



Community Care Coordination Guidelines

Secure Blue - MSHO
(Minnesota Senior Health Options)

Blue Advantage - MSC+
(Minnesota Senior Care Plus)

Updated March 2019
*Changes in Red

Table of Contents

Contact Information	7
Definitions	8
Blue Plus SecureBlue Model of Care (SNP-MOC) Policies and Procedures	10
Special Needs Plans Model of Care (SNP-MOC) Training	10
Person-Centered Practice and Planning Requirements.....	11
Delegate Responsibilities upon Notification of Enrollment	12
Blue Plus members living in a Veteran Administration Nursing Home	12
Members with another Case Manager	13
Contact Requirements	14
Member Contact	14
Physician Contact Requirements.....	15
Initial Contact with New MSHO and MSC+ Enrollee.....	15
Changing Member Demographics	17
Health Risk Assessment	17
Health Risk Assessment options	17
Health Risk Assessment requirements (HRAs required to be completed in CareCompass effective TBD)	18
LTCC (DHS Form 3428)	18
6.28 Transitional HRA	18
Minnesota Health Risk Assessment Form - DHS 3428H (when members have other case management)	19
Telephonic Health Risk Assessment – DHS 3428H (MN Health Risk Assessment Form 3428H)..	20
CW Refusals.....	21
CW Unable to Reach	21
Reassessments (HRAs required to be completed in CareCompass effective TBD).....	22
Screening Document Activity Type 10 (new section)	23
Entry of LTC Screening Document information into MMIS	23
MMIS Reminders:	23

Timeline for MMIS entry	24
Community Well (non-Elderly Waiver) enrollees	24
Assessment entry for all members on EW	24
Assessment entry for community members opening to EW for the first time (assessment result 01).....	25
Community Well members	25
CW Refusals.....	25
CW Unable to Reach	25
CW Refusing face to face visit but consents to telephonic HRA using DHS 3428H.....	26
Instructions for updating MMIS Entry for Transitional HRA or Transfers only.....	26
Comprehensive Care Plan (CCP) (Required to be completed in CareCompass effective TBD)	27
Care Planning requirements	27
Collaborative Care Plan components	28
Provider and Member Signature Requirements (See 9.15 Provider Signature FAQ Resource)	28
Home Health Care Authorization Processes	29
Medicare Skilled Home Care Services.....	29
Medical Assistance State Plan Home Care Services	30
Care Coordinator Role:	30
Process for Care Coordinator <i>Approval</i> to Blue Plus of Home Care Authorizations.....	31
Process for Care Coordinator <i>Request for Review</i>	31
New enrollees with previously approved state plan home care services	32
Members on Elderly Waiver receiving state plan home care services	32
Service Authorization Errors	32
Elderly Waiver Extended Home Care Services	33
PCA Authorization Processes (PCA assessments required to be completed in CareCompass effective TBD)	33
Requesting a PCA Assessment	33
New enrollees with existing PCA authorizations:	34
New PCA authorization requests for current enrollees:	34
Re-assessment PCA authorization requests:.....	34
Change in PCA Provider:	35
PCA Temporary Start/Temporary Increase:.....	35
Extended PCA Requests for members on EW:	35
Opening a Member to Elderly Waiver	35
Elderly Waiver Authorizations	36

MHCP Enrolled Providers.....	36
Approval-Option Service Providers	36
Service Agreements.....	37
Service Agreement Errors	37
Waiver Obligation	37
MA services included in EW Case Mix Cap.....	37
Requests to exceed Case Mix Budget Cap	38
Process to request an exception to Case Mix Budget Cap	38
Withdrawal of a request to exceed case mix cap.....	39
EW Conversion Requests	39
Process to request EW Conversion Rate	40
Process to withdrawal EW Conversion Rate	41
Elderly Waiver Services.....	42
Consumer Directed Community Supports (CDCS)	42
Home and Vehicle Modifications	43
EW Specialized Equipment and Supplies (T2029).....	44
EW T2029 authorization process for: Single EW items less than \$500.....	44
EW T2029 authorization process for: Single EW items over \$500	45
Authorization Process for Lift Chair and Mechanism	45
Chair portion	46
Customized Living and Foster Care.....	46
Nursing Facility Level of Care	47
Essential Community Supports	47
Care Coordination Delegate Management Reports	47
On-Going Care Coordination Responsibilities.....	48
Primary Care Clinic (PCC) Change	48
Transitions of Care (TOC): Required to be entered in CareCompass TBD	49
Definitions.....	49
Care Coordination TOC Documentation Responsibilities: Required to be entered in CareCompass TBD	50
Pre-Admission Screening activities.....	51
Transfers.....	52
Transfers of Care Coordination to Another Blue Plus Delegate	52

Responsibilities of the Care Coordination Delegate who is initiating the transfer	53
Responsibilities of the transferring Care Coordination Delegate	53
Responsibilities of the Care Coordination Delegate who is receiving the transfer:.....	54
Moving out of the Blue Plus service area	55
Transfers of Care Coordination within your agency	56
My Move Plan Summary	57
EW reassessments and termination of MA eligibility	58
Case Closure Care Coordination Responsibilities	58
Term due to death:.....	59
Term due to a move out of the Blue Plus Service area:.....	59
Term due to a move out of state or out of country:.....	59
Term due to lapse in MA coverage for EW members:	59
Term due to lapse in MA coverage for CW Members on MSHO	59
Term due to lapse in MA coverage for CW Members on MSC+:	59
MA closing and will not reopen:	59
Term due to health plan change:	60
90 Day Grace Period (MSHO only).....	60
DTRs—Coordination of Potential Denials, Terminations, and Reduction of Services	61
Denials	61
Terminations.....	61
Reductions	61
Grievances/Complaints Policy and Procedure	64
Definitions	64
Delegate Responsibilities.....	65
Oral Grievances	65
Written Grievances.....	65
Member and Provider Appeals	65
Interpreter Services	66
Relocation Targeted Case Management.....	66
Moving Home Minnesota	67
Out-of-Home Respite Care—Community Emergency or Disaster.....	68

Other Care Coordination Responsibilities.....	69
Blue Plus Network	69
Audit Process	69
Records Retention Policy	71

Contact Information

Behavioral Health Clinical Guides 1-866-489-6947 Option 1 BH Prior Authorization Fax: 651-662-0854 Behavioral Health Crisis Line for members 1-844-410-0745	Consultation for Mental Health and Substance Use Disorders – Care Coordinators only. Behavioral Health contact for members in crisis.
BlueRide (for members): 651-662-8648 or 1-866-340-8648 BlueRide (for Care Coordinators): 855-933-6991 or bluerideintake@logisticare.com minnesotafacbcbs@logisticare.com Logisticare’s TripCare Portal https://tripcare.logisticare.com/login	Contact information to arrange medical transportation. Email address to send requests to exceed 30/60 mileage limits. Care Coordinator portal for scheduling medical or dental rides
CaregiverCornerMN.com	BCBS hosted site with helpful information and resources for caregivers
Care Coordination Website www.bluecrossmn.com/carecoordination	Access to Care Coordination communications, guidelines, forms, letters, resources, and trainings
Delta Dental Members 651-406-5907 or 1-800-774-9049 Care Coordinator Liaison 651-994-5198 or 1-866-303-8138	Assistance to find a dental provider Schedule dental appointments Liaison for Care Coordinators only . Will assist with difficulties in accessing dental appointments and other Delta Dental specific questions.
Member Services MSHO 651-662-6013 or 1-888-740-6013 MSC+ 651-662-5545 or 1-800-711-9862 TTY: 711	Benefits questions Assistance finding an in-network provider Billing questions Grievances/appeals
Partner Relations Consultants Partner.relations@bluecrossmn.com Fax: 651-662-0015 See 9.02.01 Government Programs Partner Relations map for designated representative	Blue Plus liaison for MSHO and MSC+ Care Coordination delegate contracts. Primary contact for care coordination program and process questions including but not limited to: Member specific issues LTSS/Elderly Waiver Health Risk Assessment/Care Planning Care Coordination audits
Provider Service 651-662-5200 or 1-800-262-0820	Provider assistance Contract/provider access questions
Prime Therapeutics	Assistance to find a pharmacy Available 24/7 to assist with prior authorizations

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+ 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+ 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.

ID Prefix's are now included in front of the members ID number. The prefixes are JTM for MSHO and LMN for MSC+ , these prefixes are prior to the ID number. (i.e. JMN#####)

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 training is available online as a PowerPoint presentation at:

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

All contracted Care Coordination Delegates and staff are required to view this training annually and save a copy of attendance logs.

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 the Department of Human Services (DHS) several times throughout the month. Delegates will need to check their Delegate “Queue” in CareCompass daily to assign any new members which may appear as new enrollees or transfers throughout the month. In addition to checking the Delegate “Queue”, the Delegate has the option of generating an enrollment report at any time throughout the month which will look similar to the Full Detail reports in the past (see the AGP Systems Manual under *Reports* for information on how to generate reports). This report will include 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 change: 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.
- 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).

Upon notification via the Delegate’s queue in CareCompass, the Delegate:

1. Review the newly assigned member’s demographic information. If the member should not be assigned to your agency, Delegate will need to notify Blue Plus enrollment by emailing secureblue.enrollment@bluecrossmn.com no later than the 15th of the enrollment month.
 - a. 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.
2. Assigns a Care Coordinator per Delegate’s policy.
3. Assigns the Care Coordinator to the member in CareCompass following the process outlined in the AGP Systems Manual (Care Coordinator Assignment).
4. Informs the member of the name, number, and availability of the Care Coordinator within 10 days of notification of enrollment.
5. Enters the name and contact information of the Care Coordinator assigned into CareCompass as outlined in the AGP Systems Manual (Adding a Contact in the Address Book).
6. Documents any delays of enrollment notification.

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 instead of 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.

Members with another Case Manager

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 C+ Care Coordinator must collaborate with the other case manager. 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. 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".

The Care Coordinator must complete the following Care Coordination responsibilities:

- Required contacts with member and physician
- Completion of DHS 3428H and My ICF/DD and HCBS Waiver Care Plan. **To complete the assessment and Care Plan in CareCompass, refer to CareCompass-Member360 Manual under the *Assessments and Plan of Care* section for instructions. (Required to be completed in CareCompass effective TBD)**
- **Complete the required Assessment Complete Contact Note template to document your assessment type and date into CareCompass by the 10th of the following month. Refer to CareCompass-Member360 Manual under the *Progress Notes* section for entry details.**
- Semi-annual member contact and monitoring of goals completed on **My ICF/DD and HCBS Waiver Care Plan**
- Transition of Care activities
- Blue Plus Care Coordinator is responsible for authorizing state plan home care services, including PCA, and must follow the process in the *Home Health Care Authorization* section in coordination with the other Case Manager.
- MSHO supplemental benefit discussion (as applicable)
- MSHO enrollment with MSC+ enrollees (as applicable)
- Sign and date My ICF/DD and HCBS Waiver Care Plan.
- **Obtain member/responsible party signature on My ICF/DD and HCBS Waiver Care Plan.**
- Provide a copy of My ICF/DD and HCBS Waiver Care Plan to the member and other waiver Case Manager

- Provide a copy of My ICF/DD and HCBS Waiver Care Plan or a care plan summary letter to the physician.
- 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*.
- For members on other waivers (DD, CAC, CADI & BI), do not enter waiver service agreements into **Availity/Interactive Care Reviewer**.
- Care Coordinators will **only enter MA home care and/or PCA authorizations in ICR**. Refer to section: *Home Health Care Authorization*

Complete a new MN- Health Risk Assessment Form (3428H) and My ICF/DD and HCBS Waiver Care Plan within 365 days

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	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
due after notification of enrollment	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: MSHO CW EW Checklist or MSC+ CW EW Checklist.
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. **Once a Care Coordinator has been assigned to a member, the CC must add his/her name, email and phone number as a Contact in the Address Book in CareCompass. This is needed for notifications from Blue Plus. See the AGP Systems Manual under the *Adding a Contact in the Address Book* section for complete details.**

5. For new Blue Plus members open the case in Care Compass. See the AGP Systems Manual under the *Opening a Case for a member for the first time*.
6. Welcome call/letter (8.22 Intro Letter) to member within 30 calendar days after notification of enrollment
7. Explanation of Care Coordinator's role. Optional resource: 6.01 Welcome Call Talking Points.
8. Discuss In-Home Assessment Program. (currently on hold)
9. 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 or on the assessment if available.

MSC+ Enrollees:

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

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

10. Confirm the correct Primary Care Clinic (PCC). 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 request an update to the PCC in the Amerigroup System. The CC should follow the process listed below under "Changing Member Demographics". You must choose a clinic from one that is listed in the Primary Care Network Listing available under Resources on the Care Coordination website. 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 also 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 Amerigroup alone will not transfer care coordination.

The following PCC's provide primary care and care coordination:

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

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

Changing Member Demographics

When the member has a change in any of their demographic information or Opens to EW, the Care Coordinator must request an update be made in CareCompass using the “Demographic Change Form” located on the care coordination portal under the Amerigroup page:

- Member Residential & Mailing Address
- Member phone
- County of Residence
- Primary Care Clinic
- Elderly Waiver Open Date

The Care Coordinator must email the “Demographic Change Form” to the following email addresses:

SecureBlue MSHO: mnmmp@anthem.com

BlueAdvantage MSC+: enrollment_mn@anthem.com

Any demographic changes can be verified in Member360 within 72 hours of the request. The demographic changes will only display for up to 90 days; Care Coordinators must still notify the member’s county financial worker via DHS 5181 for the changes to get inputted into the enrollment files.

Health Risk Assessment

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

Health Risk Assessment options

LTCC (DHS 3428) Health Risk Assessment tool for initial and annual assessments.

6.28 Transitional HRA

- 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 3428H and Care Plan 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.
 - My ICF/DD and HCBS Waiver Care Plan
- HRA for members who consent to a telephonic health risk assessment (CW members who have previously refused a face-to-face HRA)
 - MN My 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 (HRAs required to be completed in CareCompass effective TBD)

LTCC (DHS Form 3428)

- 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.
- Document any delays in scheduling of the assessment
- Document any delays of enrollment notification
- **Complete the required Assessment Complete Contact Note template to document your assessment type and date into CareCompass by the 10th of the following month. Refer to CareCompass-Member360 Manual under the *Progress Notes* section for entry details.**
- Enter an LTC Screening Document in MMIS (See Entry of LTCC screening document information into MMIS section)
- Reassessment is due within 365 days of the date of this LTCC.

6.28 Transitional HRA

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 or
 - Community Support Plan

Care Coordinator enters the following into **CareCompass**:

- The required Assessment Complete Contact Note template to document your assessment type and date into CareCompass by the 10th of the following month. Refer to CareCompass-Member360 Manual under the *Progress Notes* section for entry details.

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 obtains and reviews:

- a. LTCC or MnCHOICES Assessment or DHS 3428H
- b. Current care plan:
 - MN Collaborative Plan of Care
 - Community Support Plan
 - My ICF/DD and HCBS Waiver Care Plan
 - MN My Care Plan- Telephonic

Care Coordinator completes following:

1. 6.28 Transitional Health Risk Assessment.
2. Complete the required Assessment Complete Contact Note template to document your assessment type and date into CareCompass by the 10th of the following month. Refer to CareCompass-Member360 Manual under the *Progress Notes* section for entry details.

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 (when members have other case management)

- 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.

- My ICF/DD and HCBS Waiver Care Plan: care plan to be used with members open to other waivers

*See section **Members with another Case Manager** above.*

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.

Telephonic Health Risk Assessment – DHS 3428H (MN Health Risk Assessment Form 3428H)

Care Coordinators should always offer a face-to-face HRA which is the preferred option. The Telephonic Health Risk assessment (MN Health Risk Assessment Form 3428H) 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. *To complete in CareCompass refer to CareCompass-Member360 Manual under the Assessments and Plan of Care section. (Required to be completed in CareCompass effective TBD)*
3. Complete *MN My Care Plan- Telephonic*
4. Mail a copy to the member for their records and *a copy of the signature page they can return with their signature.*
5. Enter the HRA date into *CareCompass* recording the date you completed the telephonic HRA (DHS 3428H) using the *Assessment Complete Contact Note template. Refer to CareCompass-Member360 Manual under the Progress Notes section for information on completing the Assessment Contact Note template in CareCompass*
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 (MSC+ 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:

1. Contact the member and offer a Face-to-Face assessment again per the process outlined in the Initial Contact section.
2. If the member continues to refuse the Face-to-face, review the current 3428H Health Risk Assessment and **MN My Care Plan- Telephonic** with the member by phone.
3. Complete a Transitional HRA and attach to the current DHS-3428H Health Risk Assessment and MN My Care Plan- Telephonic. **To complete in CareCompass refer to CareCompass-Member360 Manual under the *Assessments and Plan of Care* section. (Required to be completed in CareCompass effective TBD)**
4. Enter the HRA date into **CareCompass** recording the date you completed the Transitional HRA using the **Assessment Complete Contact Note template**. **Refer to CareCompass-Member360 Manual under the *Progress Notes* section for information on completing the Assessment Contact Note template in CareCompass**
5. Complete an MMIS LTC Screening Document following instructions in section Entry of LTC Screening Document information into MMIS.
 - b. Enter screening document type “H” using the following codes:
 - a. Activity Type 01 (telephone screen)
 - b. Assessment Result 35 (MSHO/MS C+)
 - c. Program Type 18

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

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:

1. Complete the **Refusal of Assessment Contact Note template in CareCompass**. **Refer to CareCompass-Member360 Manual under the *Progress Notes* section.**
2. Enter a SD using the Refusal code in MMIS
3. Continue to reach out at minimum, every six months either by mail or phone.

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 using the **Unable to Reach Assessment Contact Note template in CareCompass. Refer to CareCompass-Member360 Manual under the *Progress Notes* section for information on completing the See *Unable to Reach Assessment Note* section.**
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 **CareCompass Unable to Reach Assessment Note** 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 **CareCompass as phone contact attempts in the Unable to Reach Assessment Note.**
- You may enter the same date in **CareCompass in the Unable to Reach Assessment Note** if your attempts occurred on the same date.

Reassessments (HRAs required to be completed in CareCompass effective TBD)

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.
3. For members on other disability waivers, in an ICF/DD or DD member living in the community, **complete the Minnesota Health Risk Assessment Form DHS 3428H.**
4. The Care Coordinator shall complete the applicable care plan within 30 calendar days of the HRA:
 - **MN Collaborative Plan of Care**
 - **My ICF/DD and HCBS Waiver Care Plan**
 - **MN My Care Plan- Telephonic**
5. **Enter assessment contact note using BCBSMN-Assessment Complete Contact Note template. Refer to CareCompass-Member360 Manual under the *Progress Notes* section for information on completing the Assessment Contact Note template in CareCompass**
6. The Care Coordinator will complete 8.29 Care Plan Summary Letter to Doctor or send a copy of the care plan.

7. If state plan home care services are needed, see *Home Health Care Authorizations* section.
8. Enter Screening Documents following the process and timeframes as outlined in section, *Entry of LTC Screening Documents*.
9. Discuss SecureBlue MSHO product and assist the member to enroll if applicable. Document this **discussion in the assessment if available or in your case notes**. If member is not eligible for MSHO and the discussion did not take place, document this in the **assessment if available or in your case notes**. Information and resources can be found on the home page of the Care Coordination website. 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.

Screening Document Activity Type 10 (new section)

DHS Bulletin #18-25-05 Service Update Activity Type- Elderly Waiver and Alternative Care Programs provides instruction re: using Activity Type 10- Service Change on the LTC Screening Document. Activity type 10 was initially created to help streamline the process for fee for service clients when an update was needed but there wasn't a need for a whole new MnCHOICES assessment.

Blue Plus Care Coordinators should not use Activity Type 10. CCs would complete a new LTCC for a change in condition. If you have questions, please contact your Partner Relations Consultant.

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

Community Well (non-Elderly Waiver) enrollees

MSHO CW: Enter SD within 45 days of enrollment date and **within 45 days of reassessment**

MSC+ CW: Enter SD within 75 days of enrollment date and **within 45 days of reassessment**

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	12/20/18
February	01/23/19
March	02/20/19
April	03/21/19
May	04/22/19
June	05/23/19
July	06/20/19
August	07/23/19
September	08/22/19
October	09/20/19
November	10/23/19
December	11/19/19
January 2020	12/20/19

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 03 (person will remain in, or return to, the community without services)
 - 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)
- Program Type 18 (MSHO/MSCH+ 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 My ICF/DD and HCBS Waiver Care Plan, enter SD type "H" with the following codes:
 - Activity Type 01 (telephone screen) or 02 face to face
 - Assessment Result 35 (MSHO/MSCH+)
 - Program Type 18

CW Refusals

Enter SD within 45 days of the enrollment date using the screening document 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 screening document 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. Enter screening document type “H”

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

Instructions for updating MMIS Entry for Transitional HRA or Transfers only

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

Scenario	Transitional HRA for New Enrollee (includes product changes)	Transitional HRA for New Enrollee (includes product changes)	Change in Care Coordinator	Change in Care Coordinator
	Community Well	Elderly Waiver	Community Well	Elderly Waiver
Activity Type:	05	05	05	05
Activity Date:	Date Transitional HRA is completed	Date Transitional HRA is completed	Date delegate assumed Care Coordination responsibility	Date delegate assumed Care Coordination responsibility
LTCC CTY	BPH	BPH	n/a	n/a
Case Managers Name and 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	n/a	n/a
Effective Date:	Date Transitional HRA is completed	Date Transitional HRA is completed	n/a	n/a
Program Type Note: program type cannot be changed with 05 SD	18	03 or 04	n/a	n/a

Comprehensive Care Plan (CCP) (Required to be completed in CareCompass effective TBD)

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:

- **MN Collaborative Plan of Care:** to be used following completion of the LTCC assessment DHS 3428 (refer to resource 6.02.02 Instructions for the Collaborative Care Plan)
- **My ICF/DD and HCBS Waiver Care Plan:** 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
- **MN My 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 MN My Care Plan-Telephonic

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. **Upload into CareCompass following AGP systems Manual under *Member and Care Coordinator Signature on Care Plan.* (effective TBD)**
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). **Provider Signatures may be uploaded into CareCompass (OPTIONAL effective TBD). See the *Provider Signature Requirements* section of the CareCompass-Member360 Manual. If you choose not to upload into CareCompass, keep copies in your member's file.**
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 in CareCompass by assigning a task to BCBS-Referral to Complex Case MGT following the steps outlined in the AGP Systems Manual under *Making a referral to Case Management*.**
- 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.

Provider Signatures may be uploaded into CareCompass (OPTIONAL effective TBD). See the *Provider Signature Requirements* section of the CareCompass-Member360 Manual. If you choose not to upload into CareCompass, keep copies in your member's file.

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 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 UM. Amounts exceeding what is allowed for Care Coordinator approval will require a Prior Authorization from Blue Plus. **Both types of requests require entry into the Interactive Care Reviewer (ICR) portal (see ICR Training Materials located on the Care Coordination website).**

State plan home care services include:

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

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. Enter authorization request into ICR portal. **See ICR Training Materials located on the Care Coordination website.**
3. See ICR Training Materials on the Care Coordination website for step by step entry process if needed **prior to the start of home care services**. All home care claims submitted without **Service Authorizations in ICR** may be denied, which may result in providers having to appeal.
4. *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 *Approval* to Blue Plus of Home Care Authorizations

Care Coordinators may approve without UM review up to the following prescribed amounts. Care Coordinators will choose “approve” in the Decision Details tab following the step by step entry process in the ICR Training Materials for the following:

- 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 MA home therapy: physical, occupational, speech, or respiratory therapy
- Personal Care Assistant (PCA) Services

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 create the authorization in ICR. This visit should be included with the total number of visits needed in addition to any PRN (as needed) visits.

UM will:

1. Notify member and home care provider of the authorization via letter
2. Notify Care Coordinator **in CareCompass via a message on the Care Coordinator’s main page. The Care Coordinator can also view Authorizations in Member360 in the Member Care Summary tab.**

Process for Care Coordinator *Request for Review*

Blue Plus requires prior authorization to determine medical necessity for home care service amounts exceeding what is allowed for approval by the Care Coordinator. **Care Coordinators will choose “Request for Review” in the Decision Details tab following the step by step entry process in the ICR Training Materials for the following:**

- 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
- Home Care Nursing (formerly PDN)
- 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, attach a copy of the member’s Residential Services tool to the service auth request on the Clinical Details tab in ICR.**

Upon receipt of the prior authorization request, UM 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. Notify member and home care provider of the decision via letter
6. **Notify Care Coordinator in CareCompass via a message on the Care Coordinator's main page. The Care Coordinator can also view Authorizations in Member360.**

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:

Entering an approval of services into ICR following the process outlined in the Process for Care Coordinator Approval to Blue Plus of Home Care Authorizations (above). See the ICR Training Materials for details on how to enter authorizations in ICR.

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)
- Home Care Nursing (formerly 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)

See ICR Training Materials on the Care Coordination website for how to enter state plan home care service amounts into the EW service plan budget or ask your Partner Relations Consultant.

Service Authorization Errors

If the Care Coordinator learns of a service authorization error after entering the authorization in Availity's ICR, you must complete the **Service Agreement Error form** for UM to make the correction.

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.

PCA Authorization Processes (PCA assessments required to be completed in CareCompass effective TBD)

The Care Coordinator is responsible for the completion of activities associated with assessing PCA and authorizing services for all members eligible for the PCA services under the MSHO/MSCH+. All requests for PCA assessments or re-assessment will be routed to, managed, and completed by the assigned Care Coordinator.

To be eligible for PCA services, the recipient must:

- Have a stable medical condition not needing hospitalization and require PCA to live in the community
- Live in their home, not a hospital, nursing facility, ICF/MR, foster care setting with more than 4 residents, or any facility licensed by the Minnesota Department of Health (MDH).

Requesting a PCA Assessment:

A request for PCA can be made by numerous sources for an MSCH+/MSHO member, including but not limited to:

- the member,
- the member representatives
- public health nurses,
- treating practitioners,
- and other providers of service.

All SecureBlue (MSHO) and MSCH+ 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.

In addition to completing the required PCA assessment, Care Coordinators must also do the following:

- Obtain the member's signature (and interpreters if applicable) on the PCA assessment. Upload into CareCompass following AGP systems Manual under *PCA Assessments Signature Page—uploading a copy. (effective TBD)*
- Provide the member with a copy of the PCA assessment in addition with a copy of the MSHO or MSC+ Language Block available on the Care Coordination portal (new requirement)

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.

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.
 - If in network, the Care Coordinator will enter their authorization into ICR by choosing "Approve" in the Decision Details tab following the step by step entry process detailed in the ICR Manual.
 - For PCA providers not in our network, Care Coordinator will enter their authorization into ICR and choose "Approve" in the Decision Details tab. CC should work with the member to transition to an in-network provider within 120 days.

New PCA authorization requests for current enrollees:

1. Upon completion of the PCA assessment, the CC 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 enter their authorization into ICR by choosing "Approve" in the Decision Details tab following the step by step entry process detailed in the ICR Manual. The Care Coordinator should align the PCA date span with the EW date span, if applicable.

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 must enter their authorization into **ICR by choosing “Approve” in the Decision Details tab following the step by step entry process detailed in the ICR Manual.**
4. The Care Coordinator should align the PCA date span with the EW date span, if applicable.

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, the Care Coordinator must enter an authorization for the new provider into ICR. See the step by step entry process detailed in the ICR Manual.**

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 enter their authorization into ICR by choosing “Approve” in the Decision Details tab following the step by step entry process in the ICR Training Materials.**

Extended PCA Requests for members on EW:

For Blue Plus members open to EW, extended PCA hours may be authorized by the Care Coordinator in **ICR**. 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 under EW as allowed within the member’s EW budget. The Care Coordinator should assess for appropriateness of extended PCA. UM does not review extended PCA as it is not based on medical necessity criteria.

Opening a Member to Elderly Waiver

When opening a member to EW, you must inform Amerigroup of the member’s EW start date by completing the following:

1. Member Demographic Change Form
2. EW Case Mix and Span Fields on the Assessment Complete Progress Note in CareCompass

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 is in the Resource section of the Care Coordination website. **All EW Service Agreements are created in the Interactive Care Reviewer (ICR) portal through the Availity Clearinghouse.**

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.

Providers should visit www.bluecrossmn.com/elderlywaiver for more information.

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 Interactive Care Reviewer (ICR) training materials for details 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

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

Care Coordinators will enter Service Agreements **directly into Availity via the Interactive Care Reviewer (ICR) portal**. Care Coordinators are responsible to become familiar with this web-tool and the ICR training materials located on the care coordination website. Care Coordinators are also responsible for EW Provider inquiries related to their Service Agreement entries. **Approved authorizations can be viewed in Member360.**

Service Agreement Errors

If the Care Coordinator learns of a service authorization error after entering the authorization in Availity's ICR, you must complete the **Service Agreement Error form** for UM to make the correction.

Waiver Obligation

Information regarding a member's waiver obligation, if they have one, will be displayed in **Member360 under Active Alerts**. 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 **Amerigroup**.

Inquiries related to EW claims and Service Agreements should be directed to **Amerigroup**.

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:

1. State plan home care services including:
 - Skilled Nurse visits (SNV)
 - Home Health Aide visits (HHA)
 - Home Care Nursing (HCN) (Formerly PDN)
 - Personal Care Assistance (PCA)
- and*
2. Monthly Care Coordination *and*
3. Case Aide billing, if applicable

Requests to exceed Case Mix Budget Cap

If a member has a unique set of assessed needs that require care plan services above their EW 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 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 EW Case Mix Cap and the Care Coordinator determines there is no assessed need, the Care Coordinator must request a DTR by faxing in the *Notification of 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

1. Provide the following information to the EW Review Team via a secure email to Partner.Relations@bluecrossmn.com

- 6.27 Request to Exceed Case Mix Cap/Conversion Request form
- Care Coordination case notes for previous 2 months
- Current LTCC (reviewed within the previous 60 days)
- Current Care Plan
- A copy of Residential Services tool, if applicable (CL rate must be within CL rate limits except for EW Conversion rate requests)
- Any other supporting documents deemed appropriate
- Other documents requested by the EW Review Team
- A description of other options within the member's current budget which have been considered and why they are not possible must be included on the 6.27 or Request to Exceed Case Mix Cap template in CareCompass.

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 Care Coordinator via email
2. Enter a progress note in CareCompass with the approval information (approved amount and span)

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.

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. Request a DTR
 - a. 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
 - 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 ICR for the remainder of the EW span date after the withdrawal effective date. See ICR Training Materials for complete information.

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:

1. **Provide the following information to the EW Review Team via a secure email to Partner.Relations@bluecrossmn.com**
 - 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
 - Current LTCC
 - Current Care Plan
 - A description of other options within the member's current budget which have been considered and why they are not possible must be included on the 6.27 or Request to Exceed Case Mix Cap template in CareCompass.
 - A copy of Residential Services tool, (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 Team 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 Care Coordinator via email
2. Enter a progress note in CareCompass with the approval information (approved amount and span)

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. 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. Request a DTR
 - a. 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
 - 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 ICR for the remainder of the EW span date after the withdrawal effective date. See ICR Training Materials for complete details.

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. CDCS policy information can be found here:

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

Members can:

- Choose or design the services and supports that fit their assessed needs
- Decide when to receive services and supports and
- Hire the people they want to deliver those services and supports.

The CDCS plan must:

- Address the needs that were assessed in the LTCC
- Address health and safety needs
- Be member-specific and person-centered
- Include goal(s) for each identified service or support

Care Coordinators must:

- Approve and monitor CDCS plans
- Make sure members comply with state and federal law
- Maintain Blue Plus Care Coordination responsibilities

DHS offers a CDCS course for lead agency staff which includes:

- CDCS Basics
- Roles & responsibilities
- Reviewing a Community Support Plan
- Allowable goods and services
- Guidelines about paying spouses
- Involuntary exits from CDCS

The course is available on [TrainLink](#). See the Blue Plus Care Coordination website under the Resources tab for more information.

Notes on authorizing CDCS:

1. There should only be 1 approved/active service agreement for the CDCS budget for the FMS provider for the waiver span.
2. **See the ICR Training Materials re: entry of CDCS service agreements.**
3. Authorize Mandatory Case Management by creating a separate service agreement under code T2041. Care Coordination and Case Aide are billed under this service agreement. This is not included in the member's CDCS budget.
4. Any MA home care including PCA, HHA or SNV need to be accounted for in the CDCS budget, if applicable. (see ICR training materials)
5. PCA, HHA and SNV will be authorized under a separate home care service agreement, if applicable. (see ICR training materials)
6. CDCS Background Checks (if applicable) should be separate service agreements from the CDCS service agreement in the ICR and are not included in the member's CDCS budget.
7. There should not be any other separate service agreements authorized in combination with CDCS (besides Mandatory Case Management, CDCS background checks if applicable, and MA homecare if applicable).
8. The CDCS plan must include all services that will be paid out of the CDCS budget.
 - a. **In the event of a change to the member's budget (including COLA increases from DHS), the Care Coordinator is required to complete DHS-6633A CDCS Community Support Plan Addendum and provide to both the member and the FMS provider.**
9. Goals must include language about how the goal will be implemented and how the results will be measured.

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 CDCS community support plan created by the member or their representative.

Please refer to the AGP Systems Manual and ICR Training Materials or contact your Partner Relations Consultant directly with questions.

Home and Vehicle Modifications

The Care Coordinator may authorize Home and Vehicle Modifications under EW **in ICR** 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 **ICR** 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 in **ICR**, 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.

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 **Care Coordination website**.

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 by Medicare/MA or have been denied by Medicare/MA, see EW authorization processes below.

EW T2029 authorization process for: Single EW items less than \$500

For single item is **less than \$500** that the Care Coordinator approves, the Care Coordinator should:

1. Enter a Service Agreement in **ICR** (see the **ICR training materials for information on how to enter service agreements for T2029 items**); and
2. Document the item on the member’s Collaborative Care Plan budget worksheet.

If the Care Coordinator does not approve, follow the DTR process to deny the item.

EW T2029 authorization process for: Single EW items over \$500

For EW T2029 single items over \$500 the Care Coordinator must use professional judgement to determine if the item is medically or remedially necessary. If needed, you may contact your Partner Relations Consultant for a case consultation.

A prior authorization request (via a service agreement in ICR) is required for any single EW T2029 item over \$500.

The Care Coordinator must create a service agreement for the item in ICR. Select Request for Review. See the ICR training materials for information on how to enter service agreements for T2029.

UM will contact the Care Coordinator for any follow up questions.

UM will make a coverage determination within 10 business days and notify the Care Coordinator via message in CareCompass.

If the item is approved by UM:

- The Care Coordinator is responsible to notify the member of the approval
- Enter the item on the member's Collaborative Care Plan budget worksheet.

If the single EW item over \$500 is denied:

- UM will issue a DTR to the member
- UM will notify Care Coordinator via a message in CareCompass.

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. See the ICR Training Materials for complete details.

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 are key.

- DME provider submits a prior authorization request for Medicare coverage of the lift mechanism.
- Care Coordinator authorizes under Elderly Waiver (EW) in ICR.

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.

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. UM will enter an authorization into the claims payment system.

If *denied* under Medicare benefit:

1. 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 **one service agreement in ICR**.
If the Care Coordinator deems it is ineligible for coverage under EW, the Care Coordinator should **submit a request for a DTR following the process for denials in the ICR Training Materials**.

Chair portion

Once it has been determined if Medicare/MA will cover the lift mechanism, the Care Coordinator can enter an authorization for the lift chair in ICR:

- If lift approved by Medicare/MA, authorize the total cost of the chair portion in ICR.
- If lift denied by Medicare/MA, authorize the total cost of the lift and chair portion together on one service agreement in ICR.

If the chair portion of the lift chair is over \$950, the Care Coordinator **must consult with their supervisor and/or the Partner Relations Consultant prior to authorizing in ICR. Document this discussion in your case notes.**

Customized Living and Foster Care

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 coordinators 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. **The questions on the 3428Q-ENG are integrate into the MN LTCC Services Assessment in CareCompass when required.**

<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.

Care Coordination Delegate Management Reports

Care Coordination Delegates will have access to generate the following reports from CareCompass (effective TBD):

1. MSHO MOC Dashboard Report (aka MSHO Assessment Completion Report)
2. MSC+ Assessment Completion Report
3. Assessments Due Report
4. Enrollment Reports

Delegates are responsible to pull their own reports from CareCompass. Follow the process outlined in the AGP Systems Manual for instructions on how to generate a report. Blue Plus will not be sending out notifications that reports are ready or copies of these reports directly to Delegates.

Report Name	Description/Purpose of Report	Frequency
MSHO MOC Dashboard Report	MSHO assessments completed. Use this report to track timely assessment completion.	Monthly
MSC+ Assessment Completion Report	MSC+ assessments completed. Use this report to track timely assessment completion.	Monthly
Assessments Due Report	MSHO and MSC+ assessments coming up due- 30-, 60- & 90-day interval	Monthly
Enrollment Reports	Report of newly enrolled members, termed members, and current roster of all currently enrolled members via delegate agency assignment	Monthly

On-Going Care Coordination Responsibilities

Primary Care Clinic (PCC) Change

Blue Plus must be notified when a member changes their Primary Care Clinic (PCC). 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 **complete the "Demographic Change Form" found on the Care Coordination website and email it to:**

- MSHO members: mnmmp@anthem.com
- MSC+ members: enrollment_mn@anthem.com

For a list of all PCC's see our Primary Care Network Listing (PCNL) found on the Care Coordination website under Resources or at www.bluecrossmn.com/publicprograms . You must choose a clinic from one that is listed. If the member's PCC is not listed, 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. **Completing the Demographic Change Form** alone will not transfer care coordination. **Refer to transfer process see section; Transfers in Care Coordination to another Delegate.**

The following PCCs currently provide care coordination:

- Bluestone Physicians
- 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): Required to be entered in CareCompass TBD

The Blue Plus Care Coordinator is key to supporting the member's needs across the continuum of care. Regular engagement and contact with the member and their service providers allows the Care Coordinator to be informed of health care service needs and supports, thus allowing active management of planned and unplanned transitions. The goal of the TOC process is to reduce incidents related to fragmented or unsafe care and to reduce readmissions for the same condition.

***Transitions of Care engagement and follow up is required regardless of how or when the Care Coordinator learns of the transition. One way the CC may learn of the transition is through **Blue Plus notice of inpatient admissions, which is sent to Delegates via CareCompass on the home page under New Messages. Notification date is the date the message is viewable by the primary Care Coordinator (or notified in a different manner)**

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: Required to be entered in CareCompass TBD

1. Documenting Transitions of Care:
 - a. Complete 6.22 Transitions of Care log and upload into a BCBSMN-Contact Note in CareCompass.
OR
 - b. Complete contact note in CareCompass using template: MN Transition of Care Log. *This template does not allow for on-going updates the CC should:*
 1. Complete a separate contact note for each transition.

Use 6.22.01 Transitions Log Instructions for detailed information on the completion of the log.

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 contact 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 form: [6.22.02 Fax Notification of Care Transition found on the Care Coordination website or template from CareCompass progress note MN Notification of Care Transition. Refer to Progress Notes section of AGP Systems Manual.](#)
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. [For MSHO members offer post discharge resources. Refer to CC website: Post Discharge Resources for SecureBlue Members.](#)
 - 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 Amerigroup.](#)

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:

- Complete the BCBSMN Transfer Notes progress note template in CareCompass (see Transfers section in the AGP Systems Manual for step by step process).
- Complete the Member Demographic Change form (see Member Demographic Change process in these guidelines).

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.

Important note: The transferring Care Coordinator must have all HRA data entered into CareCompass prior to the transfer effective date. Once the member is re-assigned to the receiving Delegate in CareCompass, the transferring Care Coordinator will continue to have access to the member until removed and/or re-assigned to the new Care Coordinator.

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 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
 - 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. Document the transfer by completing the BCBSMN Transfer Notes progress note template
4. Complete and send the Member Demographic Change form to Amerigroup.

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)
 - Current Health Risk Assessment
 - Care Plan; including plan signature page and provider signature documentation
 - A copy of the Residential Services tool
 - My Move Plan Summary

2. The transferring Care Coordinator **must** have all HRA data entered into CareCompass prior to the transfer effective date. Once the member is re-assigned to the receiving Delegate in CareCompass, the transferring Care Coordinator will no longer have access to the member's record.
3. The **transferring** Care Coordinator should communicate the following to the member's financial worker:
 - a. Address change
 - b. EW eligibility
4. 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 ICR 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.
5. 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 the transfer process outlined here and change the PCC (if applicable).
6. 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 the Individual Transitions Log.

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

Once the initiating Delegate sends the Member Demographic Change form to Amerigroup, the AGP system will update but assignment will not change until after enrollment is received from DHS. The transferred member's name should appear in the receiving Delegate's queue in CareCompass the following month.

You will not be able to distinguish whether a member's name is a transfer or a new enrollee in the Delegate's queue. The Receiving delegate can confirm the member is a *transfer* by pulling an enrollment report and looking for transfer flag or by verifying the member's enrollment dates in the CareCompass ribbon after bringing the member into focus as shown here:



- If the enrollment date is the same as the current month, the member is not a transfer and is a *new enrollee*.

- If the enrollment date is a historical date prior to the current month, the member is a *transfer*.
 - a. If a transfer, review the member's progress notes and verify if there is a completed 'BCBS Transfer Notes'.
 - b. If there is not a 'BCBS Transfer Notes' in the member's record, email secureblue.enrollment@bluecrossmn.com to research and respond.

Once the transfer is confirmed, 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 CareCompass following the process outlined in the AGP Systems 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 Member360. 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.

NOTE: Authorizations entered in ICR by the previous delegate will be viewable by the new delegate in Member360.

Moving out of the Blue Plus service area

Do not follow the Transfers process. 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 ICR 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, the Care Coordinator should provide contact information so that they may register for claims to process.
4. Close Case in CareCompass after member officially terms to Blue Plus. Not required to Close the case if it was never "Opened" in CareCompass.
 - Do not close the case until all HRA data has been entered into CareCompass.

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 CareCompass
- Enter a Screening Document into MMIS
- Notify the financial worker of the change in Care Coordinator.
- Notify the physician using 8.28 Intro to Doctor Letter.

- Do not send complete the BCBSMN Transfer Notes progress note template in Care Compass for care coordinator changes 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 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. Notify AGP to close EW service agreement lines
4. Close case in CareCompass, if “opened”.
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. Notify AGP to close EW service agreements by completing the Notification of DTR form
3. Close case in CareCompass, if “opened”.
4. 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 ICR
3. Keep all service agreements open ICR
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
8. Notify AGP to close EW service agreements back to MA closure date by completing the Notification of DTR form
 - a. Enter Screening Document into MMIS to exit member from EW
9. Close case in CareCompass, if “opened”.

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 in CareCompass , if “opened” and member is not expected to reinstate within 90 days.

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

1. Close case in CareCompass, if “opened”.

MA closing and will not reopen:

1. Close member to EW in MMIS (EW only)

2. Notify AGP to close EW service agreements by completing the Notification of DTR form
3. **Close case in CareCompass, if “opened”.**
4. 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. Notify AGP to close EW service agreements by completing the Notification of DTR form
5. **Close case in CareCompass, if “opened”.**
6. 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.
- Coverage during the 90-day grace period does not include Elderly Waiver services. The Care Coordinator can close the line items in ICR 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 ICR.
- 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

Utilization Management (UM) will review all 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 notify UM within **24 hours** of a determination. UM will review the request and if a DTR is needed, will email a copy of the DTR to the Care Coordinator and mail a copy to the provider and member.

Denials

Definition: When a Care Coordinator is denying the request for an existing service authorization or a requested service not currently authorized.

Existing services: When the Care Coordinator is making the decision to deny an existing service authorization (Elderly Waiver or state plan), the CC must notify UM operations of the need for a DTR using the Care Coordinator Notification of DTR form and fax it to AGP UM Operations at 1-844-429-7763. Denying an increase to a service: When the Care Coordinator is making the decision to deny an increase to an existing service authorization (Elderly Waiver or state plan), the CC must notify UM operations of the need for a DTR using the Care Coordinator Notification of DTR form and fax it to AGP UM Operations at 1-844-429-7763.

Requested services: When the Care Coordinator is making the decision to deny a service requested by the member which does not have a current authorization in ICR, the CC must notify UM of the need for a DTR using the Care Coordinator Notification of DTR form and fax it to AGP UM Operations at 1-844-429-7763.

Terminations

Definition: When the member requests or the Care Coordinator makes the decision to terminate service authorization(s) (Elderly Waiver or state plan), the CC must notify UM operations of the need for a DTR using the Care Coordinator Notification of DTR form and fax it to AGP UM Operations at 1-844-429-7763.

Reductions

Definition: When the member requests or the Care Coordinator makes the decision to reduce an existing authorization of services (Elderly Waiver or state plan), the CC must notify UM operations of the need for a reduction using the Care Coordinator Notification of DTR form and fax it to AGP UM Operations at 1-844-429-7763.

In addition to notifying UM of the reduction, the CC will need to enter a new authorization into ICR approving the reduced amount of service following the “Creating a Service Authorization” section in the ICR Manual.

DTR Decision Guide

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

Situation	Care Coordination Notification of DTR?
meeting NF Level of Care	
Home care agency provides services without Prior Auth from Care Coordinator. Provider 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	Care Coordination Notification of DTR?
Member goes into a hospital for acute care (less than 30 days)	Notify providers of admission	Not required
Members goes into the hospital for more than 30 consecutive days	Close the waiver as of the hospital admission date	Fax DTR form 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)	Notify providers of admission	Not required
Member goes into a nursing facility (from community or shorter-term hospital stay) for more than 30 consecutive days	Close the waiver as of the NF admission date	Fax DTR form 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 fax the Care Coordinator Notification of DTR form to Amerigroup.

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 ICR by completing Care Coordinator Notification of DTR form and fax to Amerigroup.

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.

MSHO 1-888-740-6013 (Calls to this number are free)

TTY users call: **711** (Calls to this number are free)

MSC+ 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 **1-833-224-6929**

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. 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: **contact your Partner Relations Consultant for complete details.**

- My Accessible Real Time Trusted Interpreter, or MARTTI
- **United Language Group**

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. **(Program ends Dec 31, 2019)**

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 **ICR**. 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 contact 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.

Audit Process:

Partner Relations Lead Auditor will conduct an annual Delegate audit. During the audit, 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.