Care Coordination Delegation Guidelines for Members in a Nursing Facility

Secure Blue—MSHO
Minnesota Senior Health Options

2017—September

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CONTACT INFORMATION

Care Coordination Portal www.bluecrossmn.com/carecoordination	1. Access guidelines, enrollment checklists, forms, letters, resources 2. Links to: a. Webinar training recordings b. 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/	1. Elderly Waiver service agreement/claims processing questions 2. Questions about adding/deleting security and access 3. EW provider billing issues
Clinical Guide Resource Team 1-866-518-8447 Clinical.guide.resource.team@bluecrossmn.com	4. Member specific questions/issues 5. Blue Plus & community resources: i.e. formulary questions, transportation alternatives, etc. 6. 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	1. Confirm/Change Primary Care Clinics 2. Benefits questions 3. Interpreter services 4. 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	7. Contact for general Care Coordination process questions. 8. Liaison for counties and care systems in the Blue Plus service area. 9. 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

Care Coordination: *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. Examples include, but are not limited to: monthly Nursing Home assessment tracking form, Quality Improvement Project reporting, enrollment report discrepancies, Hospice care plans, missing residential service living tools, and late screening document entry follow up.*

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 and 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.

- 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.
- 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).

- 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:

- 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.
- 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).
- 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.

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

Blue Plus members living in a Veteran Administration 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

1. One face-to-face visit per year at minimum
2. One six-month member contact per year at minimum. The Care Coordinator may use the 6.21 Nursing Home Follow-up Contact form or document in case notes. This contact may be over the phone, face to face or at a care conference.
3. As needed per significant changes in member's health status. The Care Coordinator may also use the above-mentioned form to document any subsequent contacts or document in case notes.

General Contact Requirements—Physician (September updates)

1. Within 90 days of enrollment the care coordinator shall send 8.28 Intro to Doctor or, for clinic delegates, notification to primary care physician per clinic process.
2. **When there is a change in Care Coordinator, send 8.28 Intro to Doctor or, for clinic delegates, notification to primary care physician per clinic process.**
3. As needed for Transitions of Care (see Page 13).

INITIAL CONTACT WITH NEW MSHO ENROLLEE

- The Delegate is responsible to verify member's eligibility prior to delivering Care Coordination services
- Use the following optional checklist: 6.12 CW EW Checklist SB
- Delegate will inform the member of the name, number, and availability of the Care Coordinator within 10 days of notification of enrollment
- Welcome call/letter (8.22 Intro Letter) to member within 30 days after notification of enrollment
- Explanation of Care Coordinator's role. Optional resource: 6.01 Welcome Call Talking Points.
- 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.

- Discuss In-Home Assessment Program (See page 10 for details on this program)
- 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 days of enrollment date OR if delegate receives late notice of enrollment, within 30 days of this notification

HEALTH RISK ASSESSMENT AND CARE PLAN RESPONSIBILITIES

Scheduling an Assessment/Care Plan Review of the Member

- New Enrollee: 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 schedule a visit to the facility and conduct an assessment/care plan review with each new member. If a member switches Blue Plus Products (MSC+ to MSHO or MSHO to

MSC+) they are considered a new enrollee and an assessment/care plan review should be done within timeframe listed above. See Comprehensive Assessment section below.

- New nursing home admission/determination of long term placement: The Care Coordinator shall conduct an assessment when a member transfers from the community to long-term placement in a skilled nursing facility. This assessment should be conducted:
    - Within **45** days of notification of long term placement; or,
    - Within **45** days of the transfer effective date if the long term placement results in a transfer of Care Coordination Delegation; or
    - Within **365** days of the previous assessment, whichever is sooner.

  In the case of a transfer of care coordination, the date of the previous LTCC or face to face assessment shall be indicated on the form 6.08 Transfer in Care Coordination Delegation and otherwise communicated as a part of the process outlined in section: Transfer of Care Coordination to Another Delegate.
- The member visit should include but is not limited to the following: the assessment; a review of the member's record; interview of the member, member's family and guardian (if applicable); review role of care coordinator; review supplemental benefits, and interview facility staff.

Comprehensive Health Risk Assessment

The Care Coordinator will complete a thorough assessment of the member's needs which addresses all pertinent medical, social, behavioral, environmental and health issues.

- The Care Coordinator will document this assessment by completing the form entitled 6.15 NH Member Annual Assessment Care Plan Review.
- **Note:** If the member switches products (MSHO to MSC+ or MSC+ to MSHO) this is considered a new enrollment and a new 6.15 NH Member Annual Assessment Care Plan Review form must be completed within the required new member assessment time frames.
- This assessment must include participation by both the member and nursing facility staff. (Should be documented in space provided on form 6.15.)
- In-home Assessment discussion (see page 10 for details on this program).
- The assessment may be conducted by a geriatric nurse practitioner as a part of a health history and exam provided it also addresses all components mentioned above.
- 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.

Care Planning

The SecureBlue Care Coordinator must review the nursing facility's care plan and ensure that it both identifies the member's needs in a way that maximizes the member's inclusion, self-determination and choice and should incorporate an interdisciplinary, holistic, and preventive focus. The Care Coordinator facilitates the integration of these concepts into the plan of care if

they are found to be missing upon review. By thoroughly completing all sections of the 6.15 NH Member Annual Assessment form while reviewing the facility care plan, the Care Coordinator can determine if the facility care plan is addressing all of the required elements listed below:

1. The member's goals, interventions, and target dates for meeting their goals
2. The care plan should incorporate a preventative focus employing a thorough plan for addressing the health and safety needs of the members including but not limited to: diagnoses, medications, immunizations, nutritional needs, alcohol and tobacco usage, fall risk, etc. The care plan should have a person-centered focus and should include informal and formal supports as applicable.
3. The care plan or nursing facility member record should indicate advance directive planning for the member. The Care Coordinator should be prepared to initiate ongoing discussion with the member and/or authorized family members or guardians when the lack of a documented advance directive is identified through the care plan review process. The Care Coordinator can enlist the assistance of the primary care physician in helping the member with advance directive planning as well. The Care Coordinator may also use the resource optional 9.19 BCBSMN Advanced Directive and cover letter 8.27 Advanced Directive Letter to Member.
4. The Care Coordinator works in partnership with the member, authorized family members or guardians, primary care physicians and in consultation with other specialists and providers in caring for the member. The Care Coordinator should provide documentation of this consultation in the member's file.

In-Home Assessment Program (September updates)

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

Reassessment

- The Delegate is responsible to verify member's eligibility prior to delivering Care Coordination services.
- Annual reassessments must be conducted within 365* days of the previous assessment. The Care Coordinator may use form 6.15 NH Member Annual Assessment.
- In addition to monitoring progress and reviewing any health status changes, the Care Coordinator should also be evaluating and adjusting the timeliness and adequacy of the services the member is receiving by soliciting and analyzing relevant information from all sources including the member and the nursing facility staff.
- 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.

- 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.
- The Care Coordinator should be communicating effectively with the member as well as the member's interdisciplinary team to promote good health care.

*If member is temporarily in the 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.

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 (September updates)

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 provides annual, in-person Fall Training to meet the CMS SNP-MOC training requirement for on the SNP-MOC to 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.

- 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: Transfers in Care Coordination to another Delegate which will include sending in form 6.08 Transfer in Care Coordination Delegation.
The following PCCs currently provide care coordination:

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- Fairview Partners (select customized living and nursing home)
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- HealthEast
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- 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 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 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 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

- 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:
    - services currently received by the member and who provides them;
    - the name of the Primary Care Provider/Specialty Care Provider to use as a resource for current medications, chronic conditions, and current treatments;
    - The Care Coordinator contact information and a brief explanation of their role in assisting the member with care transitions.
    - Work with the discharge planner to ensure continuity in home care and home and community based services, if needed, upon discharge.
    - 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.

- 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.

- Discuss care transition process including the role of the Care Coordinator
- 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.),
- 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.
- 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:

- 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.
- 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.
- 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.

- 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.
    - 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

Communication 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.

Communication 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:

1. Appeal Determinations prior to services being rendered—Informational only
2. 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.
3. 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 initiating the transfer:

- 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)

- 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.
- 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 Transferring 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:
1. Keep the waiver span open in MMIS if the member remains eligible for EW
2. 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.
3. 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 13 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:**

- 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.
- Enter the name of the assigned Care Coordinator in Bridgeview following the process outlined in the Bridgeview manual.
- Must update the Screening Document to reflect the change in Care Coordinator, if applicable.
- Notify the financial worker of the assigned Care Coordinator's name.
- Notify the physician using 8.28 Intro to Doctor Letter.
- 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.
- 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.
- 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.
- 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:

- The **transferring** Care Coordinator is required, at a minimum, to share the following **directly** with the 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.

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

- If the member is open to EW, the **transferring** Care Coordinator should:
  4. Keep the waiver span open in MMIS if the member remains eligible for EW

5. 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.
6. Close service agreement(s) that are no longer applicable.

- 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 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:

- EW members who are permanently moving into a nursing facility
- CW members who are moving residences
- 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:

1. Evaluate the member's needs,

2. Build and share the Summary with the member,
3. Update the My Move Plan Summary,
4. Update the Collaborative Care Plan (if applicable)
5. Communicate information to others involved (if applicable), and
6. 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:

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

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

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.

Discharge Planning

The Care Coordinator shall coordinate an LTCC assessment within 20 days of the member's request for Home and Community Based Services (EW services). If the Care Coordinator currently following the member does not administer the LTCC, they are responsible for contacting the local Blue Plus Delegate who conducts the assessment. If you are unsure who the local Assessor is, contact your Partner Relations Consultant.

It is Blue Plus' expectation that both the nursing home Care Coordinator and the Assessor work together to complete all discharge planning.

The primary responsibilities of the Assessor are:

- Complete the LTCC and determining EW eligibility
- Develop the Collaborative Care Plan
- Coordinate any home care and EW services
- Complete Residential Services tool, if applicable
- Initiate the My Move Plan Summary if member will be going on the Elderly Waiver.

The Nursing Home Care Coordinator should:

- Complete TOC activities and TOC log
- Act as a resource and share information with the assessor as needed
- Upon discharge, initiate the transfer process including sending in form 6.08 and updating the PCC, if needed. Refer to Transfers section of the guidelines.

And, may assist the Assessor with the following tasks, if applicable:

- Locate another living arrangement
- Coordinate any physician discharge orders
- Assure member's pharmacy needs are in place post discharge
- Arrange transportation for day of discharge
- Coordinate any post discharge follow up appointments
- Coordinate any medical supply or equipment needs

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:

1) Home owned or leased by the individual or individual's family member.
2) 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.
3) 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:

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

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.

Assessment, Refusal, and Unable to Reach Tracking Process

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:
1. Annual
2. Initial
3. Significant Health Change
4. Product Change (MSC+ to MSHO only)
5. Health Plan Change

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.Continue care coordination activities if member is on MSHO through 90-day grace period.

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. 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

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:

- Notify Financial Worker via DHS 5181
- Close case file

Term due to lapse in MA coverage:

- **Continue care coordination activities as long as member is actively enrolled on MSHO through 90-day grace period.**

MA closing and will not reopen:

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

OTHER CARE COORDINATION RESPONSIBILITIES

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 CMS 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 will include: patient identification information, provider information, clinical information, approval notification information. All documents pertaining to pending litigation or a regulatory matter must be retained despite general disposal policy until BluePlus advises that such documents may be returned to the general disposal policy**.**

ON-GOING 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 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. The Care Coordinator should be informed and able to assist the member in identifying service providers and accessing needed resources beyond the limitations of formal services available through traditional funding sources.

4. The Care Coordinator will collaborate with other care coordinators as needed to assure smooth transitions for the member among various settings.
5. The Care Coordinator documents his or her care coordination activities with the documentation standards as set forth by their profession.
6. 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.
7. The Care Coordinator will work with the member with support from Medical Management staff and/or Government Programs Partner Relations 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 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 (i.e., those typically funded by Medicare, Medical Assistance, etc.) as well as informal supports and services. The Care Coordinator also informs the member of available community resources as applicable to assist in developing a plan of care. Thus, the Care Coordinator determines and arranges with the member the needed services, ensuring that the services are culturally sensitive. Interpreter services are available for all BluePlus members.

    Coordination with Social Service Needs. The Care Coordinator will collaborate with the local social service agency when the member may require any of the following services:

1. Pre-petition Screening
2. OBRA Level II Screening
3. Spousal Impoverishment Assessments
4. Adult Foster Care
5. Group Residential Housing and Board Payments; or
6. Extended Care of Halfway House Services covered by the Consolidated Chemical Dependency Treatment Fund
7. Targeted Mental Health Case Management
8. Adult Protection
9. Relocation Screening for community services

8. **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.
9. **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. If the Care Coordinator identifies such a need exists and is not being addressed, he or she should then assist the member in obtaining the needed services.

Care Plan Services and Guidelines

The delegate staff uses professional judgment interpreting the following guidelines to make decisions related to the care and treatment of their SecureBlue members. The Delegate can use internal and external sources to ensure decisions are objective, consistent and meet current medical standards and/or practices. The following list includes examples that are not all inclusive:

MN rules and statutes,
Federal regulations,
Omnibus Budget Reconciliation Act (OBRA) Level I
DHS policies and training,
Institute for Clinical Systems Improvement (ICSI) guidelines
Medicare Coverage criteria,
Certificate of Coverage
SecureBlue Model of Care training and guidelines