Nursing Home Care Coordination Guidelines

Secure Blue - MSHO
(Minnesota Senior Health Options)

Blue Advantage - MSC+
(Minnesota Senior Care Plus)

May 2019
Changes in Red
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<tr>
<td><strong>Behavioral Health Clinical Guides</strong></td>
<td>Consultation for Mental Health and Substance Use Disorders – Care Coordinators only.</td>
</tr>
<tr>
<td>1-866-489-6947 Option 1</td>
<td></td>
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<tr>
<td>BH Prior Authorization Fax: 651-662-0854</td>
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<tr>
<td><strong>Behavioral Health Crisis Line for members</strong></td>
<td>Behavioral Health contact for members in crisis.</td>
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<tr>
<td>1-844-410-0745</td>
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<tr>
<td><strong>BlueRide</strong> (for members): 651-662-8648 or 1-866-340-8648</td>
<td>Contact information to arrange medical transportation.</td>
</tr>
<tr>
<td><strong>BlueRide</strong> (for Care Coordinators): 855-933-6991 or <a href="mailto:bluerideintake@logisticare.com">bluerideintake@logisticare.com</a></td>
<td>Email address to send requests to exceed 30/60 mileage limits.</td>
</tr>
<tr>
<td><a href="mailto:minnesotafacbcs@logisticare.com">minnesotafacbcs@logisticare.com</a></td>
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<tr>
<td>Logisticare’s TripCare Portal</td>
<td>Care Coordinator portal for scheduling medical or dental rides</td>
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<tr>
<td><a href="https://tripcare.logisticare.com/login">https://tripcare.logisticare.com/login</a></td>
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<tr>
<td><strong>CaregiverCornerMN.com</strong></td>
<td>BCBS hosted site with helpful information and resources for caregivers</td>
</tr>
<tr>
<td><strong>Care Coordination Website</strong></td>
<td>Access to Care Coordination communications, guidelines, forms, letters, resources, and trainings</td>
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<tr>
<td><a href="http://www.bluecrossmn.com/carecoordination">www.bluecrossmn.com/carecoordination</a></td>
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<tr>
<td><strong>Delta Dental</strong></td>
<td>Assistance to find a dental provider</td>
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<tr>
<td><strong>Members</strong> 651-406-5907 or 1-800-774-9049</td>
<td>Schedule dental appointments</td>
</tr>
<tr>
<td><strong>Care Coordinator Liaison</strong> 651-994-5198 or 1-866-303-8138</td>
<td>Liaison for Care Coordinators only. Will assist with difficulties in accessing dental appointments and other Delta Dental specific questions.</td>
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<tr>
<td><strong>Member Services</strong></td>
<td>Benefits questions</td>
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<tr>
<td><strong>MSHO</strong> 651-662-6013 or 1-888-740-6013</td>
<td>Assistance finding an in-network provider</td>
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<tr>
<td><strong>MSC+</strong> 651-662-5545 or 1-800-711-9862</td>
<td>Billing questions</td>
</tr>
<tr>
<td><strong>TTY</strong>: 71</td>
<td>Grievances</td>
</tr>
<tr>
<td><strong>Partner Relations Consultants</strong></td>
<td>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: <strong>Member specific issues</strong> LTSS/Elderly Waiver Health Risk Assessment/Care Planning Care Coordination audits</td>
</tr>
<tr>
<td><a href="mailto:Partner.relations@bluecrossmn.com">Partner.relations@bluecrossmn.com</a></td>
<td></td>
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<td>Fax: 651-662-0015</td>
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<td>See 9.02.01 Government Programs Partner Relations map for designated representative</td>
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<tr>
<td><strong>Provider Service</strong></td>
<td>Provider assistance</td>
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<tr>
<td>651-662-5200 or 1-800-262-0820</td>
<td>Contract/provider access questions</td>
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<tr>
<td><strong>Prime Therapeutics</strong></td>
<td>Assistance to find a pharmacy</td>
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<tr>
<td>1-800-509-0545</td>
<td>Available 24/7 to assist with prior authorizations</td>
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<tr>
<td><strong>Pharmacist</strong></td>
<td>Speak with a Blue Plus pharmacist about medication questions</td>
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<tr>
<td>MSHO Donna Boreen, Clinical Pharmacist</td>
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<tr>
<td>651-662-1264 or 1-800-711-9868 ext. 21264</td>
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<tr>
<td><a href="mailto:Donna.boreen@bluecrossmn.com">Donna.boreen@bluecrossmn.com</a></td>
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<tr>
<th>MSC+ Adrienne Matthews, Clinical Pharmacist</th>
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<tbody>
<tr>
<td>651-662-1053 ext. 21053</td>
</tr>
<tr>
<td><a href="mailto:Adrienne.Matthews@bluecrossmn.com">Adrienne.Matthews@bluecrossmn.com</a></td>
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<tr>
<th>Bridgeview Company</th>
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<tr>
<td>1-800-584-9488</td>
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<td><a href="mailto:EWproviders@bridgeview.com">EWproviders@bridgeview.com</a></td>
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<tr>
<th>Elderly Waiver service agreement/claims processing questions</th>
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<td>Questions about adding/deleting security and access</td>
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<tr>
<td>Enrollment, Care Coordination assignment, entering</td>
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<td>HRA’s/Refusals/Unable to Reach</td>
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For assistance with enrollment, contact the MSHOW Sales Outreach Specialist:

Michelle Mjelde (in purple on map) 651-662-4737
[Michelle.Mjelde@bluecrossmn.com](mailto:Michelle.Mjelde@bluecrossmn.com)

Provide the following:

- Member Name/ID and DOB
- CC Contact Information
- Member Contact Information
- Name of Primary Care Clinic/PCC

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**Definitions**

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

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

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

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

**Delegate** is defined as the agency, such as counties, private agencies and clinics, that are contracted to provide Care Coordination services for Blue Plus. Delegates are responsible for periodic reporting to Blue Plus as requested and needed to meet business requirements. Examples include but are not limited to: monthly Nursing Home assessment tracking form, Quality Improvement Project reporting, enrollment report discrepancies, Hospice care plans, missing residential service living tools, and late screening document entry follow up.

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

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

**Transfer** is defined as an existing (already enrolled) Blue Plus member who has been transferred to a new Blue Plus delegate.
**Required Caseload per worker** for Community Well, Nursing Facility, and Elderly Waiver is as follows: Elderly Waiver/Community Well mix = **40-70**, Nursing Facility only = **90-120**, and Community Well only = **75-100**.

**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########)

**Bridgeview ID:** This number will be 8+PMI for identification in Bridgeview. This is not the members ID number on their medical card.

**AGP/Blue Cross Member ID:** Members will continue to have a member ID number assigned by Amerigroup. (i.e. 726xxxxxx, 727xxxxxx)

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

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

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

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

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

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

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**

It is our expectation that all members 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 practices apply to all but not be limited to:

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

Members and/or their responsible party should be encouraged to:

- Direct their own services and supports, when desired
- Include preferences, strengths, skills, and opportunity to promote dignity and respect
Delegate Responsibilities upon Notification of Enrollment

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

1. **New CAP**: List of members who are newly enrolled to MSHO or MSC+ and is available in Bridgeview the first week of each month. Occasionally this report is ready a few days prior to the enrollment month. Do not start care coordination activities until on or after the 1st of the enrollment month.

2. **Full Detail**: A comprehensive list of all members assigned to the Delegate agency for the month and includes the following flags:
   - **New**: Enrollees who enrolled after the DHS capitation
   - **Reinstated**: Members who were going to term but were reinstated with no lapse in coverage
   - **Termed**: Coverage termed
   - **Product changes**: Changed from MSC+ to MSHO or vice versa (these members are treated as brand new enrollees and will need a new HRA)
   - **Transfer**: Existing enrollee who transferred to you. Official notification is via form 6.08 Transfer in Care Coordination Delegation.
   - **Future Term Dates**: Lists Month/Year. Member will be termed at the end of the month listed. CC should follow up to determine if the reason for disenrollment requires mediation (i.e., MA paperwork not submitted yet).

3. **Daily Add**: Includes new enrollees who were retroactively enrolled by DHS after both the New CAP and Full Detail reports were received by DHS and processed.

Upon notification, the Delegate:

1. Reviews the “New CAP” list to check for discrepancies (For example, member is incorrectly assigned to your agency) and reports them to **secureblue.enrollment@bluecrossmn.com** no later than the 15th of the enrollment month.

2. Compares the “Full Detail” list to the previous months Full Detail list to check for discrepancies and reports them to **secureblue.enrollment@bluecrossmn.com** no later than the 15th of the enrollment month.

3. Reviews the Daily Add report for discrepancies and reports them to **SecureBlue.Enrollment@bluecrossmn.com** no later than 15 days from notification. The Delegate will receive an email if there’s a Daily Add report and be directed to log into Bridgeview to access it. Please treat these as new enrollees for the month and follow the Guidelines for seeing these members within 30 or 60 days of notification as applicable.

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

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

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

2. Determine if Change in PCC requires a transfer in Care Coordination:
   If the member’s PCC is contracted with Blue Plus to provide care coordination (See list below), the change in PCC may also trigger a change in who provides Care Coordination for the member. Send notification to SecureBlue.Enrollment@bluecrossmn.com for enrollment miss-assignments or follow the process outlined in section: Transfers in Care Coordination to another Delegate, which includes sending in form 6.08 Transfer in Care Coordination Delegation.

   The member’s PCC may determine the Blue Plus delegate that provides care coordination (see list below). Changing the PCC in Bridgeview alone will not transfer care coordination.

   The following PCC’s provide primary care and care coordination:
   • Bluestone Physicians (also responsible for: HealthEast and Fairview Partners)
   • 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.
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.

Contact Requirements

1. One face-to-face visit per year at minimum.
   • If member is unable to fully participate in the assessment the CC is required to reach out at a minimum one time to the guardian, POA or their responsible party. The Care Coordinator documents this contact on the MN NH Member Annual Assessment.

2. One semi-annual member contact per year at minimum.
   • This contact may be face-to-face or over the phone with the member or responsible party, or at a care conference. If member is unable to fully participate the Care Coordinator is required to reach out at a minimum one time to the guardian, POA or their responsible party. The Care Coordinator documents this semi-contact on the MN NH Member Annual Assessment.

3. Contact as needed per significant changes in member’s health status.
   • These contacts can be documented in Case Notes.

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

Physician Contact Requirements

• New Member: Send Intro to Doctor Letter within 90 days of notification of enrollment
  • Send 8.28 Intro to Doctor letter OR
  • Send 8.29.01 NH Post Visit Summary Letter- Intro to Doctor Letter which combines both the Intro and Summary letters. 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.
• Initial Assessment and Reassessment: Within 90 days, send 8.29.01 NH Post Visit Summary Letter-Intro to Doctor Letter
As needed for Transitions of Care
When there is any change in Care Coordinator
For clinic delegates, notification to primary care physician documented per clinic process using an EHR is acceptable.

Initial Contact with New MSHO and MSC+ Enrollee

New Enrollee is a:
Member who is newly enrolled in Blue Plus.
Member who switches products within Blue Plus (i.e., MSC+ to SecureBlue (MSHO) or vice versa).
(Note: a change in rate cell does not mean the member is newly enrolled even if it results in a change in Care Coordination)

Complete the following requirements for all new enrollees:

1. Verify member’s eligibility prior to delivering Care Coordination services
2. Confirm the correct Primary Care Clinic (PCC).
3. Use optional checklist: MSHO MSC+ NH Checklist.
4. Inform the member of the name, number, and availability of the Care Coordinator within 10 calendar days of notification of enrollment. This requirement can be met by sending the 8.22 Intro Letter.
5. Send welcome call/letter (8.22 Intro Letter) to member within 30 days after notification of enrollment. Optional resource: 6.01 Welcome Call Talking Points
6. Assign Care Coordinator to the member in Bridgeview.
7. Schedule a visit to the facility and complete the MN NH Member Annual Assessment within 30 calendar days for MSHO or 60 calendar days for MSC+ of enrollment date, OR if delegate receives late notice of enrollment, within 30 or 60 calendar days of this notification.
8. Send Intro to Doctor Letter within 90 days of notification of enrollment
   a. Send 8.28 Intro to Doctor letter OR
   b. Send 8.29.01 NH Post Visit Summary Letter-Intro to Doctor 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.

For clinic delegates, notification to primary care physician documented per clinic process.

Initial Assessment Responsibilities

1. Complete the MN NH Member Annual Assessment.

   The initial assessment should include but is not limited to the following:
   • Face-to-face assessment. If member is unable to fully participate in the assessment CC is required to reach out at a minimum one time to the guardian, POA or their responsible party.
   • Review of the member’s nursing home record including nursing facility’s care plan.
• Review of the role of Care Coordinator.
• Review explanation of Supplemental Benefits using the resource 6.26 for MSHO members or discuss MSHO enrollment for MSC+ members. Document this discussion on the checklist(s) or in your case notes.
• Interview facility staff.

2. Mail within 90 days of face-to-face visit the:
   • 8.35 Nursing Home Visit Summary Letter to the member or if member was unable to participate to the guardian, POA or responsible party. Letter should additionally be sent to parties identified by the member.
   • 8.35.01 Unable to Reach-Nursing Home Visit Summary Letter to the POA or Responsible Party. To be sent if the Care Coordinator has been unable to reach the POA or Responsible Party.
   • Send 8.29.01 NH Post Visit Summary Letter- Intro to Doctor Letter.

3. Enter the assessment information into Bridgeview by the 10th of the following month.
   (see Bridgeview Manual for entry instructions)

**Nursing Home Product Change**

Completion of a new MN NH Member Annual Assessment is required for all new enrollees within 30 calendar days for MSHO or 60 calendar days for MSC+ from enrollment notification. A new enrollee is defined as member who is newly enrolled in Blue Plus and those members that have had a product change within Blue Plus (i.e., MSC+ to SecureBlue (MSHO) or vice versa)

Care Coordinators have *two options* for when a member has had a product change.

1. Perform a face-to-face visit and complete a *new* MN NH Member Annual Assessment.
   • Enter the assessment information into Bridgeview. Next annual assessment is due 365 days from *this* assessment date.

2. Perform a face-to-face visit and complete the section on the MN NH Member Annual Assessment called Nursing Home Transitional Health Risk Assessment for Product Change.
   • This option requires a review of the current MN NH Member Annual Assessment done in the last 365 days. In addition, the Care Coordinator must document any updates to the care plan and discussions with member and/or Responsible Party.
   • Enter the assessment information into Bridgeview. Next annual assessment is due 365 days from the *last full* assessment date.
Review of Nursing Facility Plan of Care

The Care Coordinator must review the nursing facility’s care plan and ensure that it both identifies the member’s needs in a way that maximizes the member’s inclusion, self-determination and choice and should incorporate an interdisciplinary, holistic, and preventive focus.

The Care Coordinator facilitates the integration of these concepts into the plan of care if they are found to be missing upon review. The Care Coordinator should complete thoroughly all sections of the MN NH Member Annual Assessment while reviewing the facility care plan, the Care Coordinator can determine if the facility care plan is addressing all the required elements listed below:

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

Semi-Annual Contact Responsibilities

The Care Coordinator’s semi-annual contact may be face-to-face, a care conference or over the phone. If member is unable to fully participate the CC should reach out to the guardian, POA or responsible party. CC is required to reach out at a minimum one time to the guardian, POA or their responsible party. This contact should include a discussion of:

- recent acute episodes or hospitalizations
- significant changes in condition or level of care
- desires and/or ability to relocate back to the community or another facility
- unmet needs/care concerns
- The Care Coordinator documents this contact on the MN NH Member Annual Assessment in the semi-annual contact section.
Reassessment Responsibilities

1. The Delegate is responsible to verify member’s eligibility prior to delivering Care Coordination services.

2. Annual reassessments must be a face-to-face visit conducted within 365 days of the previous assessment. If member is unable to fully participate in the assessment the CC should reach out to the guardian, POA or responsible party. CC is required to reach out at a minimum one time to the guardian, POA or their responsible party.

3. Complete MN NH Member Annual Assessment.
   The annual assessment should include but is not limited to the following:
   • Face-to-face assessment
   • Review of the member’s nursing home record including the nursing facility’s care plan
   • Review of the role of Care Coordinator
   • Review explanation of Supplemental Benefits using the resource 6.26 for MSHO members or discuss MSHO enrollment for MSC+ members. Document this discussion on the MN NH Member Annual Assessment. Interview facility staff.

4. Care Coordinator should also:
   • monitor progress and review any health status changes,
   • evaluate and adjust the timeliness and adequacy of the services the member is receiving
   • solicit and analyze relevant information from all sources
   • communicate with the member as well as the member’s interdisciplinary team

5. Mail within 90 days of face-to-face visit the:
   • 8.35 Nursing Home Visit Summary Letter to the member or if member was unable to participate to the guardian, POA or responsible party. Letter should additionally be sent to parties identified by the member.
   • 8.35.01 Unable to Reach-Nursing Home Visit Summary Letter to the POA or responsible party. To be sent if the Care Coordinator has been unable to reach the POA or responsible party.
   • Send 8.29.01 NH Post Visit Summary Letter- Intro to Doctor Letter.

6. Enter the assessment information into Bridgeview by the 10th of the following month.

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

Transitions of Care (TOC) Activities:

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.

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

**Definitions:**

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

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

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

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

**Care Coordination TOC Documentation Responsibilities:**

1. Complete 6.22 Transitions of Care log.  
   *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.

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.

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 that impacts care coordination, the CC must:

1. Confirm the new Care Coordination Delegate by referring to 9.07 Care Coordination Delegate Listing and Contact Table or contact your Partner Relations Consultant.
2. Complete the 6.08 Transfer in Care Coordination Delegation form and send directly with case documents to the new delegate.
3. Update the member’s address, county of residence and/or PCC in Bridgeview.
4. Notify the member’s financial worker by completing the DHS 5181.
5. Keep copies of all forms and letters related to the transfer for your records.

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.

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 (also responsible for: HealthEast and Fairview Partners)
   - 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.
2. If the PCC needs to be changed, follow the PCC change process as outlined in the *Primary Care Clinic (PCC) Change* section.

**Responsibilities of the transferring Care Coordination Delegate:**

1. Complete the 6.08 Transfer in Care Coordination Delegation form and send directly with case documents to the new delegate.

2. 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
   - My Move Plan Summary

3. The **transferring** Care Coordinator should communicate the following to the member’s financial worker:
   a. Address change
   b. EW eligibility

4. If a member enters an inpatient setting such as a hospital, Residential Treatment Center, etc. outside of the county the member resides in, the Care Coordination responsibility continues with the current Care Coordinator. Once it is determined the member will not be returning to the original county, the transferring Care Coordinator should proceed with the transfer process outlined here and change the PCC (if applicable).

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

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

The receiving delegate will receive the 6.08 Transfer in Care Coordination Delegation form for review and as notification of the transfer.

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

Optional: Either Delegate may update the address and County of Residence in Bridgeview. This will be done automatically after the Financial Worker makes their changes; however, those changes may take up to a month to reach Bridgeview. Changing the address and county of residence manually will update the current month’s enrollment report. Follow the process outlined in the Bridgeview manual to make these manual changes.

**Note:** Manual changes made to the member information except the PCC in Bridgeview are saved for only 90 days. You must notify the financial worker to permanently change the member’s information.

### 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 Bridgeview
- 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.

### 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, 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, 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.

To provide our member with a smooth transfer of care coordination services for transfers outside of the Blue Plus service area complete the following tasks:

1. Share a copy of the most recent MN NH Member Annual Assessment directly with the new Care Coordinator

2. Communicate the following to the member’s financial worker:
   - Address change
   - EW eligibility

**On-going Care Coordination Responsibilities**

**Assessment Tracking Process**

Blue Plus requires all care coordination Delegates to track the number and type of assessments, each month. **Entry of the HRA information must be entered by the 10th of the following month** into Bridgeview.

Assessments required to be entered include:

- Initial
- Annual
- Product Change (MSC+ to MSHO and vice versa)
- Significant Health Change
- Health Plan Change

**Discharge Planning**

The Care Coordinator shall coordinate an LTCC assessment within 20 calendar days of the member’s request for Home and Community Based Services (EW services).

If the Care Coordinator currently following the member does not administer the LTCC, they are responsible for contacting the local Blue Plus Delegate who conducts the assessment. If you are unsure who the local Assessor is, contact your Partner Relations Consultant.

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

The primary responsibilities of the Assessor are:

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

The Nursing Home Care Coordinator should:
• Complete TOC activities and TOC log
• Act as a resource and share information with the assessor as needed
• Upon discharge, initiate the transfer process
• update the PCC, if needed, in Bridgeview.
  Refer to Transfers section of the guidelines for complete details.

And, may assist the Assessor with the following tasks, if applicable:
• Locate another living arrangement
• Coordinate any physician discharge orders
• Assure member’s pharmacy needs are in place post discharge
• Arrange transportation for day of discharge
• Coordinate any post discharge follow up appointments
• Coordinate any medical supply or equipment needs

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 use services under the member’s medical coverage and/or the Elderly Waiver. If the Elderly Waiver or services under the medical benefit do not meet all the identified transitional needs of the member, Care Coordinators may explore MHM services.
The member must meet the MHM eligibility criteria below to apply for the program. With permission from the member, some referrals may come into DHS MHM Intake by someone other than the Care Coordinator (i.e. nursing home, family member, etc.). When this occurs, a member of the Partner Relations Team will reach out to the Care Coordinator for more information. Referrals from a Care Coordinator should be sent using secure email to Partner.Relations@bluecrossmn.com for consultation and next steps.

MHM eligibility criteria:

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

   and

2. Member meets eligibility requirements for MA at time of discharge; and
3. MA has paid for at least one day of institutional services prior to leaving the facility; and
4. Member opens to the Elderly Waiver at the time of discharge; and
5. Member is transitioning to one of the following settings:
   - Home owned or leased by the individual or individual’s family member; or
   - Apartment with an individual lease with lockable access and egress which includes living, sleeping, bathing, and cooking areas over which the individual or individual’s family has domain and control; or
   - A residence in a community based residential setting in which no more than four unrelated individuals reside.

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

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

Assessment entry for eligible members opening to Moving Home Minnesota (MHM) program: Do not enter this type of screening until a member of the Partner Relations Team has provided instructions to do so:

Enter SD upon Blue Plus notification of approval for MHM services.
   - Activity type is: “04” (face-to-face in institutions)
• Activity date is date of your face-to-face assessment with the member or authorized representative to discuss the MHM program.
• Current living arrangement is: “04” (living in congregate setting)
• Planned housing can be: “05” (foster care) or “09” (own home)
• Current program license is: “02” (ICF/DD), “03” (hospital) or “11” (NF)
• Planned program license cannot be: “03” (hospital) or “08” (housing with services class F
• Assessment result can be: “04, 06 – 09 or 18”.
• Effective date is: date of the informed consent was signed
• Program type is: “19” (MSHO/MSC+ recipients)
• MHM IND is: Y

Link to MHM Program Manual:

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

My Move Plan Summary

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

The My Move Plan Summary must be offered when a member who is expected to go on EW (i.e. from the nursing home) is 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. NH members who are moving residences and not going on EW

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

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

The Care Coordinator is responsible to:
1. Evaluate the member’s needs,
2. Build and share the Summary with the member,
3. Update the My Move Plan Summary,
4. Update the Collaborative Care Plan (if applicable)
5. Communicate information to others involved (if applicable), and
6. Sign and keep a copy of the completed document in the member’s file.

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

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

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

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

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

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. 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

Term due to a move out of the Blue Plus Service area:
1. 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. Notify Financial Worker via DHS 5181

Term due to lapse in MA coverage:
1. Continue care coordination activities if member is on MSHO through 90-day grace period.

MA closing and will not reopen:
1. 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. Refer to Moving out of the Blue Plus Service Area section of the guidelines

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.

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.
- 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.

Communication from Utilization Management (UM)

Amerigroup’s UM notifies Care Coordinators of health plan prior authorization request approvals and denials for behavioral health and medical services via CareCompass via a message. Examples of potential notifications include, but are not limited to, surgical procedures, durable medical equipment, and Medicare skilled days in a nursing facility. The purpose of the notification is to support the Care Coordinator’s expanded role of coordination of all Medicaid and Medicare funded preventive, routine, specialty, and long-term care supports and services, whether authorized by the Care Coordinator or Blue Plus. Follow up with a member after receipt of authorization notification may be required. You may be notified of Medicare covered days in a nursing facility for a current nursing facility resident that did not follow a hospital stay. In this case, transition of care activities is not required.

Communication from Consumer Service Center or 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

Grievances/Complaint Policy and Procedure

Definitions

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

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

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

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

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

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

**Delegate Responsibilities for Policy and Procedure**
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/MSC+ Member services number is:

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. Original documentation should be maintained on file by the delegate.

Out of Country Care—Medicaid

Medicaid payments, will not be made:

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

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

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

Audit Process

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

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 visit, the Auditor will conduct care coordination system and care plan audits for elderly waiver and community well members using the DHS approved MSHO and MSC+ EW Care Planning Audit Protocol. They will also conduct audits for nursing home members using a Nursing Facility Member Chart Review Audit Tool (if applicable).

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

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

If a problem or findings are identified during assessment, the Delegate will be required to respond to Blue Plus with a Corrective Action Plan” (CAP) meaning a list of actions and an associated timetable for implementation to remedy a specific problem, which includes a root cause analysis, interventions, necessary tasks required for improvement, the person responsible for resolution and a timetable for resolution.

Findings are defined as an area of non-compliance discovered through assessment or other means related to a regulation, statute, policy, procedure, contract or sample review for a given requirement or obligation, including Care Coordination guideline and requirements.

Mandatory Improvements will also be noted and are defined as an action that must be taken in order to resolve an issue identified through auditing and monitoring, which does not meet the criteria for a CAP. These are required actions in order to prevent the risk of a future Finding.

For example, unclear or incomplete Policies and Procedures or sample documentation.

A CAP may be assigned to resolve Findings or mitigate compliance risks when one or more of the following apply:
1) the 95.00% compliance standard for samples is not met.
2) Policies and procedures are not documented,
3) beneficiary’s rights are impacted,
4) there is a repeat finding from a previous assessment or monitoring,
5) compliance issues that are related to a high-risk area, where swift correction of the action is required.

Each Delegate will be required to provide a written response within 1 month of receipt of the written audit results if there are Findings or Mandatory Improvements. Although there may be an identify a need for ongoing interventions to make corrections for some of the finding areas, target end dates for completion and correction must be within 3 months of the start date of the described intervention. It is the responsibility of each delegate to alert Blue Plus with the completion dates of the corrective actions implemented.

OTHER CARE COORDINATION RESPONSIBILITIES

1. **QIPs**—The Care Coordinator will participate in the on-going performance improvement projects that are designed to achieve significant favorable health outcomes for members. These projects incorporate standards and guidelines outlined by the Centers for Medicare and Medicaid (CMS) with input by the Minnesota Department of Human Services (DHS).

2. **Vulnerable Persons Reporting.** It is the duty of mandated reporters to report suspected maltreatment of a vulnerable adult or child. Minnesota has a new central system for reporting suspected maltreatment of vulnerable adults. Call 844-880-1574 or go to mn.gov/dhs/reportadultabuse/

   Web-based training is available at no cost to all mandated reporters:

   http://registrations.dhs.state.mn.us/WebManRpt/ for adults; and

   http://www.dhs.state.mn.us/id_000152 for children
3. **Documentation**—The Care Coordinator shall document all activities in the member’s case notes.

4. The Care Coordinator shall comply with any applicable Federal and State laws that pertain to member rights including HIPAA laws and the Minnesota Data Privacy Act and your organization’s confidentiality policy.

5. The Care Coordinator should be coordinating with local agency case managers (mental health, developmental disabilities, adult protection, etc.), financial workers and other staff as necessary to meet the member’s needs. This includes using the Case Manager/Financial Worker Communication Form (DHS # 5181) when:
   - A member requests waiver services
   - A member receiving waiver services has a change in circumstances (exits waiver, moves to SNF, expires, etc.)
   - For more information refer to DHS Bulletin #07-21-09

**Care Coordination Best Practices**

- Assist the member in identifying service providers and accessing needed resources beyond the limitations of formal services available through traditional funding sources.
- Document his or her care coordination activities with the documentation standards as set forth by their profession.
- Coordinate 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.
- Provide range of choices. The Care Coordinator assists the member to identify formal as well as informal supports and services, including community resources. The Care Coordinator ensures that the services are culturally sensitive. Interpreter services are available for all Blue Plus members.
- Coordination with Veteran’s Administration (VA). The Care Coordinator shall coordinate services and supports with those provided by the VA if known and available to the member.
- Identification of Special Needs and Referrals to Specialists. The Care Coordinator should have the ability to identify special needs that are common geriatric medical conditions and functional problems such as polypharmacy issues, lack of social supports, high risk health conditions, cognitive problems, etc. If the Care Coordinator identifies such a need exists and is not being addressed, he or she should then assist the member in obtaining the needed services.

**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.