/summaries
        - Plan of care information including the completed signature page
        - A copy of the Residential Services tool
        - Any state plan service authorization information and
        - My Move Plan Summary.

2. The **transferring** Care Coordinator should communicate the following to the member's financial worker:
    - Address change
    - EW eligibility

3. If the member is open to EW, the **transferring** Care Coordinator should:

a. Keep the waiver span open in MMIS if the member remains eligible for EW
b. Keep all active service agreement(s) in Bridgeview open, if services will continue with the same provider. Be sure to share this information with the new delegate.
c. Close service agreement(s) that are no longer applicable.

4. If any EW services are provided while the member is still enrolled with Blue Plus by an EW provider who is not enrolled with Bridgeview, the Blue Plus Care Coordinator should provide Bridgeview contact information so that they may register in order claims to process and pay.

Transfers of Care Coordination within your agency

If there is a change in Care Coordinator within the Delegate agency, the Delegate agency must inform the member of the name, number, and availability of the new Care Coordinator within 10 calendar days of this change. The new Care Coordinator may use the 8.30 CM Change Intro letter for this purpose. The Delegate must update the Care Coordinator assigned in the Bridgeview web tool. The Care Coordinator should enter a Screening Document and notify the financial worker of the change in Care Coordinator.

My Move Plan Summary

The My Move Plan Summary (DHS-3936) helps to clarify role expectations before, during and after a move. It is a tool to communicate all key elements of the plan.

The My Move Plan Summary must be offered in the following scenarios:

1. When a member who is on EW is moving to a new residence,
2. When a member who is expected to go on EW (i.e. from the nursing home) is moving to a new residence
3. When a member who is on EW or expected to go on EW expresses interest in moving to a new residence.

The My Move Plan Summary is optional in the following scenarios:

1. EW members who are permanently moving into a nursing facility
2. CW members who are moving residences
3. NH members who are moving residences and not going on EW

The Summary is not required for temporary placements or for members who are not on a waiver.

If the member is on a disability waiver, the Care Coordinator should ensure that the waiver CM completes the My Move Plan Summary form with the member. If not done by the CM, the Care Coordinator will be responsible for the My Move Plan Summary and can provide a copy to the other CM as appropriate.

The Care Coordinator is responsible to:

- Evaluate the member's needs,

- Build and share the Summary with the member,
- Update the My Move Plan Summary,
- Update the Collaborative Care Plan (if applicable)
- Communicate information to others involved (if applicable), and
- Sign and keep a copy of the completed document in the member's file.

The My Move Plan Summary form includes identification of "my follow up support" person. This person may be the Care Coordinator or another identified support person. The "Follow Up person" is responsible to ensure the My Move Plan is implemented and the follow up contacts are made with the member including contact:

1. on the day of the move,
2. within the first week of the move,
3. within the first 45 days of the move,
4. and provide an on-going review of the plan as needed.

If the My Move Plan Summary was not completed, the Care Coordinator should indicate the reason on DHS-3936 and retain a copy in member's case file:

- CC was not aware of the move, or
- Member declined to complete a move plan summary, or
- Other reason.

Please see the DHS Person Centered Protocol for more information about the My Move Plan Summary form and Person Centered Practices.

MA Termination and EW Reassessments (MSHO EW and MSC+ EW only)

Care Coordinators are required to complete reassessments for Elderly Waiver members who lose MA eligibility for up to 90 days when it is expected that the member's MA will be reinstated during the 90-day period. This applies to all EW members in both MSHO and MSC+, usually due to members not renewing their MA timely. These members may show on the enrollment report flagged with a "future term" date. In these cases, the care coordinator should follow up with the member and confirm the reason for the term.

This requirement does not apply to those who lose eligibility for moves out of state, who exceed income or asset limits, or for whose MA is not expected to be reinstated within the 90 days.

If the member's annual EW reassessment is due during the 90-day term window and it is expected that the MA will be reinstated during the 90 term window, the care coordinator must complete and retain the following documents in the member's file:

1. LTCC Screening Tool DHS 3428,
2. Collaborative Care Plan, and
3. OBRA Level I.

The care coordinator should work with the member and their financial worker to reinstate the MA as quickly as possible. The LTC Screening Document DHS 3427, must be entered in MMIS when the member's MA is reinstated.

*See instructions below for care coordinator case closure responsibilities and tasks associated with term due to lapse in MA coverage for EW members

Refer to DHS Bulletin 15-25-10 (Scenario 10, DHS 6037A, page 12) for more information.

Case Closure Care Coordination Responsibilities **(September updates)**

Activities required when closing a member's case depends on the reason for the termination. If you have any questions, always contact your Partner Relations Consultant. **Care Coordinators should be referring to the DTRs—Coordination of Potential Denials, Terminations, and Reductions of Services section to determine if a DTR is needed.** Here are some common "termination" scenarios (not all inclusive):

Term due to death:

- No need to notify Blue Plus
- Must send notification to the Financial Worker via DHS 5181
- May enter date of death into Bridgeview, however, this is not mandatory
- **Close service agreements in Bridgeview back to the date of death, (EW only)**
- **Close member to EW in MMIS (EW only)**

Term due to a move out of the Blue Plus Service area:

- Refer to Moving out of the Blue Plus Service Area section of the guidelines

Term due to a move out of state or out of country:

- **Close member to EW in MMIS (EW only)**
- **Close service agreements in Bridgeview (EW only)**
- Notify Financial Worker via DHS 5181

Term due to lapse in MA coverage for <u>EW members</u>:

1. Keep case open as member may reinstate within the following 90 days
2. Keep waiver span open in MMIS and Bridgeview
3. Keep all service agreements open Bridgeview
4. Send <u>DHS form #6037</u> to the County of Residence (COR) by Day 60 if MA has not been re-established and you anticipate the member will term by Day 90.
5. If the member is due for re-assessment during the lapse, see "MA Termination and EW Reassessments" section above.
    a. Refer to DHS resource 6037A Scenario 10 for more information
6. If the member is reinstated:
    a. Enter assessment screening document**, if applicable**
    b. Adjust service agreement(s) as applicable
7. If the member is not reinstated after 90 days, you can close the member's case.
    a. Close member to EW in MMIS back to MA closure date
    b. Close Service Agreements in Bridgeview back to MA closure date

c. Enter Screening Document into MMIS to exit member from EW

Term due to lapse in MA coverage for <u>CW Members</u>:

1. Continue care coordination activities if member is on MSHO through 90-day grace period.
2. Close case file if member is not expected to reinstate within 90 days.

MA closing and will not reopen:

1. **Close member to EW in MMIS (EW only)**
2. **Close service agreements in Bridgeview (EW only)**
3. Refer member to Senior Linkage Line for assistance with finding other insurance or Part D prescription coverage if needed.

Term due to health plan change:

- Confirm health plan change in Mn-ITS
- Send DHS Form 6037 to the new health plan **(EW only)**
- If on EW, do not close waiver span in MMIS
- Close service agreements in Bridgeview **(EW only)**
- Refer to Moving out of the Blue Plus Service Area section of the guidelines

90 Day Grace Period (MSHO only)

If a SecureBlue/MSHO member has Medicare and loses eligibility for Medical Assistance, Blue Plus may continue to provide Medicare-covered Plan benefits for up to three months. Care coordination services will continue during this 90 day period.

- Coverage with Blue Plus will end after three months if the member has not regained Medical Assistance. At that time, the member will need to choose a new Part D plan in order to continue getting coverage for Medicare covered drugs. If the member needs assistance, they can call the Senior Linkage Line at 1-800-333-2433.
- Coverage during the 90 day grace period does not include Elderly Waiver services. The Care Coordinator can close the line items in Bridgeview but do **<u>not</u>** exit from the waiver. If the member's MA is renewed, EW services can resume and new service agreements can be entered into Bridgeview.
- No DTR is needed since EW services are closing due to MA ineligibility.
- The three month grace period may **not** be applicable in all cases where a MSHO member loses MA. Contact the member's financial worker with questions about MA disenrollment.
- To determine if the member is covered by Blue Plus during this 90 day period, the care coordinator can email secureblue.enrollment@bluecrossmn.com.

See DHS Bulletin #09-24-01 for more information.

DTRs—Coordination of Potential Denials, Terminations, and Reduction of Services

Blue Plus will review notifications of Denial, Termination, and Reduction of Services or eligibility for State Plan and Elderly Waiver Programs.

If the Care Coordinator, not the provider, recommends a DTR of State Plan Home Care Services or Elderly Waiver Services, the Care Coordinator must fax 6.05 Notification of Potential Denial Termination or Reduction of Services to Blue Plus Medical Management at 651-662-6054 or 1-866-800-1665. The notification must be faxed within 24 hours of a determination. Blue Plus Utilization Management (UM) will review the request and if a DTR is needed, will fax/email a copy of the DTR to the Care Coordinator and mail a copy to the provider and member.

DTR Decision guide (September updates)

Situation	6.05 Notification of Potential DTR to Blue Plus?
Member's Medical Assistance eligibility ends for any reason	Not required
Member moves out of the Blue Plus service area	Not required
Member switches to another health plan or fee-for-service	Not required
Member dies	Not required
Change in service provider (no change in authorized service or number of units)	Not required
Member's EW/State Plan services are temporarily on hold for 30 consecutive days or less and the plan is for the member to resume services. (i.e., short term NF admission, vacation out of area, short term hospitalizations, etc.) (For additional details see Reference Guide for Hospital and Nursing Home Stays, below)	Not required
Member's EW/State Plan services are on hold for **more** than 30 consecutive days (For additional details see Reference Guide for Hospital and Nursing Home Stays, below)	Required
Assessment is completed for a CW member and it is determined that she/he is not eligible for EW and she/he is **not** requesting services	Not required
Assessment is completed for a CW member and it is determined that she/he is not eligible for EW and she/he is	Required

Situation	6.05 Notification of Potential DTR to Blue Plus?
requesting services	
Member requests to reduce or terminate services (EW or state plan) or requests to close EW	Required
Member elects to use less PCA than was assessed.	**Required**
CC is making decision to reduce or terminate services (EW or state plan) or closing EW	Required
Customized Living/24 Hour Customized Living/Adult Foster Care rate is reduced due to a reduction or termination of a CL/AFC service	Required
Member no longer qualifies for EW due to no longer meeting NF Level of Care	Required
Home care agency provides services without PA from Care Coordinator. They later approach the CC requesting authorization for services rendered and the CC does not agree that the services were necessary	Required

DTR Reference Guide for Hospital or Nursing Home Stays

Situation	Action Needed	6.05 Notification of Potential DTR to Blue Plus?
Member goes into a hospital for acute care (less than 30 days)	Close the line items in Bridgeview back to the admission date	Not required
Members goes into the hospital for 30 consecutive days or more	- Close the line items and service agreement in Bridgeview back to the hospital admission date. - Close the waiver as of the hospital admission date	Fax 6.05 on day 31 or within 24-hours of the determination that the hospital stay will exceed 30 consecutive days
Members goes into a nursing facility (from community or short-term hospital stay) for acute care/rehab (less than 30 days)	Close the line items in Bridgeview	Not required
Member goes into a nursing facility (from community or shorter-term hospital stay) for 30 consecutive days or more	- Close the line items and service agreement in Bridgeview - Close the waiver as of the NF admission date	Fax 6.05 on day 31 or within 24 hours of the determination that they NF stay will exceed 30 consecutive days

If a member loses NF Level of Care (which allows EW eligibility) the NFLOC statute requires a minimum of 30 days advance notice for termination of services. The Care Coordinator will:

- Send a 6.05 Notification of Potential DTR to Blue Plus within 24 hours of determination

Blue Plus UM will process the request and send the Care Coordinator a copy of the Denial Termination Reduction letter which will include the effective date (which is 30 days from the date of processing). This effective date will be used as the date of EW closure and the last date services are covered.

The Care Coordinator will duplicate the effective date given by UM to:

- Send DHS 5181 to the Member's Financial Worker.
- Enter a screening document into MMIS following instructions outlined in Bulletin 14-25-12
- Close the service agreement in Bridgeview

Grievances/Complaint Policy and Procedure

Definitions

Grievance

Grievances are verbal or written expressions of dissatisfaction about any matter other than an Action (see definition below), including but not limited to, the quality of care or services provided or failure to respect the member's rights. Some examples of grievances include: *the quality of home delivered meals (food is cold), transportation providers being late, dislike of a roommate in the nursing home, impolite staff, in ability to access services appointment, missed or delayed diagnosis, or lack of treatment.* Grievances can be filed either orally or in writing.

Grievant

The grievant is the person that is submitting the grievance for consideration. This may be a member, any individual acting on behalf of the member, or a provider with the member's written consent.

Action

An action is a denial or a limitation of an authorization of a requested service, which includes:

- The type or level of service,
- the reduction, suspension or termination of a previously approved service
- the denial, in whole or in part for the payment for a service
- The failure to provide services in a timely manner
- The failure of the health plan to act within the required timeframes for resolution of appeals and grievances.
- For a resident of a rural area with only one Health Plan, the denial of a Medicaid member's request to exercise services outside of the network.

Appeal
An appeal is a request to change a previous decision or *action* made by the health plan. Appeals may be filed orally or in writing. Anyone, including a care coordinator, who is making an appeal on behalf of a member may need an Authorized Release of Information signed by the member.

Authorized Representative
An authorized representative is an individual that is authorized by the member, or a surrogate who is acting in accordance with State law on behalf of the member in order to obtain an organization determination or deal with any level of the appeals process.

Delegate Responsibilities
The delegate must have a Policy and Procedure and system in place for handling grievances for MSHO/SecureBlue, and MSC+/Blue Advantage. A copy of written grievances, if submitted to the Delegate, must also be retained in the member's file.

A contact person will need to be established by each delegate for grievances. The contact person will be responsible to obtain any necessary information to resolve written or oral grievances submitted directly to us. The delegate must be able to retrieve records within two business days.

Required Oral Grievance Member Assistance
Care Coordinators should direct members to report all oral grievances to Blue Plus by calling member services, seven (7) days a week 8:00 a.m. to 8:00 p.m. Central Time.
Care Coordinators may also call Blue Plus to report an oral grievance on behalf of the member if the member requires assistance. MSHO/MSC+ Member services number is:

MSHO (651)-662-6013 or 1-888-740-6013 (Calls to this number are free)
TTY users call: **711** (Calls to this number are free)

MSC+ (651)-662-5545 or 1-800-711-9862 (Calls to this number are free)
TTY users call: **711** (Calls to this number are free)

Written Grievances
If a member requests the assistance of the Care Coordinator in filing a written grievance, the grievance should be transcribed in the member's words and faxed to Blue Plus Consumer Service Center within one business day of the receipt of the grievance. Fax: 651-662-9517 or call 651-662-5545 or 1-800-711-9862

The information faxed to Blue Plus should include both the written grievance and all other pertinent information or documentation related to the grievance. Blue Plus Consumer Service Center may contact the delegate for additional information during investigation of the grievance. Blue Plus 6.11 Grievance Form may be used to document the written grievance. Original documentation should be maintained on file by the delegate.

Assessment, Refusal, and Unable to Reach Tracking Process (September updates)

CMS requires reporting of initial and annual assessments, refusals and unable to reach activities for Special Needs Plans. Blue Plus requires all care coordination Delegates to track the number and type of assessments, refusals and unable to reach activities each month. Entry of the HRA information must be entered by the 10th of the following month into the Bridgeview Company's web tool. Detailed instructions for entering this information can be found in the Bridgeview manual located on their website (See Contact Information).

Assessments required to be entered include:

- Annual
- Initial
- Significant Health Change
- Product Change (MSC+ to MSHO only)
- Health Plan Change
- Refusal
- Unable to Reach (see below)

Notes on entering Unable to Reach: Before entering an Unable to Reach, the Care Coordinator must:

- Make a minimum of three attempts to contact the member via phone, e-mail, or letter to offer an HRA.
- Then mail an 8.40 Unable to Contact Letter to the member,
- The date of the Unable to Contact Letter should be the same date entered in BV and should be the same date as the activity date for the SD in MMIS.
- Document the dates for each of these attempts in Bridgeview (see notes below).
- Enter a Screening Document in MMIS using the refusal code within 45 days of enrollment or within 365 days of the previous attempts **for activity type date prior to September 1, 2017**.
- **For activity type date of September 1, 2017 or after, enter a screening document "H" with new assessment value "50" within 45 days of enrollment or within 365 days of the previous attempts**

Important tips for Unable to Reach:

1. Follow-up contacts need to be started with plenty of time to accommodate all attempts before the initial or 365-day deadline.
2. If applicable, CCs should be reaching out to other contacts to obtain a working phone number. You may document those dates in Bridgeview as phone contact attempts.
3. You may enter the same date in BV if your attempts occurred on the same date.

Additional details and instructions can be found on the Blue Plus Care Coordination Portal www.bluecrossmn.com/carecoordination. Click on Access Trainings. If you have any questions, contact your Partner Relations Consultant.

Requests to exceed Case Mix Budget Cap

If a member has a unique set of assessed needs that require care plan services above their budget cap, a request for a higher monthly case mix budget cap may be submitted to Blue Plus for review and consideration. It is expected that the Care Coordinator has a discussion with the member/authorized rep and has already considered reducing various services to keep all EW service costs within the Case Mix Cap before submitting a request. If needed, the Care Coordinator should consult with their supervisor or a member of the Partner Relations team to decide if they indeed wish to submit a request to exceed. If the member requests to exceed Cap and the Care Coordinator determines there is no assessed need, then they should send in the Notification of Potential DTR form. Note: requests to exceed published Customized Living or 24 Customized Living rate limits are unallowable unless as part of an approved Conversion rate request.

First-time requests must take place prior to the service initiation. A reauthorization request of a previously approved rate must be made at least 30 days prior to the end of the current authorization period.

To request an exception to the case mix cap, the Care Coordinator must fax the following information to the attention of **EW Review Team,** at 651-662-6054 or 1-866-800-1665 following the time frames above:

- 6.27 Request to Exceed Case Mix Cap/Conversion Request form
- Care Coordination case notes for previous 2 months
- Member's LTCC assessment completed within the previous 60 days
- Member's Collaborative Care Plan
- A description of what other options within the member's current budget have been considered and why they are not possible
- A copy of Residential Services tool, if applicable (CL rate must be within CL rate limits with the exception of EW Conversion rate requests)
- A copy of the member's PCA assessment (if applicable)
- Any other supporting documents deemed appropriate
- Other documents requested by the EW Review Team

The Blue Plus Review Team will:

1. Review the request within 10 business days/14 calendar days, whichever is sooner, of the receipt of all the required information/documents
2. Confer with the Care Coordinator if the documentation provided does not support the requested level of service
3. Consult with the submitting Care Coordinator to ask for clarification or request further documentation as needed
4. Consult with the Medical Management Medical Director as needed
5. Approve, deny, or recommend a change in the budget rate request.

6. If request is approved, Review Team will determine the length of time for the approval. Requests to exceed the case mix cap approval period will be determined based on the member needs and reason for exception, not to exceed a twelve month period

EW Review Team will then:

1. Send notification to Bridgeview Company
2. Send notification to Care Coordinator

The Care Coordinator must:

1. Place the full CAP amount (rather than the approved amount that exceeds case mix cap) in the Case Mix/DRG Amount field on the LTC screening document.
2. Update the LTCC case mix section in Bridgeview. Use Case Mix Z with the approval date span as determined by the EW review team.

If the request is not approved, the EW Review Team will:

a. Advise the Care Coordinator on how to assist the member to look at other options which may include adjusting the level of service to more appropriately reflect the documented need and/or explore other provider options.
b. Blue Plus Medical Management will then issue a Denial, Termination, or Reduction (DTR) letter to the member and Care Coordinator within 10 business days/14calendar days, whichever is sooner, of the receipt of all the required information/documents.

Withdrawals:

If at any time the Care Coordinator decides to withdraw the Request to Exceed Case Mix Budget Cap prior to the authorized end date, the Care Coordinator must:

- Communicate the withdrawal request in writing to Partner.Relations@bluecrossmn.com Be sure to include:
  - Member Name
  - Member ID number
  - Date of initial request
  - Request to Exceed Case Mix Cap Z end date
  - Modified MA plan services amount for the case mix cap Z span that is ending
  - New Case Mix Cap (after removal of case mix cap Z)
  - New Case Mix Cap date span (to and from date)
  - Adjusted MA plan services for the remainder of the New Case Mix Cap EW span
  - Reason for withdrawal (Examples: no changes in services but due to DHS Annual COLA increase the member no longer exceeds their case mix cap; member initiated a reduction in current services; member expired and no longer needs request to exceed case mix cap, etc.)
- Update the member's service agreement(s) in Bridgeview for the remainder of the EW span date after the withdrawal effective date.

The EW Review Team will send the withdrawal notification to Bridgeview to make the rest of the necessary changes. A representative from Bridgeview will make the changes and reach out to the Care Coordinator to review for accuracy. The Care Coordinator is responsible to ensure the information in Bridgeview is correct.

The EW Review Team will notify the Care Coordinator via a confirmation notification email.

EW Conversion Requests

First-time Conversion requests must take place prior to the service initiation. A reauthorization request of a previously approved rate must be made at least 30 days prior to the end of the current authorization period.

To request Conversion rate, the Care Coordinator must fax the following information to the attention of **EW Review Team,** at 651-662-6054 or 1-866-800-1665 following the time frames above:

- DHS-3956 Elderly Waiver Conversion Rate Request **or** DHS -3956A Elderly Waiver Consumer Directed Community Supports (CDCS) Conversion Rate Request (both available on DHS e-Docs, fax all conversion rate requests forms to 651-662-6054, do not fax or send to DHS)
- 6.27 Request to Exceed Case Mix Cap/Conversion Request form
- Care Coordination case notes for previous 2 months
- Member's LTCC assessment completed within the previous 60 days
- Member's Collaborative Care Plan
- A description of what other options within the member's current budget have been considered and why they are not possible
- A copy of Residential Services tool, (if applicable)
- A copy of the member's PCA assessment (if applicable)
- Any other supporting documents deemed appropriate
- Other documents requested by the EW Review Team

The Blue Plus Review Team will:

1. Review the request within 10 business days/14 calendar days, whichever is sooner, <u>of the receipt of all the required information/documents</u>
2. Confer with the Care Coordinator if the documentation provided does not support the requested level of service
3. Consult with the submitting Care Coordinator to ask for clarification or request further documentation as needed
4. Consult with the Medical Management Medical Director as needed
5. Approve, deny, or recommend a change in the budget rate request
6. If request is approved, Review Team will determine the length of time for the approval.
    a. <u>Initial Conversion Rate</u> for members transitioning out of a nursing facility, authorization will be given for a six month period. This will allow the Care Coordinator and the EW Review team time to determine if the member is stable in their new community environment and if services and rates need to be adjusted to meet any changes in the identified needs of the member
    b. <u>Reauthorization without Change in Level of Service:</u> If the EW Review team agrees with the level of services authorized for members who have previously transitioned to the community using an approved EW conversion budget, Blue Plus will reauthorize

the budget for a twelve month period. This applies to current and newly enrolled MSC+ /MSHO members

c. Reauthorization with Change in Level of Service: If the EW Review Team assesses the member to need a different level service than what was previously authorized for a member who has transitioned to the community using an approved EW conversion budget, the authorization period will be for six months. This will allow the Care Coordinator and the EW Review Ream time to determine if the member is stable with the new service levels and if services and rates need to be adjusted to meet any changes in the identified needs of the member

EW Review Team will then:

- Send notification to Bridgeview Company
- Send notification to Care Coordinator

The Care Coordinator must:

1. Place the full CAP amount (rather than the higher conversion rate) in the Case Mix/DRG Amount field on the LTC screening document.
2. Update the LTCC case mix section in Bridgeview. Use Case Mix Z with the approval date span as determined by the EW review team.
3. For approved Conversion Requests when a member will/does reside in Customized Living, the Care Coordinator must fully complete the CL workbook pages concerning the authorization of monthly conversion budget limits.

If the request is not approved, the EW Review Team will:

1. Advise the Care Coordinator on how to assist the member to look at other options which may include adjusting the level of service to more appropriately reflect the documented need and/or explore other provider options.
2. Blue Plus Medical Management will then issue a Denial, Termination, or Reduction (DTR) letter to the member and Care Coordinator within 10 business days/14calendar days, whichever is sooner, of the receipt of all the required information/documents.

Withdrawals:

If at any time the Care Coordinator decides to withdraw the Conversion request prior to the authorized end date, the Care Coordinator must:

1. Communicate the withdrawal request in writing to Partner.Relations@bluecrossmn.com
   Be sure to include:
   - Member Name
   - Member ID number
   - Date of initial request
   - Case Mix Cap Z end date
   - Modified MA plan services amount for the case mix cap Z span that is ending
   - New Case Mix Cap (after removal of case mix cap Z)
   - New Case Mix Cap date span (to and from date)
   - Adjusted MA plan services for the remainder of the New Case Mix Cap EW span
   - Reason for withdrawal (Examples: no changes in services but due to DHS Annual COLA increase the member no longer exceeds their case mix cap;

member initiated a reduction in current services; member expired and no longer needs request to exceed case mix cap, etc.)

2. Update the member's service agreement(s) in Bridgeview for the remainder of the EW span date after the withdrawal effective date.

The EW Review Team will send the withdrawal notification to Bridgeview to make the rest of the necessary changes. A representative from Bridgeview will make the changes and reach out to the Care Coordinator to review for accuracy. The Care Coordinator is responsible to ensure the information in Bridgeview is correct.

The EW Review Team will notify the Care Coordinator via a confirmation notification email.

Interpreter Services

The Blue Plus contract with the Minnesota Department of Human Services requires that persons with limited English proficiency receive language assistance as necessary. If a Blue Plus member does not speak English as their primary language and has a limited ability to read, speak, write or understand English, the Care Coordinator may initiate the use of a Blue Plus contracted interpreter to assist in assessment, care planning and on-going care coordination. Blue Plus prefers the use of a formal interpreter over a family member, as best practice.
To initiate the process for interpreters or for any questions contact our Member Services at 651-662-6013 or 1-888-740-6013.

For Face-to-Face Interpreters: The Care Coordinator can also initiate the process by contacting an in-network provider directly.

For Over-the-Phone Interpreters: The Care Coordinator may contact Via Language as described in the instructions provided by your Partner Relations Consultant.

If the Blue Plus member is requesting information about the use of an interpreter for their medical appointments (such as a clinic visit), the member should be directed to Member Services.

Moving Home Minnesota

Moving Home Minnesota (MHM) is a DHS/CMS demonstration project offered to reduce or eliminate barriers to receiving long-term care services in home and community settings rather than in institutional settings.

Eligibility requirements for MHM include:

- Member has resided for a minimum of 90 consecutive days (exclusive of Medicare rehab days) in one or more of the following settings:

    - Intermediate care facility for individuals with developmental disabilities (ICF/DD)
    - Nursing facility
    - Hospitals, including community behavioral health hospitals
    - Institution for Mental Disease (i.e. Anoka Metro Regional Treatment Center)
- Member meets eligibility requirements for MA at time of discharge
- Member opens to the Elderly Waiver at the time of discharge
- MA has paid for at least one day of institutional services prior to leaving the facility
- Member is transitioning to one of the following settings:
    - Home owned or leased by the individual or individual's family member
    - Apartment with an individual lease with lockable access and egress which includes living, sleeping, bathing, and cooking areas over which the individual or individual's family has domain and control
    - A residence in a community based residential setting in which no more than four unrelated individuals reside

The Care Coordinator's role is to assist the member in accessing the services available with this program. The Care Coordinator creates a plan that identifies the person's need and wants and arranges for the services and supports to meet those needs. The Care coordinator shall authorize the services in accordance with the eligibility requirements and information available on the DHS website:

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_162194

The Care Coordinators can authorize the Moving Home Minnesota service or support and document it in the members care plan; no service agreement in Bridgeview nor prior authorization notification to Blue Plus is needed. Thus, the Care Coordinator must inform the MHM provider of the amount, duration, and frequency of the authorization. For services authorized under EW, follow the usual process of creating a service agreement in the Bridgeview web tool.

Notes related to billing:

- Claims for MHM services are to be submitted to BluePlus by the MHM provider
- EW claims should be submitted to Bridgeview per the normal process.

Out-of-Home Respite Care—Community Emergency or Disaster

In the event of a community emergency or disaster that requires an emergency need to relocate a member, and a currently licensed out-of-home respite provider is not available, out-of-home respite services may be provided in an unlicensed facility/home. Contrary to normal out-of-home respite practice, a caregiver may reside in the same temporary location as the member. The primary caregiver may not be paid to provide respite services. Requests for out-of-home respite services in these rare circumstances must be approved by Blue Plus.

To request out-of-home respite care for a member because of a community disaster:

a) Care Coordinator contacts their Partner Relations Consultant to discuss the specific situation of any member(s).
b) Partner Relations Consultant works with DHS staff to present situation and request the necessary approvals.
c) Partner Relations Consultant communicates decision to Care Coordinator.

Note: The DHS Commissioner must approve all requests as a necessary expenditure related to the emergency or disaster. The DHS Commissioner may waive other limitations on this service in order to ensure that necessary expenditures related to protecting the health and safety of members are reimbursed. In the event of an emergency involving the relocation of waiver participants, the Commissioner may approve the provision of respite services by unlicensed providers on a short-term, temporary basis.

OTHER CARE COORDINATION RESPONSIBILITIES

1. QIPs—The Care Coordinator will participate in the on-going performance improvement projects that are designed to achieve significant favorable health outcomes for members. These projects incorporate standards and guidelines outlined by the Centers for Medicare and Medicaid (CMS) with input by the Minnesota Department of Human Services (DHS).
2. Vulnerable Persons Reporting. It is the duty of mandated reporters to report suspected maltreatment of a vulnerable adult or child. Minnesota has a new central system for reporting suspected maltreatment of vulnerable adults. Call 844-880-1574 or go to mn.gov/dhs/reportadultabuse/
   Web-based training is available at no cost to all mandated reporters:
   http://registrations.dhs.state.mn.us/WebManRpt/ for adults; and
   http://www.dhs.state.mn.us/id_000152 for children
3. Documentation—The Care Coordinator shall document all activities in the member's case notes.
4. The Care Coordinator shall comply with any applicable Federal and State laws that pertain to member rights including HIPAA laws and the Minnesota Data Privacy Act and your organization's confidentiality policy.
5. The Care Coordinator should be coordinating with local agency case managers (mental health, developmental disabilities, adult protection, etc), financial workers and other staff as necessary to meet the member's needs. This includes using the Case Manager/Financial Worker Communication Form (DHS # 5181) when:
   - A member requests waiver services
   - A member receiving waiver services has a change in circumstances (exits waiver, moves to SNF, expires, etc)
   - For more information refer to DHS Bulletin #07-21-09

Out of Network Providers

Blue Plus Network

Blue Plus members do not have out of network benefits for services that are not emergent/urgent. (i.e., Our member, Mildred, is visiting her daughter in Missouri and needs outpatient I.V. therapy. This service is not emergent/urgent and thus would not be covered)

Note: Questions related to in-network providers and benefit questions should be directed to Provider Services at 1-800-262-0820 or 651-662-5200.

Out of Country Care—Medicaid. Medicaid payments, including EW, will not be made:

1. For services delivered or items supplied outside of the United States; or
2. To a provider, financial institution, or entity located outside of the United States.

United States includes the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Reminder: Any Benefit questions should be directed to Member Services.

Audit Process

The BluePlus contract with DHS and CMS requires the auditing of care coordination activities on an annual basis.

Care Systems Review:
Each delegate will be asked to submit documentation related to the elements selected. Documentation may include Policies and Procedures, case load statistics, job descriptions, elderly waiver vendor lists, or other supporting documentation. Partner Relations staff will review the submitted documentation to determine whether or not it meets the contractual requirements. This review may be done on-site during the on-site audit or as part of a desk review.

On-site Care Plan Audit process:
Partner Relations Lead Auditor will conduct an annual Delegate site visit. During the visit the designated staff will conduct care coordination system and care plan audits for elderly waiver and community well members using the DHS approved MSHO and MSC+ EW Care Planning Audit Data Abstraction Protocol and Tool. They will also conduct audits for nursing home (if applicable) members using Nursing Facility Member Chart Review Audit Tool.

Elderly Waiver members

- Review of selected members' files, using an established statistical process of an 8/30 record review sampling methodology. If any element is missing or not met in the first 8 records, another 22 records will be pulled and reviewed in the areas not met in the initial sample.

Community Well and Nursing Home (if applicable) members

- Review of a random sampling of 5 records for each population. If any element is missing or not met in those 5 records, another 5 records will be reviewed in the areas not met in the initial sample.
- If Delegate only serves Nursing Home members, review selected member files using an established statistical process of an 8/30 record review sampling methodology will be used. If any element is missing or not met in the first 8 records, another 22 records will be pulled and reviewed in the areas not met in the initial sample.

If a problem or findings are identified during assessment, the Delegate will be required to respond to Blue Plus with a Corrective Action Plan" (CAP) meaning a list of actions and an associated timetable for implementation to remedy a specific problem, which includes a root cause analysis, interventions, necessary tasks required for improvement, the person responsible for resolution and a timetable for resolution. Findings are defined as an area of non-compliance discovered through assessment or other means related to a regulation, statute, policy, procedure, contract or sample review for a given requirement or obligation, including Care Coordination guideline and requirements. Mandatory Improvements will also be noted and are defined as an action that must be taken in order to resolve an issue identified through auditing and monitoring, which does not meet the criteria for a CAP. These are required actions in order to prevent the risk of a future Finding. For example, unclear or incomplete Policies and Procedures or sample documentation. A CAP may be assigned to resolve Findings or mitigate compliance risks when one or more of the following apply: 1) the 95.00% compliance standard for samples is not met. 2) Policies and procedures are not documented, 3) beneficiary's rights are impacted, 4) there is a repeat finding from a previous assessment or monitoring, 5) compliance issues that are related to a high risk area, where swift correction of the action is required. Each Delegate will be required to provide a written response within 1 month of receipt of the written audit results if there are Findings or Mandatory Improvements. Although there may be an identify a need for ongoing interventions to make corrections for some of the finding areas, target end dates for completion and correction must be within 3 months of the start date of the described intervention. It is the responsibility of each delegate to alert Blue Plus with the completion dates of the corrective actions implemented.

Records Retention Policy

The Delegate must have policies and procedures to address record retention in accordance with DHS and Center for Medicare and Medicaid Services rules and regulations. Files, either in electronic or hard copy format, are to be kept for 10 years from the date the files are closed. After 10 years the files may be destroyed.

- File information includes: patient identification information, provider information, clinical information, and approval notification information.
- All documents pertaining to pending litigation or a regulatory matter must be retained despite general disposal policy until Blue Plus advises that such documents may be returned to the general disposal policy.

Care Coordination Services Overview

The Care Coordinator will work with the member with support from Medical Management staff and/or Government Programs staff to assure that the member has access to the following services as needed:

- Rehabilitative Services. These are services that promote the rehabilitation of members following acute events and for ensuring the smooth transition and coordination of information between acute, sub-acute rehabilitation, nursing home and community settings.
- Range of Choices. The care coordinator is key in ensuring access to an adequate range of choices for members by helping the member identify formal as well as informal supports and services, ensuring that the services are culturally sensitive. Interpreter services are available for all BluePlus members.
- Coordination with Social Services. The Care Coordinator will collaborate with the local Social Service Agency when the member may require any of the following services:
    - Pre-petition Screening
    - OBRA Level II Screening
    - Spousal Impoverishment Assessments
    - Adult Foster Care
    - Group Residential Housing and Board Payments; or
    - Extended Care or Halfway House Services covered by the Consolidated Chemical Dependency Treatment Fund
    - Targeted Mental Health Case Management
    - Adult Protection
- Coordination with Veteran's Administration (VA). The Care Coordinator shall coordinate services and supports with those provided by the VA if known and available to the member.
- If the Care Coordinator receives notification of a member's hospital admission, contact will be made with the hospital social worker/ discharge planner, to assist with discharge planning. The Care Coordinator can work with the discharge planner, member or home care nurse (if appropriate) to complete the following:
    - Assess the member's medical condition;
    - Identify any significant health changes;
    - Reassess and revise the CSP for the member to meet their new health needs, if required; and
    - Schedule an interdisciplinary team conference, if needed at this time.
- Identification of Special Needs and Referrals to Specialists. The Care Coordinator should have the ability to identify special needs that are common geriatric medical conditions and functional problems such as polypharmacy issues, lack of social supports, high risk health conditions, cognitive problems, etc. and assist the member in obtaining specialized services to meet identified needs.

Care Plan Service and Guidelines

Delegate staff use professional judgment interpreting the following guidelines to make decisions related to the care and treatment of their SecureBlue members:

- MN rules and statutes,
- DHS policies and training,
- County program training and guidelines,
- Provider training and guidelines,
- Medicare coverage criteria,
- Long Term Care Screening Document,
- Disease Management protocols,
- Case mix caps/budget, and
- SecureBlue Certificate of Coverage
- SecureBlue Model of Care training and guidelines