



Community Care Coordination Guidelines

Secure Blue - MSHO
(Minnesota Senior Health Options)

Blue Advantage - MSC+
(Minnesota Senior Care Plus)

September 2018

Table of Contents

Contact Information	6
Definitions	7
Blue Plus SecureBlue Model of Care (SNP-MOC) Policies and Procedures	9
Special Needs Plans Model of Care (SNP-MOC) Training.....	9
Person-Centered Practice and Planning Requirements.....	10
Delegate Responsibilities upon Notification of Enrollment	10
Blue Plus members living in a Veteran Administration Nursing Home	12
Contact Requirements	12
Member Contact	12
Physician Contact Requirements.....	13
Initial Contact with New MSHO and MSC+ Enrollee.....	13
In-Home Assessment Program MSHO members only	14
Health Risk Assessment	15
Health Risk Assessment options	15
Health Risk Assessment requirements	16
Long Term Care Consultation (LTCC DHS Form 3428).....	16
6.28 Transitional Health Risk Assessment.....	16
Minnesota Health Risk Assessment Form - DHS 3428H.....	17
CW Refusals.....	19
ICF/DD and non-EW HCBS Waiver Refusals	19
CW Unable to Reach	19
Telephonic Health Risk Assessment – DHS 3428H.....	20
Reassessments.....	21
Entry of LTC Screening Document information into MMIS	22
MMIS Reminders:.....	22
Timeline for MMIS entry	22
New Community Well (non-Elderly Waiver) enrollees.....	22
Assessment entry for all members on EW	22
Assessment entry for community members <i>opening to EW for the first time</i> (assessment result 01)	23
Community Well members	23

CW Refusals	24
CW Unable to Reach.....	24
CW Refusing face to face visit but consents to telephonic HRA using DHS 3428H.....	24
Instructions for updating MMIS Entry for Transitional HRA or Change in Care Coordinator.....	24
Comprehensive Care Plan (CCP)	25
Care Planning requirements	26
Collaborative Care Plan components	26
Provider and Member Signature Requirements (See 9.15 Provider Signature FAQ Resource).....	27
Home Health Care Authorization Processes	28
Medicare Skilled Home Care Services.....	28
Medical Assistance State Plan Home Care Services	28
Care Coordinator Role:	29
Process for Care Coordinator <i>Notification</i> to Blue Plus of Home Care Authorizations.	29
Process for Care Coordinator <i>Prior Authorization Request</i>	30
New enrollees with previously approved state plan home care services.....	30
Members on Elderly Waiver receiving state plan home care services	30
Elderly Waiver Extended Home Care Services	31
PCA Authorization Processes	31
PCA requirements:	32
New enrollees with existing PCA authorizations:	32
New PCA authorization requests for current enrollees:.....	32
Re-assessment PCA authorization requests:.....	33
Change in PCA Provider:	33
PCA Temporary Start/Temporary Increase:.....	33
PCA Denial, Termination, Reduction (DTR):.....	33
Extended PCA Requests for members on EW:	34
Elderly Waiver Authorizations	34
MHCP Enrolled Providers.....	34
Approval-Option Service Providers	35
Service Agreements.....	35
Waiver Obligation	35

MA services included in EW Case Mix Cap.....	36
Requests to exceed Case Mix Budget Cap	36
Process to request an exception to Case Mix Budget Cap	37
Withdrawal of a request to exceed case mix cap.....	38
EW Conversion Requests	38
Process to request EW Conversion Rate.....	39
Process to withdrawal EW Conversion Rate	40
Elderly Waiver Services	41
Consumer Directed Community Supports (CDCS)	41
Home and Vehicle Modifications	41
EW Specialized Equipment and Supplies (T2029).....	42
EW T2029 authorization process for: Single EW items less than \$500	42
EW T2029 authorization process for: Single EW items over \$500 and/or Exceptions to EW T2029	
Coverage Guide	43
Prior Authorization Process for Lift Chair and Mechanism.....	44
Lift Chair/Mechanism Process Flow	46
Customized Living, Foster Care and Residential Care Services	46
Nursing Facility Level of Care	47
Essential Community Supports	47
On-Going Care Coordination Responsibilities.....	48
Primary Care Clinic (PCC) Change	48
Transitions of Care (TOC).....	48
Care Coordination TOC Documentation Responsibilities:	49
Pre-Admission Screening activities.....	51
Transfers.....	51
Transfers of Care Coordination to Another Blue Plus Delegate	51
Responsibilities of the Care Coordination Delegate who is receiving the transfer ..	53
Moving out of the Blue Plus service area	54
Transfers of Care Coordination within your agency	55
My Move Plan Summary.....	55
EW reassessments and termination of MA eligibility	56

Case Closure Care Coordination Responsibilities	57
Term due to death:.....	57
Term due to a move out of the Blue Plus Service area:.....	57
Term due to a move out of state or out of country:.....	57
Term due to lapse in MA coverage for EW members:	57
Term due to lapse in MA coverage for CW Members on MSHO	58
Term due to lapse in MA coverage for CW Members on MSC+:	58
MA closing and will not reopen:	58
Term due to health plan change:	58
90 Day Grace Period (MSHO only).....	58
DTRs—Coordination of Potential Denials, Terminations, and Reduction of Services	59
DTR Decision guide.....	59
DTR Reference Guide for Hospital or Nursing Home Stays	60
Grievances/Complaints Policy and Procedure	61
Member and Provider Appeals	63
Interpreter Services	63
Relocation Targeted Case Management.....	64
Moving Home Minnesota	64
Out-of-Home Respite Care—Community Emergency or Disaster.....	65
Other Care Coordination Responsibilities.....	66
Blue Plus Network	66
Audit Process	67
Records Retention Policy	68

Contact Information

<p>Behavioral Health Clinical Guides 1-866-489-6947 Option 1 BH Prior Authorization Fax: 651-662-0854</p>	<p>Consultation for Mental Health and Substance Use Disorders</p>
<p>BlueRide</p> <p>Transportation.liaison@bluecrossmn.com</p> <p>BlueRide Portal</p> <p>https://www.bluecrossmn.com/blueride</p>	<p>An e-mail box to send transportation specific transportation problems/requests. Include member name, PMI, name of transportation provider, dates of service, detailed summary of problem/issue</p> <p>Care Coordinator portal for scheduling medical or dental rides</p>
<p>Bridgeview Company 1-800-584-9488 EWproviders@bridgeview.com https://www.bluecrossmn.com/healthy/public/bridgeview/home/</p>	<p>Elderly Waiver service agreement/claims processing questions Questions about adding/deleting security and access Enrollment, Care Coordination assignment, entering HRA's/Refusals/Unable to Reach</p>
<p>CaregiverCornerMN.com</p>	<p>BCBS hosted site with helpful information and resources for caregivers</p>
<p>Care Coordination Portal</p> <p>www.bluecrossmn.com/carecoordination</p>	<p>Access to Care Coordination communications, guidelines, forms, letters, resources, and trainings.</p>
<p>Clinical Guide Resource Team 1-866-518-8447 Clinical.guide.resource.team@bluecrossmn.com</p>	<p>Assistance with member specific issues Blue Plus and community resources: i.e. transportation alternatives, claim denials, medication alternatives, etc. Pre-Admission Screening (PAS)</p>
<p>Delta Dental Members 651-406-5907 or 1-800-774-9049</p> <p>Care Coordinator Liaison 651-994-5198 or 1-866-303-8138</p>	<p>Assistance to find a dental provider Schedule dental appointments</p> <p>Liaison for Care Coordinators only. Will assist with difficulties in accessing dental appointments and other Delta Dental specific questions.</p>
<p>Enrollment Questions/Issues SecureBlue.enrollment@bluecrossmn.com</p>	<p>Discrepancies with MSHO and MSC+ enrollment reports</p>
<p>Member Services MSHO 651-662-6013 or 1-888-740-6013 MSC+ 651-662-5545 or 1-800-711-9862 TTY: 711</p>	<p>Benefits questions Interpreter services Assistance finding an in-network provider Billing questions/Grievances</p>
<p>Medical Management and Intake</p>	<p>Assistance w/ Prior Authorization requests PCA/Home Care Prior Authorizations/DTR</p>

651-662-5540 or 1-800-711-9868	<p>Fax: 651-662-4022 or 1-866-800-1655</p> <p>Surgical/DME Prior Authorizations</p> <p>Fax: 651-662-2810</p> <p>Assistance identifying new Care Coordination Delegate for a member being transferred</p>
<p>Partner Relations Consultants</p> <p>Partner.relations@bluecrossmn.com</p> <p>Fax: 651-662-0015</p> <p>See 9.02.01 Government Programs Partner Relations map for designated representative</p>	<p>Contact for general Care Coordination process questions.</p> <p>Liaison for counties and care systems in the Blue Plus service area.</p> <p>HRA entry/audit questions in Bridgeview</p>
<p>Provider Service</p> <p>651-662-5200 or 1-800-262-0820</p>	<p>Provider assistance</p> <p>Contract/provider access questions</p>
<p>Prime Therapeutics</p> <p>1-800-509-0545</p>	<p>Assistance to find a pharmacy</p> <p>Available 24/7 to assist with prior authorizations</p>
<p>Pharmacist</p> <p>MSHO Donna Boreen, Clinical Pharmacist</p> <p>651-662-1264 or 1-800-711-9868 ext. 21264</p> <p>Donna.boreen@bluecrossmn.com</p> <p>MSC+ Adrienne Matthews, Clinical Pharmacist</p> <p>651-662-1053 ext. 21053</p> <p>Adrienne.Matthews@bluecrossmn.com</p>	<p>Speak with a Blue Plus pharmacist about medication concerns</p>

Definitions

Blue Plus’ contracts with the Department of Human Services for *Care Coordination* for both MSHO and MSC +. 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. For MSC+ members this means “the assignment of an individual who coordinates the provision of all Medicaid health and long-term care services for MSC+ Enrollees, and who coordinates services to an MSC+ Enrollee. This coordination is 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/MS C+ 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: Quality Improvement Project reporting, enrollment report discrepancies, Hospice care plans, missing residential services 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., MS C+ 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**.

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 statutes 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.

Care Coordinators should use professional judgement interpreting the following guidelines and policies to make decisions related to the care and treatment of Blue Plus members:

- MN rules and statutes
- DHS policies and training
- County program training and guidelines
- Provider training and guidelines
- Medicare coverage criteria
- Disease Management protocols
- Blue Plus Certificates of Coverage

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://carecoordination.bluecrossmn.com/training/>

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.

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

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 received by DHS and 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 enrollment month.
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 Blue Plus 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 Nursing Home

For MSHO and MSC + 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 these members are designated by DHS as a Rate Cell A (Community Well) and 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.

Contact Requirements

Member Contact

Assessments required for:

- Annual
- Initial
- Significant Health Change
- Product Change
- Health Plan Change
- Refusal
- Unable to Reach (see below)
- Member Request (HRA needs to be completed within 20 calendar days of member’s request.)

Contact Requirements				
Contact/year	MSHO CW	MSHO EW	MSC+ CW	MSC+ EW
Initial Assessment *due after notification of enrollment*	CC contact info given w/in 10 days	CC contact info given w/in 10 days	CC contact info given w/in 10 days	CC contact info given w/in 10 days
	Face-to-Face w/in 30 days	Face-to-Face w/in 30 days	Face-to-Face w/in 60 days	Face-to-Face w/in 30 days
*Transitional HRA’s may be done telephonically. *				
Annual Assessment	Face-to-Face within 365 days	Face-to-Face within 365 days	Face-to-Face within 365 days	Face-to-Face within 365 days

Semi-annual Contact	Minimum— phone contact	Face-to-Face	Minimum— phone contact	Minimum— phone contact
New/Change in Care Coordinator	CC contact info given w/in 10 days of the change			
As Needed Contact	Contact for significant change in member’s health status or as requested			

Physician Contact Requirements

New Member: Send Intro to Doctor Letter within 90 days of notification of enrollment (8.28 or 8.29)

- Send 8.28 Intro to Doctor letter **OR**
- Send 8.29 Care Plan Summary Letter – Intro to Doctor; which combines the Intro and Summary letter. This letter can be used in lieu of 8.28 Intro to Doctor letter if the face-to-face visit and this letter is mailed within 90 days of notification of enrollment.

Reassessment and Significant changes:

- Send 8.29 Care Plan Summary Letter to Doctor or a copy of the care plan (not required for members who have refused an HRA).
- As needed for updates to care plan following a Transitions of Care (TOC)
- When there is any change in Care Coordinator, provide new Care Coordinator contact information to the doctor.
- For clinic delegates, notification to primary care physician documented per clinic process.

Initial Contact with New MSHO and MSC+ Enrollee

1. The Delegate is responsible to verify member’s eligibility prior to delivering Care Coordination services
2. Use the following optional checklists: 6.12 CW EW Checklist SB or 6.12.01 EW Checklist MSC+.
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. Discuss In-Home Assessment Program. (see next section)
7. Have the following discussions:
MSHO Enrollees:

- Explain MSHO supplemental benefits using resource 6.26 Explanation of Supplemental Benefits.
- Document this discussion on the checklist(s) or in your case notes.

MSC+ Enrollees:

- Discuss SecureBlue MSHO product and provide enrollment resources, if applicable. See SecureBlue MSHO Enrollment Resources page on the portal.
- Document this discussion or ineligibility for MSHO on the checklist(s) or in your case notes.

Information about enrollment, including resources, can be found in the resources link on the care coordination portal.

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 a 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.

The following PCC's currently provide care coordination:

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

In-Home Assessment Program MSHO members only

Blue Cross and Blue Shield is working with a vendor, MedXM, to provide newly enrolled MSHO members with an In-Home annual wellness visit (AWV), health risk assessment (HRA) and at-home colorectal cancer screening, kidney disease monitoring, and/or other labs based on member identified need. The project goal is to insure the member's health care needs are

identified early, document member's current health status, and improve the accuracy of risk score data.

This program is available for *new* MSHO members only. MedXM will receive a list of new Blue Plus MSHO enrollees each month including the assigned Care Coordinator and their email address for outreach.

When Care Coordinators meet with new MSHO members at their initial Health Risk Assessment, they should inform the member to expect:

- Initial MedXM program introductory letter
- Phone call from MedXM to schedule the home visit
- Reminder call the day before the member's appointment
- A visit from the MedXM medical professional which will include an assessment of their current health needs
- A summary document left behind at the end of the visit
- A summary document will be sent to the member's primary physician
- Referrals for more immediate needs if identified at the home visit

What the Care Coordinator should expect:

- An automated email from MedXM the day before the member's appointment with details about the member and the name of the practitioner who will see the member
- If urgent or emergent needs are identified by the practitioner, the Care Coordinator will receive a referral and follow up information with the complete assessment within 24-48 hours of the home visit via secure email
- A copy of the Physician Summary document within 30 days of the member's home visit date

Health Risk Assessment

(See Contact Requirements above for HRA timelines and required member and physician letters)

Health Risk Assessment options

Long Term Care Consultation (LTCC DHS Form 3428)

- Health Risk Assessment tool for initial and annual assessments.

6.28 Transitional Health Risk Assessment

- Optional HRA tool for newly enrolled members or product changes who have had an LTCC or MnCHOICES Assessment within 365 days of enrollment and who have not experienced a significant change.
- May also be used for members who have had a Telephonic HRA within the last 365 days.

Minnesota Health Risk Assessment Form (DHS 3428H)

- HRA for members on non-EW waivers (DD, CAC, CADI or BI); are living in an ICF/DD; or DD member living in the community.
 - 6.17 Care Plan-ICFDD and HCBS Waivers: care plan to be used with members open to other waivers

- HRA for members who consent to a telephonic health risk assessment (CW members who have previously refused a face-to-face HRA)
 - 6.40 Care Plan-Telephonic: care plan to be used with telephonic HRA.

Community Well (CW) Refusals

- Members not open to a waiver or receiving home care services who refuse completion of an HRA. Care Coordination is still required for refusals.

Community Well (CW) Unable to Reach

- Unable to reach members after Care Coordinator has made three contact attempts to offer an HRA.

Health Risk Assessment requirements

Long Term Care Consultation (LTCC DHS Form 3428)

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, 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 an LTC Screening Document in MMIS (See Entry of LTCC screening document information into MMIS section)
6. Reassessment is due within 365 days of the date of this LTCC.

6.28 Transitional Health Risk Assessment

The 6.28 Transitional Health Risk Assessment can be used in the following circumstances.

1. For *new enrollees* who have had an LTCC/MNCHOICES within 365 days.

Care Coordinator reviews and obtains:

- a. LTCC or MnCHOICES Assessment

b. Current care plan:

- Collaborative Care Plan
- Community Support Plan

Care Coordinator enters the following into Bridgeview:

- Assessment prior to enrollment (LTCC or MnCHOICES)
- 6.28 Transitional HRA

***Reference Bridgeview Care Coordination Delegate User Guide: Fee for Service LTCC/MnCHOICES completed prior to enrollment Transitional HRA*

2. For members that have had a **product change** and have had an LTCC/MNCHOICES or a DHS 3428H MN Health Risk Assessment in the last 365 days.

Care Coordinator reviews and obtains:

a. LTCC or MnCHOICES Assessment or DHS 3428H

b. Current care plan:

- Collaborative Care Plan
- Community Support Plan
- 6.17 Care Plan-ICFDD and HCBS Waivers
- 6.40 Care Plan-Telephonic

Care Coordinator enters the following into Bridgeview:

- 6.28 Transitional HRA

Additional notes related to use of the Transitional HRA:

- The above assessments/care plans can be reviewed either telephonically or in person to ensure the information has not changed and the care plan is addressing the member's needs. If any portion of the paired documents is missing or unsigned, the Care Coordinator is responsible for obtaining the missing information. If unable to obtain the missing information, the Care Coordinator must complete a new assessment and care plan.
- The next reassessment is due within 365 days of the LTCC/MnCHOICES assessment or the DHS 3428H **not** the date of the Transitional HRA.
- Care Coordinator should complete screening document in MMIS.

Minnesota Health Risk Assessment Form - DHS 3428H

Members who are on non-EW waivers (DD, CAC, CADI or BI); are living in an ICF/DD; or a DD member living in the community 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/MS+ Care

Coordinator must collaborate with the other case manager and complete the following Care Coordination responsibilities:

- Required contacts with member and physician
- Completion of DHS-3428H Health Risk Assessment and form 6.17 Care Plan-ICFDD and HCBS Waivers (next annual re-assessment is due 365 days from completion of DHS-3428H)
- Semi-annual member contact and monitoring of goals completed on form 6.17
- Transition of Care activities
- Authorization of MA state plan homecare services, including state plan PCA services
- Bridgeview entry
- MSHO supplemental benefit discussion (as applicable)
- MSHO enrollment with MSC+ enrollees (as applicable)
- All other responsibilities and timeframes as outlined in these guidelines

Note: Some of these members may be designated by DHS as a Rate Cell D (nursing home) and will show up as Rate Cell D on the enrollment report. The Delegate should be aware of this and proceed with the responsibilities as outlined in these community guidelines.

1. Document monitoring/progress of goals during the semi-annual contact and as needed throughout the year.
2. Sign and date form 6.17
3. Provide a copy of form 6.17 to the member and other waiver Case Manager
4. Provide a copy of 6.17 or a care plan summary letter to the physician.
5. Enter the assessment type and date into the Bridgeview Company's web tool by the 10th of the following month. Refer to sections: *Assessment and Refusal Tracking Process* and *Entering Health Risk Assessment Information Assessment and Refusal Tracking Process* in Bridgeview's Web Tool User Guide
6. Enter Screening Document(s) 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). Refer to section: *Entry of LTC Screening Document information into MMIS*.
7. Blue Plus Care Coordinator is responsible for authorizing state plan home care services and must follow the process in the *Home Health Care Authorization* section in coordination with the other Case Manager.
8. For members on other waivers (DD, CAC, CADI & BI), do not enter service agreements into Bridgeview.
9. Complete a new 3428H Health Risk Assessment and form 6.17 within 365 days.
10. Document goal outcomes on the 6.17 during the semi-annual contact and as needed throughout the year.

CW Refusals

Refusals can only be made by the member or responsible party. If a face to face HRA is refused, offer the option of completing the DHS 3428H which can be done telephonically. Community well members receiving Home Care or PCA services cannot refuse the HRA and continue to receive services.

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.
- d. Continue to reach out at minimum, every six months either by mail or phone.

ICF/DD and non-EW HCBS Waiver Refusals

Members open to another HCBS waiver will show on your enrollment list as Community Well/Rate Cell A or those residing in an ICF will show as rate cell D. These members should be assessed following these community guidelines.

Though primary case management responsibilities are completed by their waiver case manager, Care Coordinators are still required to offer these members completion of a health risk assessment and care plan using DHS-3428H and 6.17 Care Plan-ICFDD and HCBS Waivers. Completion of these requirements can only be refused by the member or their representative. If the member or guardian refuses completion of DHS 3428H, follow the steps above under “CW Refusals”.

CW Unable to Reach

If you are not able to reach the member or their authorized representative for their assessment the Care Coordinator must:

1. Make a minimum of three attempts to contact the member via phone, e-mail, or letter to offer an HRA.
2. Document the dates for each of these attempts in Bridgeview following the process outlined in Assessment and Refusal Tracking Process in Bridgeview’s Web Tool User Guide
3. Mail 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.
4. Enter a screening document type “H” with assessment result “50”

- a. For initial complete within 45 days of enrollment.
- b. For reassessments, within 365 days of the previous assessment screening document.

Important tips for Unable to Reach:

- Follow-up contacts need to be started with plenty of time to accommodate all attempts before the initial or 365-day deadline.
- 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.
- You may enter the same date in BV if your attempts occurred on the same date.

Telephonic Health Risk Assessment – DHS 3428H

Care Coordinators should always offer a face-to-face HRA which is the preferred option. The Telephonic Health Risk assessment is only for use with Community Well members (Rate Cell A) who refuse a face-to-face assessment and who are not receiving EW or home care services. 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 using DHS 3428H

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 DHS 3428H over the phone with the member or the guardian following the contact requirements.
3. Complete 6.40 Care Plan-Telephonic.
4. Mail a copy to the member for their records.
5. 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.
6. Complete an MMIS LTC Screening Document following instructions in section Entry of LTC Screening Document information into MMIS.
 - a. Enter screening document type "H" using the following codes:
 - Activity Type 01 (telephone screen)
 - Assessment Result 35 (MSHO/MS C+)
 - Program Type 18

Product Changes: if a member switches products (MS C+ to MSHO or vice versa) they are considered a new enrollee and an HRA is required. To complete the required HRA for those who have previously agreed to and completed DHS 3428H telephonically:

- a) Contact the member and offer a Face-to-Face assessment again per the process outlined in the Initial Contact section.
- b) If the member continues to refuse the Face-to-face, review the current 3428H Health Risk Assessment and 6.40 Care Plan-Telephonic with the member by phone, and complete a 6.28 Transitional HRA and attach to the current DHS-3428H Health Risk Assessment and 6.40 Care Plan-Telephonic.

- c) If you are unable to reach the member, enter an Unable to Reach in MMIS and Bridgeview, or
- d) Enter a screening document in MMIS and Transitional HRA assessment information in Bridgeview.

Reminder: Reassessments must be completed within 365 days of the previous DHS 3428H Health Risk Assessment and 6.40 Care Plan-Telephonic.

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 under Minnesota Health Risk Assessment Form DHS 3428H.
 - The same LTCC tool should be used for no more than three assessments. Best practice is the Care Coordinator uses a new tool at each assessment.
3. The Care Coordinator shall complete the applicable care plan within 30 calendar days of the HRA:
 - 6.02.01 Collaborative Care Plan
 - 6.17 Care Plan-ICFDD and HCBS Waivers
 - 6.40 Care Plan – Telephonic
4. Enter the assessment type and date into the Bridgeview Company's web tool by the 10th of the following month.
5. The Care Coordinator will complete 8.29 Care Plan Summary Letter to Doctor or send a copy of the care plan.
6. If state plan home care services are needed, see *Home Health Care Authorizations* section.
7. Enter Screening Documents following the process and timeframes as outlined in section, *Entry of LTC Screening Documents*.
8. Discuss SecureBlue MSHO product and assist the member to enroll if applicable. Document this discussion on the checklist(s) or in your case notes. If member is not eligible for MSHO and the discussion did not take place, document this in the case notes. Information and resources can be found on the home page of the Care Coordination portal. Under Resource Management is a link to all SecureBlue MSHO enrollment resources including:
 - Contact information for our MSHO sales specialist Explanation of extra Supplemental Benefits (available to only SecureBlue MSHO enrolled members)
 - SecureBlue Advantages Compared to MSC+ member resource
 - Care Coordinator Talking Points

- Contact numbers for questions
- Members can enroll into SecureBlue MSHO at any time with enrollment being effective the first of the following month

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

Entry of LTC Screening Document information into MMIS

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).

MMIS Reminders:

- The *LTCC CTY* field for all Blue Plus screening entries is *BPH*
- Upon entry of the Screening Document (SD) prior to saving, review the SD for edits and document status (do not leave the SD in a Suspended status).
- Case Manager Comment Screen is used for the Care Coordinator to add additional comments regarding the screening or assessment visit, as applicable.
 - When using 05/98, in the comment screen clarify the purpose of the screening document i.e. Care Coordinator change, THRA, etc.
- DHS Comment Screen is used to communicate back to the Care Coordinator.
- SD type H: *Cannot* be used to open or reopen program eligibility nor extend or close program eligibility

Timeline for MMIS entry

New Community Well (non-Elderly Waiver) enrollees

MSHO CW: Enter SD within 45 days of enrollment date

MSC+ CW: Enter SD within 75 days of enrollment date

Assessment entry for all members on EW

Reassessments and screening documents must be entered by the cut-off dates listed below. When MMIS entry is late and results in EW closure, the member reverts to rate cell A (community well) status. The member will get a new i.d. card and potentially have co-pays. It may also impact their medical spenddown, if applicable. When the waiver span lapses, Blue Plus continues to pay out EW claims for these members without the correct reimbursement from DHS.

SD must be entered into MMIS by these cut-off dates:

When the First Month of the Eligibility Span is:	Last Day to Enter Screening Document timely is:
January	12/20/17
February	1/23/18
March	2/20/18
April	3/22/18
May	4/20/18
June	5/22/18
July	6/21/18
August	7/23/18
September	8/23/18
October	9/20/18
November	10/23/18
December	11/20/18
2019	12/20/18

Assessment entry for community members *opening to EW for the first time* (assessment result 01)

Enter SD in MMIS within 60 days of your assessment date or no later than 365 days from the member’s previous face to face assessment, whichever date comes first.

Community Well members

For CW members assessed using LTCC and not receiving PCA:

- **Enter SD type “L”**
- Activity Type 02 face to face
- Assessment Result 02 or 03 (MSHO/MSC+)
- Program Type 18

For CW members receiving PCA services and not on a HCBS waiver:

- **Enter SD type “L”**
- Select value 21 PCA Health Care for “Reason for Referral” field
- Activity Type 02 (community face to face)
- Assessment result 02 (in community without waiver or AC services) or 03 (in community without services)
- Program Type 18 (MSHO/MSC+ Community)
- Service Plan summary: select 18 (personal care) or 80 (home care nursing) with funding source code F (formal)

For CW members on another Waiver (CADI, CAC, BI, DD) assessed using 3428H Health Risk Assessment and 6.17 Care Plan-ICFDD and HCBS Waivers, enter **SD type “H”** with the following codes:

- Activity Type 01 (telephone screen) or 02 face to face
- Assessment Result 35 (MSHO/MSC+)
- Program Type 18

CW Refusals

Enter SD within 45 days of the enrollment date using the **SD type “H”**, activity type 07 and refusal code 39 for the assessment result.

CW Unable to Reach

Enter SD within 45 days of the enrollment date. For all assessments completed on or after September 1, 2017, enter a **SD type “H”** with activity type 07 and assessment result “50”.

CW Refusing face to face visit but consents to telephonic HRA using DHS 3428H

Enter SD within 45 days of enrollment date. For all assessments completed on or after June 1, 2018, enter **SD type “H”**.

- Activity Type 01 (telephone screen)
- Assessment Result 35 (MSHO/MS C+)
- Program Type 18

Instructions for updating MMIS Entry for Transitional HRA or Change in Care Coordinator

The delegate is responsible for updating an existing LTC Screening Document in MMIS for either EW or 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

SD type for entering THRA into MMIS is dependent on whether the member is open to EW and or accessing PCA services.

Use SD Type H:

- CW not accessing PCA services
- CW on other waivers

Use SD Type L:

- Enrolled or Enrolling to EW
- CW and Accessing PCA Services

Scenario	Transitional HRA for New Enrollee (includes product changes)	Transitional HRA for New Enrollee (includes product changes)	Change in Care Coordinator only	Change in Care Coordinatoro
	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 Care Coordinator assumed responsibility	Date Care Coordinator assumed responsibility
Case Managers Name and UMPI Number	Use your MCO UMPI number	Use your MCO UMPI number	Use your MCO UMPI number	Use your MCO UMPI number
Assessment Result:	98	98	98	98
Effective Date:	Date Transitional HRA is completed	Date Transitional HRA is completed	Date delegate/Care Coordinator assumed responsibility	Date delegate/Care Coordinator assumed responsibility
Program Type	18	03 or 04	program type cannot be changed with 05 SD	program type cannot be changed with 05 SD

Comprehensive Care Plan (CCP)

Care Coordinators shall develop a comprehensive care plan in collaboration with the member, caregiver, and/or other interested persons at the member's request, within 30 calendar days of the completing the member's Health Risk Assessment. Completion of a care plan would *not* apply to the following:

- 6.28 Transitional Health Risk Assessment (unless there is not an attached CSP/CCP)
- Unable to Reach
- Community Well Refusal

The care plan options include the following:

- 6.02.01 Collaborative Care Plan: to be used following completion of the LTCC assessment DHS 3428 (refer to resource 6.02.02 Instructions for the Collaborative Care Plan)
- 6.17 Care Plan-ICFDD and HCBS Waivers: to be used following completion of the Minnesota Health Risk Assessment Form DHS 3428H for members on non-EW waivers (DD, CAC, CADI or BI); living in an ICF/DD; or a DD member living in the community
- 6.40 Care Plan – Telephonic: to be used following completion of the Minnesota Health Risk Assessment Form DHS 3428H via telephone. All CW members who were previously refusals should be offered completion of DHS 3428H and 6.40 Care Plan - Telephonic Care.

Care Planning requirements

The Care Coordinator must:

1. Complete all sections of the appropriate care plan.
2. Sign the care plan
3. Obtain the member's signature
4. Provide a complete copy of the care plan to the member and any care team members chosen by the member.
5. Mail 8.25 (SB) or 8.25.01 (MSC+) Care Plan Cover Letter which includes the Medicare and/or Medicaid Member Rights and Complaint information.
6. Send a copy of the care plan or care plan summary (8.29 Care Plan Summary Letter) to the member's physician
7. Obtain necessary provider signatures (see Provider and Member Signature Requirements in next section).
8. Create goals that are person-centered
9. Evaluate and update any changes to the member's condition and corresponding services and supports, at minimum every 6 months.
10. Care Coordinators are expected to monitor and document progress of the member goals. Review and document outcomes on each specific goal every 6 months, as needed, and at re-assessment.

Collaborative Care Plan components

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 the 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/physician (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.
- Identification of any risks to health and safety and plans for addressing these risks. Including Informed Choices made by members to manage their own risk.
- Discussion of Medical Management telephonic programs. 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
- Preventive discussions to 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 and providers.

Provider and Member Signature Requirements (See 9.15 Provider Signature FAQ Resource)

Provider signature requirements apply *only* to those members on Elderly Waiver.

The Care Coordinator must discuss, with member or representative, the CMS requirement of sharing their care plan and service information with EW and PCA providers. EW and PCA providers must sign to indicate their acknowledgement of the services and supports in the plan and their agreement to deliver them as outlined. The Care Coordinator must follow the process outlined in 6.02.02 Instructions for the Collaborative Care Plan—number 51 and 60.

1. Signatures required for:
 - Initials
 - Annuals
 - Changes to the plan that affect how the Elderly Waiver and PCA (if applicable) service is provided (i.e., changes in hours/units, change in provider, or addition of a new provider). The member must sign acknowledging their agreement to the change. The Care Coordinator will follow the process outlined in the Instructions for the Collaborative Care Plan, number 60.

2. Signatures not required for:

- Members not on EW
- MA State Plan Home Care Services: Home Health Aide and Skilled Nursing Visits (only required for MA State Plan PCA)
- Community Well members who have PCA
- Approval-option: purchased-item services
- Consumer Directed Community Supports (CDCS)
- Residential Services (RS) Tool and Individual Community Living Services (ICLS) Planning Form. The CC can send the RS tool or ICLS planning form (DHS-3751) to the provider in lieu of the entire care plan if the member makes an informed choice to do so. Both the RS tool and ICLS planning form include a provider signature field.

Home Health Care Authorization Processes

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 other HCBS waivers (ICF/DD, CAC, CADI, BI). 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 may 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. For members on another waiver (CAC, CADI, ICF/DD, or BI) the Care Coordinator is responsible for authorizing state plan home care services and must follow these processes in coordination 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 Care Coordinator *Notification to Blue Plus of Home Care Authorizations*

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)
 - if the member does not live in Adult Foster Care or Customized Living
 - 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:

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

Process for Care Coordinator *Prior Authorization Request*

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

- Any visits exceeding notification limits above.
- 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:

1. 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.
2. Request any necessary medical information needed directly from the home care agency. Submitting clinical documentation is the home care agency's responsibility.
3. Contact the Care Coordinator if additional input from the Care Coordinator is required
4. Make a coverage determination within 10 business days or 14 calendar days
5. Enter decision into Blue Plus system for payment purposes
6. Notify member and home care provider of the decision via letter
7. 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. If the provider is not in network, a temporary authorization may be approved for up to 120 days. The CC should assist the member with transitioning to an in-network provider before the temporary authorization expires.

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 previous 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:

- Physical Therapy (PT)
- Occupational Therapy (OT)
- 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 as allowed within the member's EW budget. 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.

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 tools:

- Personal Care Assistance (PCA) Assessment and Service Plan (DHS-3244-ENG) which must be completed by RN or PHN, or
- LTCC in conjunction with the DHS tool Supplemental Waiver Personal Care Assistance (PCA) Assessment and Service Plan (DHS-3428D-ENG) which can be completed by a social worker, RN or PHN. Blue Plus will not accept the LTCC Assessment tool without the supplemental form.

Note: If a member is on a DD, CAC, CADI, BI waiver, it is the responsibility of the Care Coordinator to authorize PCA following the authorization process below. The Care Coordinator must coordinate/communicate with the other waiver case manager and Blue Plus.

PCA requirements:

- Care Coordinator or PCA assessor completes the appropriate tool.
- The Care Coordinator must fax the assessments to Blue Plus Utilization Management (UM) with form 6.04.05 PCA Authorization Request.
- Blue Plus UM will review all PCA requests within 10 business days to determine the number of units the member is eligible for under state plan services.
- Once a decision is made, UM will notify the member, PCA provider, and Care Coordinator of the decision.
- Blue Plus will send any letters (approval or denial) to the member and agency via mail and the Care Coordinator via fax.
- If Blue Plus has questions regarding an assessment, UM may contact the Care Coordinator or the 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.
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
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 should 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 should 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.
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:

If a 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 UM does not review extended PCA as it 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 count 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 EW services, the Care Coordinator is expected to be compliant with all EW program rules. Care Coordinators should follow all appropriate bulletins related to EW, and follow directions found in the MN Health Care Program (MHCP) Provider Manual Chapter 26A: Elderly Waiver and Alternative Care and directions found in the Community Based Services Manual (CBSM). A link to these manuals are in the Resource section of the Care Coordination web-portal.

MHCP Enrolled Providers

EW services must be delivered by a provider enrolled with Minnesota Health Care Programs (MHCP). Blue Plus does not contract directly with any Elderly Waiver providers. Providers must 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. DHS enrolled providers can be added to the Bridgeview system for Blue Plus Elderly Waiver service agreements. 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

Care Coordinators must ensure members are given information to enable them to choose among available DHS enrolled 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.

Approval-Option Service Providers

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.

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 contracted 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.

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 Bridgeview web tool. Waiver obligations may change retroactively, and any questions should be referred to the member’s county financial worker. Questions regarding which provider was assigned the waiver obligation for a specific month may be directed to Bridgeview Company.

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

MA services included in EW Case Mix Cap

Care Coordinators must calculate the following services in addition to the cost of all EW services into the monthly case mix budget cap:

State plan home care services including:

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

and

Monthly Care Coordination and Case Aide billing.

- 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.**

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. The Care Coordinator must consult with their supervisor if they decide they wish to submit a request to exceed. Care Coordinators may also consult with their Partner Relations Consultant prior to submitting the request.

Notes related to requests to exceeds:

- If the member has requested to exceed the Case Mix Cap and the Care Coordinator determines there is no assessed need, send in the Notification of Potential DTR form.
- 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.

Process to request an exception to Case Mix Budget Cap

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
- LTCC assessment completed within the previous 60 days
- Collaborative Care Plan
- Description of other options within the member's current budget which 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 except for EW Conversion rate requests)
- PCA assessment (if applicable)
- Any other supporting documents deemed appropriate
- Other documents requested by the EW Review Team

The EW 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.

If approved, the EW Review Team will:

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 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 UM will 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.

Withdrawal of a request to exceed case mix cap

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:

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
 - 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.)
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.

EW Conversion Requests

A monthly conversion budget limit is an exception to the monthly case mix budget caps for an EW participant leaving a nursing facility.

- 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.

Process to request EW Conversion Rate

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
- LTCC assessment completed within the previous 60 days
- Collaborative Care Plan
- Description of other options within the member's current budget which 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 EW 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, EW Review Team will determine the length of time for the approval.
 - a. Initial Conversion Rate 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. Reauthorization without Change in Level of Service: 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

If approved, the EW Review Team will:

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 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 complete the “Conversion Limit” tab in the CL workbook.

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 service options.
2. Blue Plus UM 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.

Process to withdrawal EW Conversion Rate

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.

Elderly Waiver Services

Consumer Directed Community Supports (CDCS)

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 (CCP) within the required timeframes. The CCP should coordinate with the community support plan created by the member or their representative. The Bridgeview Service Agreement web-tool contains two fields specific to CDCS: CDCS Eligible and CDCS Monthly Amount.

Note related to CDCS:

- 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 and are not included in the members CDCS budget.

Please refer to the Web Tool User Guide and / or contact Bridgeview or your Partner Relations Consultant directly with questions.

Home and Vehicle Modifications

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.

- 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 contract with Blue Plus to act as a billing "pass-through" for approval option service 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 as allowed within the budget.

- If the modification exceeds the case mix budget, refer to the Requests to Exceed Case Mix Budget Cap.

EW Specialized Equipment and Supplies (T2029)

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:

1. Review DHS-3945 Long-Term Services and Supports Service Rate Limits to ensure item fits within member's assessed case mix cap
2. Review MHCP Supplies/Equipment Coverage Guide
3. Review Medicare.gov for coverage determination
4. 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.
5. 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 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:

1. Enter a Service Agreement in Bridgeview; and
2. Document the item on the member's Collaborative Care Plan budget worksheet.

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).

- a. 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:

1. 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.
2. If CC approves, is single item *under* \$500?
 - a. If YES, enter SA in Bridgeview.
 - b. Document on Member's Collaborative Care Plan budget worksheet
3. If CC does not approve item, submit 6.05 Notification of Potential DTR to Blue Plus

EW T2029 authorization 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.

1. 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.
2. 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
- Enter all approved EW items in Bridgeview Company service agreement web tool
- 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.

All service agreements for Extended Supplies and Equipment 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.

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 **\$951** or more for coverage under EW
- Care Coordinator authorizes under Elderly Waiver (EW):
 - Chair portion of the lift chair if it is **\$950 and under**.
 - 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:

1. Blue Plus UM will send a DTR to the member and the provider and will notify the Care Coordinator via secure email.
2. The Care Coordinator may review for authorization of the lift mechanism under the EW benefit.

3. If the Care Coordinator approves the lift mechanism under EW, the lift mechanism and chair portion should be entered as separate service agreements.
4. 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 \$950 and under

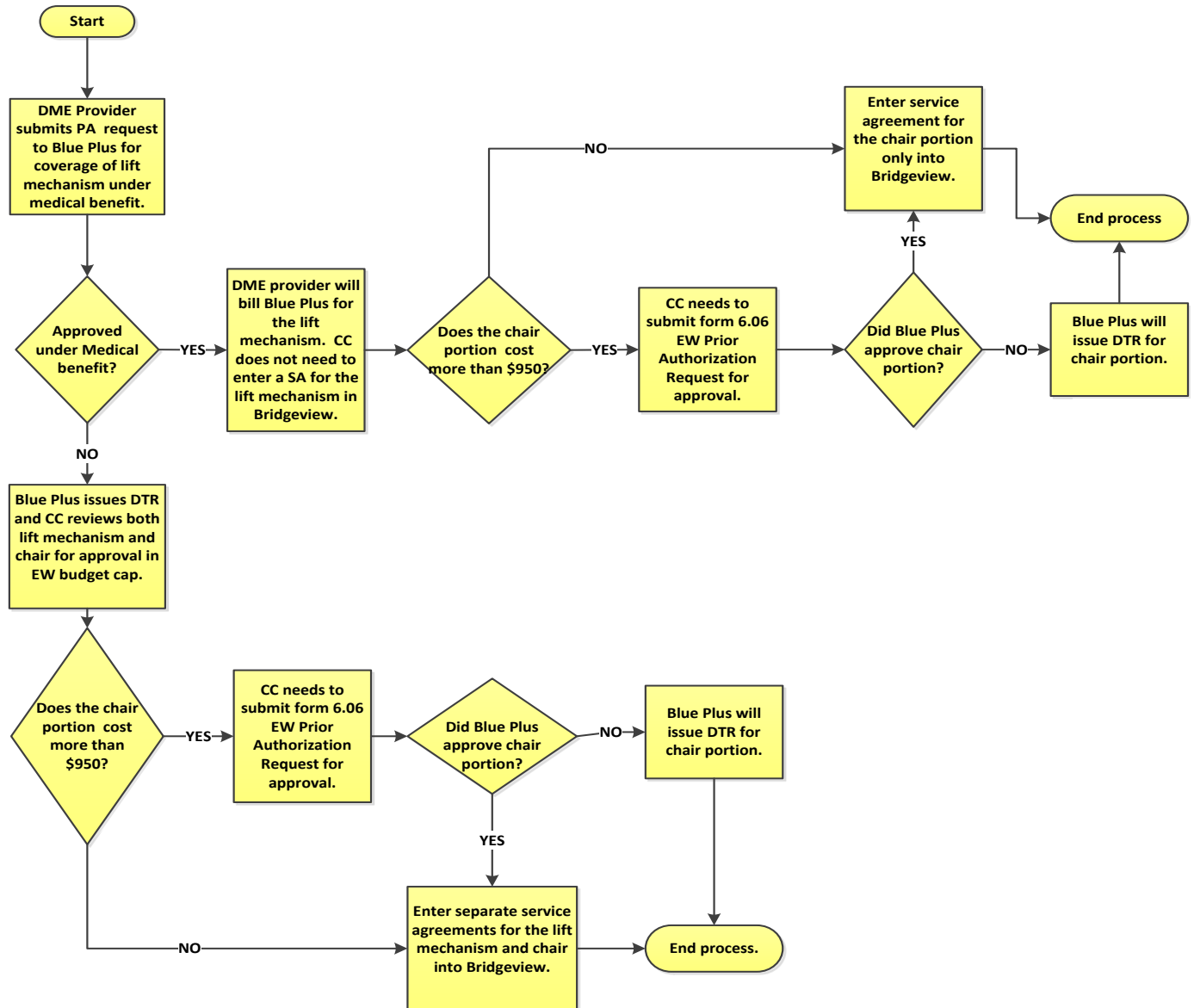
The Care Coordinator can authorize the chair portion under EW without submitting a prior authorization request to Blue Plus. The authorization should be entered as a Service Agreement in the Bridgeview web-tool. No form or documentation needs to be submitted to Blue Plus unless the cost of the furniture portion will be over \$950 (see section below).

Chair portion over \$950

The Care Coordinator must request prior authorization from Blue Plus.

1. Do not enter Service Agreements until approval is received.
2. 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:
 - a. the cost of the chair vs. the lift mechanism and
 - b. 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.
3. Blue Plus UM will review the request and make a determination within 10 business days of receipt of all necessary documentation.
4. *If denied*, Blue Plus will send the DTR to both the member and the Care Coordinator.

Lift Chair/Mechanism Process Flow



Customized Living, Foster Care and Residential Care Services

See DHS bulletin #16-25-02 for the Comprehensive Policy on Elderly Waiver (EW) Residential Services.

Customized Living and Adult Foster Care are residential settings covered under the Elderly Waiver. Residential services are individualized and consist of covered component services designed to meet the assessed needs and goals of an EW participant. Residential service providers are required to be approved and enrolled through DHS.

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 after SD entry.

Care Coordinators are required to use the DHS Residential Services Workbook (RS tool) for residential service planning and rate-setting in addition to submitting the tool to DHS. Refer to the DHS website below for the details including DHS bulletins, most recent versions of the tool, and instructions for completion and submission of the tool. With the member's permission, care coordinator's must send a complete RS tool to the provider.

Effective 8/1/18, Care Coordinators must complete "Person's Evaluation of Foster Care, Customized Living, or Adult Day Service" DHS-3428Q-ENG form at each assessment for those residing in residential care or receive adult day services. See DHS bulletin #18-25-04 for specific details.

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

Nursing Facility Level of Care

A face-to-face assessment determines Nursing Facility Level of Care (NF LOC). For Blue Plus members, this assessment is the LTCC.

If a member loses NF LOC, which determines EW eligibility, the NF LOC 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*.

Members that lose NF LOC should be offered alternative services including: State Plan Home Care or PCA if they are eligible.

Essential Community Supports

Care Coordinators may continue to have members who qualified for ECS program following the NF LOC changes effective January 2015. Members can participate in ECS if 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.

See the Essential Community Supports section of the CBSM for complete details.

On-Going Care Coordination Responsibilities

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/HealthEast
- Essentia Health
- 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 goal of the TOC process is to reduce incidents related to fragmented or unsafe care and to reduce readmissions. The Care Coordinator is key to supporting the member's needs across the continuum of care.

***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.

If the member has an additional case manager (i.e. CADI waiver case manager), the Care Coordinator may communicate applicable information about the transition(s) with them. However, the Care Coordinator is responsible for completing all required tasks related to the transition(s) of care.

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.

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

Care Coordination TOC Documentation Responsibilities:

1. Care Coordinator documents transitions 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. TOC logs are required if the CC learns of a transition while the member is in any phase of the transition process.
3. If the 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.

Note: **TOC logs are *not* required when the Care Coordinator finds out about all transition(s) 15 calendar days or more after the member has returned to their usual care setting. The Care Coordinator should still follow-up with the member to discuss the transition, 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.

4. 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.
5. 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. 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.

6. 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.
7. 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 or within 1 business day of learning of the transition and should discuss the following:
 - Care transition process including the role of the Care Coordinator
 - Changes to health status.
 - Discuss and update any changes to plan of care. 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.
 - Medication Self-Management.
 - Knowledge of red flags
 - Use of a Personal Health Record

NOTE: Communication with the Customized Living or Nursing Facility staff does not replace the requirement to contact the member/member's representative.

- 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.

Pre-Admission Screening activities

Pre-Admission Screening activities are done 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 a secure email notification that a PAS was completed by BP on a CW member. Blue Plus will send the OBRA Level 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).

If 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 assessment is required. The assigned Care Coordinator or back-up staff will conduct the face-to-face assessment before discharge to the NF.

For CW members who have been determined to need an OBRA level II evaluation, Blue Plus will make the referral to the county. For EW members the CC should make a referral to the county for OBRA level II evaluation if they determine a referral is appropriate.

Transfers

Transfers of Care Coordination to Another Blue Plus Delegate

When a Care Coordinator becomes aware that a member is moving from their service area or the member chooses a PCC contracted with Blue Plus to provide care coordination, the CC must notify Blue Plus via form 6.08 Transfer in Care Coordination Delegation.

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 avoid gaps in care during the transition.

If the CC needs to confirm who the new Care Coordination Delegate will be, including where to send assessment information, refer to 9.07 Care Coordination Delegate Listing and Contact Table or contact your Partner Relations Consultant.

For a list of all tasks associated with a transfer, refer to form 6.08.01 Transfer in Care Coordination Delegation Checklist.

****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.

Responsibilities of the Care Coordination Delegate who is initiating 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/HealthEast
 - Essentia Health
 - 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.
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 transferring Care Coordination Delegate:

1. The **transferring** Care Coordinator is required, at a minimum, to share the following **directly** with the new delegate:
 - The next face-to-face assessment date (within 365 days of previous assessment)
 - Send the following documents, if applicable:
 - HRA/Long Term Care Consultation (LTCC)/MnCHOICES assessment/summaries
 - Care Plan; including plan signature page and provider signature documentation
 - 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 Review.
2. The **transferring** Care Coordinator should communicate the following to the member's financial worker:
 - a. Address change
 - b. 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 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. This includes documenting this move on 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 Notify the financial worker of the assigned Care Coordinator's name.
4. Notify the physician using 8.28 Intro to Doctor Letter.
5. 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.
6. 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.
7. 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.
8. 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 new Care Coordinator:
 - a. Completed DHS-6037 HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form. Refer to DHS Bulletin 15-25-10 for complete details.
 - b. The next face-to-face assessment date (within 365 days of previous assessment)
 - c. Send the following documents, if applicable:
 - HRA/Long Term Care Consultation (LTCC)/MnCHOICES assessment/summaries
 - Care Plan; including plan signature page and provider signature documentation
 - A copy of the Residential Services tool
 - Any state plan service authorization information and
 - My Move Plan Summary.
2. Communicate the following to the member's financial worker:
 - a. Address change
 - b. EW eligibility

3. If the member is open to EW, the 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 until disenrollment date.
 - c. If there is a time span that the member is still open to Blue Plus and has a new EW service *provider* who is not enrolled with Bridgeview, the Care Coordinator should provide Bridgeview contact information so that they may register in order for claims to process.

Transfers of Care Coordination within your agency

If there is a change in Care Coordinator within the Delegate agency, the Delegate agency must:

- Inform member of the name, number, and availability of new Care Coordinator within 10 calendar days (new CC may use 8.30 CM Change Intro letter)
- Update the Care Coordinator assigned in the Bridgeview web tool
- Enter a Screening Document
- Notify the financial worker of the change in Care Coordinator.

Notify the physician using 8.28 Intro to Doctor Letter.

Do not send form 6.08 Transfer in Care Coordination Delegation to Blue Plus for care coordinator transfers within your agency.

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

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

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.

EW reassessments and termination of MA eligibility

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+ and is 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 this time, 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 and resource DHS 6037A HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form: Scenarios for People on AC, EW, or ECS for more information.

Case Closure Care Coordination Responsibilities

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:

1. No need to notify Blue Plus
2. Must send notification to the Financial Worker via DHS 5181
3. May enter date of death into Bridgeview, however, this is not mandatory
4. Close service agreements in Bridgeview back to the date of death, (EW only)
5. 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:

1. Close member to EW in MMIS (EW only)
2. Close service agreements in Bridgeview (EW only)
3. Notify Financial Worker via DHS 5181

Term due to lapse in MA coverage for EW members:

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 DHS form #6037 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 *EW reassessments and termination of MA* 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 CW Members on MSHO

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.

Term due to lapse in MA coverage for CW Members on MSC+:

1. Close case file

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:

1. Confirm health plan change in Mn-ITS
2. Send DHS Form 6037 to the new health plan (EW only)
3. If on EW, do not close waiver span in MMIS
4. Close service agreements in Bridgeview (EW only)
5. 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. The three-month grace period may **not** be applicable in all cases where an MSHO member loses MA. Member's in a 90-day grace period will show as termed in Mn-ITS but will continue to appear on your enrollment. If applicable, you must continue to provide Care Coordination services during this time.

- Contact the member's financial worker with questions about MA disenrollment.
- To confirm coverage by Blue Plus during this 90-day period, email secureblue.enrollment@bluecrossmn.com.
- 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 **not** 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.
- During their 90-day grace period, if the member has *a product change or is due for a reassessment*, the CC must make an attempt to complete the assessment timely per the member contact requirements. The CC must continue to follow the member until they officially term off the enrollment report. The only exception to this is if the member moves out of state.

- Coverage with Blue Plus will term 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 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.

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

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

Situation	6.05 Notification of Potential DTR to Blue Plus?
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 requesting services	Required
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	<ul style="list-style-type: none"> - 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	<ul style="list-style-type: none"> - 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:

1. 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:

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

Grievances/Complaints 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 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.

Oral Grievances

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. 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.

Member and Provider Appeals

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

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 an 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.

When engaging interpreter services, Care Coordinators should use the most cost-effective means. Care Coordinators are encouraged to use over the phone interpretation as a first option when possible. The following are available to support and assist Care Coordinators when providing services to our members.

Over the Phone Interpretation: Find instructions for phone interpretation on the Care Coordination Portal. (9.25 Blue Plus Government Programs Phone Translation Services)

- My Accessible Real Time Trusted Interpreter, or MARTTI
- Via Language

Video/Virtual: Video service provides effective web-based interpretation. This can be done on a laptop, tablet or smartphone.

- My Accessible Real Time Trusted Interpreter, or MARTTI

Face-to Face Care Coordination visits

- Delegate agency may work with any interpreter agency registered with DHS, pay the interpreter agency directly and submit claims for payment on the member service claim.

If a 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.

Note: All providers are responsible for arranging for interpreter services for Blue Plus MHCP members at the time the appointment is scheduled.

Care Coordinators may email questions/concerns to interpreterservices@bluecrossmn.com

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.

Moving Home Minnesota

Moving Home Minnesota (MHM) is Minnesota's Money Follows the Person Rebalancing Demonstration. The goal of this program is to promote transitions for people living with chronic conditions and disabilities residing in qualifying institutions an opportunity to return to the community.

When deciding if MHM is right for a member, Care Coordinators must evaluate and prepare to first use services under the member's medical coverage and/or the Elderly Waiver. If the services under the medical benefit and Elderly Waiver do not meet all the identified transitional needs of the member, the Care Coordinators may explore MHM services.

The member must *meet the MHM eligibility criteria below* to apply for the program. With permission from the member, some referrals may come into DHS MHM Intake by someone other than the Care Coordinator (i.e. nursing home, family member, etc). When this occurs, a member of the Partner Relations Team will reach out to the Care Coordinator for more information. Referrals from a Care Coordinator should be sent using secure email to Partner.Relations@bluecrossmn.com for consultation and next steps.

MHM eligibility criteria:

1. Member has resided for a minimum of 90 consecutive days in one or more of the following settings:
 - Hospitals, including community behavioral health hospitals; or
 - Institutions for Mental Disease (i.e. Anoka Metro Regional Treatment Center); or
 - Intermediate care facility for individuals with developmental disabilities (ICF/DD); or
 - Nursing facility;

and

2. Member meets eligibility requirements for MA at time of discharge; **and**
3. MA has paid for at least one day of institutional services prior to leaving the facility; **and**

4. *Member opens to the Elderly Waiver at the time of discharge; and*
5. Member is transitioning to one of the following settings:
 - Home owned or leased by the individual or individual's family member; or
 - 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; or
 - A residence in a community based residential setting in which no more than four unrelated individuals reside.

Blue Plus will notify the Care Coordinator when the MHM request has been *approved* and will provide additional instructions. **Do not start MHM services until you receive confirmation from a member of the Partner Relations Team.** After the MHM provider has been selected, the Care Coordinator will collaborate with the MHM Transition Coordinator to create a plan and arrange supports and services. Monthly member updates must be provided to the Partner Relations Consultant Representative.

Note: MHM services do not count towards the member's monthly Elderly Waiver case mix budget. Do not enter service agreements into Bridgeview. A member of the Partner Relations Team will reach out to the Care Coordinator with additional instructions for entering service agreements upon confirmation of the MHM services delivered.

Link to MHM Program Manual:

https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_180133

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:

1. Care Coordinator contacts their Partner Relations Consultant to discuss the specific situation of any member(s).
2. Partner Relations Consultant works with DHS staff to present situation and request the necessary approvals.
3. 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 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

Blue Plus Network

Blue Plus members must use in network providers. They do not have coverage for services received from a provider who is not in our network unless it is emergency or urgently needed care.

There is no coverage for care out of the state of Minnesota unless urgent or emergent.

There is no coverage for urgently needed care or any other non-emergency care received outside of the United States.

Members should contact member services with coverage questions. Providers should contact provider services. See *Contact Information* section.

Audit Process

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

Delegate 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 it meets the contractual requirements. This review may be done on-site 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 Auditor 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 Protocol. They will also conduct audits for nursing home members using a Nursing Facility Member Chart Review Audit Tool (if applicable).

Elderly Waiver members:

- Review of selected member 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 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.
- For Nursing Home Only Delegates, review of 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 to resolve an issue identified through auditing and monitoring, which does not meet the criteria for a CAP. These are required actions 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. Interventions to make corrections for 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.