Community
Care Coordination Guidelines

Secure Blue - MSHO
(Minnesota Senior Health Options)

Blue Advantage - MSC+
(Minnesota Senior Care Plus)

Updated June 2020
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<th>Department</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavioral Health Crisis Line:</strong></td>
<td>• For members in crisis who need support from a clinician specializing in mental health</td>
</tr>
<tr>
<td>1-844-410-0745</td>
<td></td>
</tr>
<tr>
<td><strong>BlueRide Transportation</strong></td>
<td>• Contact to arrange medical transportation</td>
</tr>
<tr>
<td><strong>For members:</strong> 651-662-8648 or 1-866-340-8648</td>
<td></td>
</tr>
<tr>
<td><strong>For Care Coordinators:</strong></td>
<td>• Care Coordinator portal for scheduling medical or dental rides</td>
</tr>
<tr>
<td><a href="https://blueride.bluecrossmn.com">Access through Bridgeview Care Coordination website or https://blueride.bluecrossmn.com</a></td>
<td>• BlueRide page on the Care Coordination website for info and forms</td>
</tr>
<tr>
<td><a href="https://carecoordination.bluecrossmn.com/blueride/">https://carecoordination.bluecrossmn.com/blueride/</a></td>
<td></td>
</tr>
<tr>
<td><strong>Bridgeview Company</strong></td>
<td>• Elderly Waiver service agreement questions</td>
</tr>
<tr>
<td>1-800-584-9488</td>
<td>• EW Claims Processing</td>
</tr>
<tr>
<td><a href="mailto:EWProviders@bluecrossmn.com">EWProviders@bluecrossmn.com</a></td>
<td>• <a href="https://www.bluecrossmn.com/healthy/public/bridgeview/home/">https://www.bluecrossmn.com/healthy/public/bridgeview/home/</a></td>
</tr>
<tr>
<td><strong>CaregiverCornerMN.com</strong></td>
<td>• BCBS hosted site with helpful information and resources for caregivers</td>
</tr>
<tr>
<td><a href="https://www.bluecrossmn.com/carecoordination">www.bluecrossmn.com/carecoordination</a></td>
<td></td>
</tr>
<tr>
<td><strong>Care Coordination Website</strong></td>
<td>• Access to Care Coordination communications, guidelines, forms, letters, resources, and trainings</td>
</tr>
<tr>
<td><a href="https://www.bluecrossmn.com/carecoordination">www.bluecrossmn.com/carecoordination</a></td>
<td>• Links to Amerigroup resources</td>
</tr>
<tr>
<td><strong>Delta Dental</strong></td>
<td>• Assistance with finding dental providers</td>
</tr>
<tr>
<td><strong>For Members:</strong> 651-406-5907 or 1-800-774-9049</td>
<td>• Scheduling assistance</td>
</tr>
<tr>
<td>For Care Coordinators: 651-994-5198 or 1-866-303-8138</td>
<td></td>
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<tr>
<td><strong>Member Services</strong></td>
<td>• Benefit questions</td>
</tr>
<tr>
<td>MSHO: 651-662-6013 or 1-888-740-6013</td>
<td>• Interpreter services</td>
</tr>
<tr>
<td>MSC+: 651-662-5545 or 1-800-711-9862</td>
<td>• Assistance finding an in-network providers</td>
</tr>
<tr>
<td>TTY: 711</td>
<td>• Billing questions/grievances</td>
</tr>
<tr>
<td>Department</td>
<td>Questions</td>
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<td>-----------------------------------</td>
<td>---------------------------------------------------------------------------</td>
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<tr>
<td>Nurse Line</td>
<td>• Health questions answered by an RN&lt;br&gt;• Available 24 hours a day, seven days a week&lt;br&gt;• Members need to choose “talk to a nurse” option when calling.</td>
</tr>
<tr>
<td>MSHO: 651-662-6013 or 1-888-740-6013&lt;br&gt;MSC+: 651-662-5545 or 1-800-711-9862</td>
<td></td>
</tr>
<tr>
<td><strong>Partner Relations Consultant Team</strong></td>
<td><strong>Blue Plus liaison for MSHO and MSC+ Care Coordination contracts</strong>&lt;br&gt;<strong>Primary contact for care coordination program and process questions including but not limited to:</strong>&lt;br&gt;• Member specific issues&lt;br&gt;• LTSS/Elderly Waiver&lt;br&gt;• Health Risk Assessment/Care Planning&lt;br&gt;• Care Coordination audits&lt;br&gt;• Care Coordination program operations</td>
</tr>
<tr>
<td>Stormy Church, Manager&lt;br&gt;Kim Flom-Brooks, LSW&lt;br&gt;Melinda Heaser, LSW, CCM&lt;br&gt;Kim Pirkl, LSW, CCM&lt;br&gt;Nissa Roberts, MA, MBA, MHP, LGSW&lt;br&gt;Ricky Vang, RN, BSN, PHN, MHA&lt;br&gt;<a href="mailto:Partner.Relations@bluecrossmn.com">Partner.Relations@bluecrossmn.com</a>&lt;br&gt;Fax: 651-662-0015</td>
<td></td>
</tr>
<tr>
<td>Pharmacist</td>
<td>Email a Blue Plus pharmacist about medication concerns&lt;br&gt;Include the following information:&lt;br&gt;• Member Name, ID, DOB&lt;br&gt;• Name of medication(s)&lt;br&gt;• Detailed description of the question/concern</td>
</tr>
<tr>
<td>MSHO: Donna Boreen,&lt;br&gt;Pharmacist Business Segment Director, Medicare&lt;br&gt;<a href="mailto:Donna.boreen@bluecrossmn.com">Donna.boreen@bluecrossmn.com</a></td>
<td></td>
</tr>
<tr>
<td>MSC+: Adrienne Matthews,&lt;br&gt;Pharmacist Business Segment Director, Medicaid&lt;br&gt;<a href="mailto:Adrienne.Matthews@bluecrossmn.com">Adrienne.Matthews@bluecrossmn.com</a></td>
<td></td>
</tr>
<tr>
<td>Prime Therapeutics</td>
<td>• Pharmacy assistance&lt;br&gt;• Available 24/7 to assist with prior authorizations</td>
</tr>
<tr>
<td>1-800-509-0545</td>
<td></td>
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<tr>
<td>Provider Services</td>
<td>• Provider assistance (not including EW)&lt;br&gt;• Contract/provider access questions</td>
</tr>
<tr>
<td>1-866-518-8448</td>
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Department | Questions
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SecureBlue MSHO Enrollment | Care Coordinator’s should refer members to the following for assistance with MSHO enrollment:
- County Financial Worker
- Senior Linkage Line: 1-800-333-2433

Definitions

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

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

The Care Coordinator conducts the initial assessment, and periodic re-assessment 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/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.). This includes documentation of all paid services authorized through Blue Plus and other HCBS waivers and non-paid informal services. 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, including discharge planning, 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.

**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 member’s 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).

**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 re-assessment.

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. All contracted Care Coordination Delegates and staff are required to view this training annually and save a copy of their 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/re-assessment
- Planning process
- Creation of service plans
- Review of services plans and collaborative care plans
- Transitions

**Members and or authorized representatives should be encouraged to:**

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

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

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

Full Detail: A comprehensive list of all members assigned to the Delegate agency available in Bridgeview by the 15th of each month which 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 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. Official notification is via form 6.08 Transfer in Care Coordination Delegation.
- TERMED FUTURE: 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).
- GRACE PERIOD ENDING: Lists Month/Date/Year which will be 30/60/90 days out from the enrollment month. These are MSHO members whose MA has termed but continue to have MSHO coverage for 90 days. See 90 Day Grace Period (MSHO only) section of the guidelines for care coordinator tasks.

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; these could come late in the month.

Upon notification, the Delegate:

1. Reviews the “New CAP” list to check for discrepancies (i.e. 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 month’s 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. These members are new enrollees for the month and Guidelines should be followed for timely assessment within 30 or 60 days of notification, as applicable.

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

4. Assigns a Care Coordinator per Delegate’s policy.

5. Informs the member of the name, number, and availability of the Care Coordinator within 10 days of notification of enrollment.

6. Enters the name of the Care Coordinator assigned in Bridgeview.

7. Documents any delays of enrollment notification in case notes.

Blue Plus Members Living in a Veteran Administration Nursing Home

For MSHO and MSC + members living in a Veteran’s Administration Nursing Home, the Care Coordinator should follow the processes and timelines outlined in the Nursing Home/Intermediate Care Facility Care Coordination Guidelines.

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 open to a non-EW waiver (DD, CAC, CADI or BI) already have assessments and care planning completed by another waiver case manager. While the primary case management responsibility will remain with the other waiver case manager, the MSHO/MSC+ 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. 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”.

For MSHO and MSC + members with a developmental disability who are living in an intermediate care facility (ICF), they will show on your enrollment report as a Rate Cell D. Care Coordinators should follow the processes and timelines outlined in the Nursing Home/Intermediate Care Facility Care Coordination Guidelines.
The Care Coordinator must complete the following Care Coordination responsibilities:

- Contact other waiver CM via phone or mail 8.39 Intro Letter to Other Waiver CM
- Required contacts with member and physician
- Completion of DHS 3428H and 3428H Care Plan every 365 days.
- Enter assessment into Bridgeview.
- Semi-annual member contact and monitoring of goals completed on 3428H 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 3428H Care Plan
- Obtain member/responsible party signature on 3428H Care Plan
- Provide a copy of 3428H Care Plan to the member and other waiver Case Manager
- Provide a copy of 3428H 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 Bridgeview.
- Care Coordinators are responsible to authorize MA home care and/or PCA authorizations. All authorizations are faxed using the “Care Coordinator Request for Service Authorization Form” to AGP UM Operations at 1-844-429-7763.

Complete a new MN Health Risk Assessment Form (DHS 3428H) and 3428H Care Plan within 365 days.

Contact Requirements

Member Contact

Assessments required for:

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

<table>
<thead>
<tr>
<th>Contact/year</th>
<th>MSHO CW</th>
<th>MSHO EW</th>
<th>MSC+ CW</th>
<th>MSC+ EW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Assessment</strong>*</td>
<td>CC contact info given w/in 10 days</td>
<td>CC contact info given w/in 10 days</td>
<td>CC contact info given w/in 10 days</td>
<td>CC contact info given w/in 10 days</td>
</tr>
<tr>
<td>(includes product changes)</td>
<td>Face-to-Face w/in 30 days</td>
<td>Face-to-Face w/in 30 days</td>
<td>Face-to-Face w/in 60 days</td>
<td>Face-to-Face w/in 30 days</td>
</tr>
<tr>
<td><em>due after notification of enrollment</em></td>
<td><em>Transitional HRA’s may be done telephonically.</em></td>
<td><em>DHS 3428H may be offered for CW members who refuse a Face-to-Face.</em></td>
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<tr>
<td>Annual Assessment</td>
<td>Face-to-Face within 365 days</td>
<td>Face-to-Face within 365 days</td>
<td>Face-to-Face within 365 days</td>
<td>Face-to-Face within 365 days</td>
</tr>
<tr>
<td>Semi-annual Contact</td>
<td>Minimum—phone contact</td>
<td>Face-to-Face</td>
<td>Minimum—phone contact</td>
<td>Minimum—phone contact</td>
</tr>
<tr>
<td>New/Change in Care Coordinator</td>
<td>CC contact info given w/in 10 days of the change</td>
<td></td>
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<tr>
<td>As Needed Contact</td>
<td>Contact for significant change in member’s health status or as requested</td>
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**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.
Re-assessment 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

New Enrollee is defined as a:

- member who is newly enrolled in Blue Plus, or a
- member who changes products within Blue Plus (i.e., MSC+ to MSHO or vice versa).

Note: a change in rate cell/living arrangement does not mean the member is newly enrolled even if it results in a change in Care Coordination

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. Welcome call/letter (8.22 Intro Letter) to member within 30 calendar days after notification of enrollment
5. Explanation of Care Coordinator’s role. Optional resource: 6.01 Welcome Call Talking Points.
6. 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), in your case notes, or on the assessment/care plan 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), in your case notes, or on the assessment/care plan if available.
- Information about enrollment, including resources, can be found in the MSHO enrollment link on the care coordination website.

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

**Determine if a Change in PCC requires a transfer in Care Coordination:**

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 on the care coordination website or contact your Partner Relations Consultant.

**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)
- who consent to a telephonic health risk assessment (CW members who have previously refused a face-to-face 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**
Members who the Care Coordinator has not been able to reach. CC has made three contact attempts and sent a letter (total of 4 contact attempts) to offer an HRA.

**Health Risk Assessment Requirements**

**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 Sneakers may be appropriate.
- Document any delays in scheduling of the assessment
- Documents any delays of enrollment notification
- Enter the assessment type and date into the Bridgeview Company’s web tool (refer to Bridgeview manual) by the 10th of the following month.
- Enter an LTC Screening Document in MMIS (See Entry of LTCC screening document information into MMIS section)
- Re-assessment 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 for **new enrollees** which includes members who have had a product change, who have had an LTCC/MnCHOICES or a 3428H within 365 days.

**Care Coordinator reviews and obtains:**

- LTCC or MnCHOICES Assessment / 3428H
- Current care plan:
  - Collaborative Care Plan or
  - Coordinated Services and Supports Plan (CSSP)
  - 3428H Care Plan

**Care Coordinator mails the following required letters for new enrollees:**

- **Within 30 days of enrollment notification/product change:**
  - 8.22 Intro Letter
- **Within 90 days of enrollment notification/product change:**
  - Send 8.29 Care Plan Summary Letter – Intro to Doctor (which meets the requirement of Intro to Doctor letter and sending of the care plan)

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

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

**Reference Bridgeview Care Coordination Delegation User Guide:** LTCC/MnCHOICES completed prior to enrollment (Transitional HRA entry)

**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 re-assessment is due within 365 days of the LTCC/MnCHOICES assessment or the DHS 3428H **not** the date of the Transitional HRA.
Minnesota Health Risk Assessment Form - DHS 3428H

HRA for members:

- on non-EW waivers (DD, CAC, CADI or BI) or DD member living in the community
- CW members to refuse a face to face HRA, are not receiving EW or home care services and who consent to a telephonic health risk assessment
- 3428H Care Plan: care plan to be used with DHS 3428H

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 the Nursing Home/Intermediate Care Facility Care Coordination Guidelines.

Telephonic Health Risk Assessment – DHS 3428H

Care Coordinators should always offer a face-to-face HRA which is the preferred option. DHS 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.
3. Complete 3428H Care Plan.
4. Mail a copy to the member for their records and a copy of the signature page they can return to the Care Coordinator with their signature.
5. Enter the HRA date into Bridgeview recording the date you completed the telephonic HRA (DHS 3428H).
6. Complete an MMIS LTC Screening Document following instructions in section *Entry of LTC Screening Document information into MMIS*.
   - Enter screening document type “H” using the following codes:
     - Activity Type 01 (telephone screen)
     - Assessment Result 35 (MSHO/MSC+)
     - Program Type 18
**Product Changes:** if a member changes product (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 3428H Care Plan with the member by phone.
3. Complete a Transitional HRA and attach to the current DHS-3428H Health Risk Assessment and 3428H Care Plan.
4. Enter the HRA date into Bridgeview recording the date you completed the Transitional HRA.
5. Complete an MMIS LTC Screening Document following instructions in section *Entry of LTC Screening Document information into MMIS.*
   - Enter screening document type “H” using the following codes:
     - Activity Type 01 (telephone screen)
     - Assessment Result 35 (MSHO/MSC+)
     - Program Type 18

**Reminder:** Re-assessments must be completed within 365 days of the previous DHS 3428H Health Risk Assessment and 3428H Care Plan.

**Community Well (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. Document in the member record a case note stating that the member refused the health risk assessment.
2. Enter a SD using the Refusal code in MMIS
3. Enter the refusal in Bridgeview following instructions found in the Bridgeview manual.
4. Continue to reach out at minimum, every six months either by mail or phone.
Community Well (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 total of four attempts to contact the member via phone, e-mail, or letter to offer an HRA. The fourth and final attempt must be mailing 8.40 Unable to Contact Letter to the member.

2. Document the dates for each of these attempts in Bridgeview following the process outlined in the Bridgeview manual.
   a. The assessment date should be the same as the date the final letter was sent.

3. Enter into MMIS, a screening document type “H” with assessment result “50”
   a. This should be the same as the assessment date entered into Bridgeview.
   b. For initial, complete within 45 days of enrollment.
   c. For re-assessments, within 365 days of the previous assessment screening document.

Important tips for Unable to Reach:

- Follow-up contacts need to be started with plenty of time to accommodate all attempts before the initial or 365-day deadline.
- If applicable, CCs should be reaching out to other contacts to obtain a working phone number. You may document those dates in Bridgeview as phone contacts.
- You may enter the same date in BV if your attempts occurred on the same date.
- Your final attempt must be a letter which is the activity date entered into Bridgeview and MMIS.

Signature Requirements

Wet signatures are preferred. Blue Plus will allow electronic signatures when necessary, using these options:
- Electronically typed as: /s/ Jane Doe
- Computer software (such as DocuSign or Adobe) which captures and date stamps electronic signatures

Re-assessments

The following steps are to be completed with each re-assessment for EW and CW. If the member is temporarily in nursing home or hospital at the time re-assessment 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 re-assessments.

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 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:
   - 6.02.01 Collaborative Care Plan
   - 3428H Care Plan

5. Enter the assessment type and date into the Bridgeview Company’s web tool by the 10th of the following month.

6. The Care Coordinator will complete 8.29 Care Plan Summary Letter to Doctor or send a copy of the care plan.

7. If state plan home care services are needed, 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.

10. 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 about enrollment, including both Care Coordinator and Member resources, can be found in the SecureBlue MSHO Enrollment link on the care coordination website.

**Screening Document Activity Type 10**

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. As of 05/01/2020, Blue Plus Care Coordinators may use Activity Type 10 following the instructions and guidance below. Care Coordinators are required to complete a new LTCC in all other circumstances.

**SD Activity Type 10 may be used when all of the following apply:**
- The member is currently open to Elderly Waiver.
- The member is experiencing a significant temporary health change expected to be short term; less than 3 months (i.e. acute illness or injury).
- The member is not due for their reassessment relatively soon.
- The member has had a significant temporary health change and needs additional services that exceed their previously assessed monthly case mix budget/CDCS case mix budget or the establishment of eligibility for 24hr CL rate.
• If a member’s assessed needs require an increase in PCA hours, do not use Activity Type 10. Care Coordinator must complete a full LTCC/and a new PCA assessment.

**Care Coordinators must:**
1. Complete a face to face visit and use the DHS -3428G to complete the SD using Activity Type 10
2. Update all areas of Care Plan
   a. Supports and Services, Goals, Safety Plan, Budget workbook, and Signatures
3. Share and obtain required signatures for the updated Care Plan/Care Plan summary/RS tool; with member/Authorized Rep, ICT members, PCP, and applicable providers
4. Update Bridgeview
   a. Update LTCC & Case Mix
   b. Update MA Services field as applicable (i.e. CC, HHA)
   c. Update/add Service Agreements
5. Update all applicable providers of changes to Service Agreements
6. As applicable, submit a revised Residential Services (RS) Tool to DHS following the normal process. The effective date of the RS/CL rate change cannot be prior to the date of the SD Activity Type 10.
7. Complete “Care-Coordinator-Request-For-Service-Authorization-Form” for any changes/or new State Plan Home Care Services

**Reminders:**
• Activity Type 10 does not create or extend an EW eligibility span. The new case mix span will be prorated to the remaining months in the current waiver span. The next reassessment is due from the date of the last full face to face HRA (LTCC/MnCHOICES).
• The Case Manager/Care Coordinator UMPI and LTCC CTY on the SD Activity Type 10 document must match the Case Manager/Care Coordinator UMPI and LTCC CTY on the last approved face to face LTCC SD in MMIS. If the Case Manager/Care Coordinator information does not match, prior to entering a SD Activity Type 10, use SD Activity Type 05 with assessment result 98 to update the Case Manager/Care Coordinator information.
• The SD Activity Type 10 “effective date” cannot be prior to the SD Activity Type 10 “activity date”; SD Activity Type 10 cannot be used to make retroactive changes.
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 re-assessment
- MSC+ CW: Enter SD within 75 days of enrollment date and within 45 days of re-assessment

Assessment entry for all members on EW

Re-assessments 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 ID 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:

<table>
<thead>
<tr>
<th>When the first month of the waiver eligibility span is:</th>
<th>Last Day to enter timely screening document into MMIS is:</th>
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<tbody>
<tr>
<td>January 2020</td>
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<td>11/18/20</td>
</tr>
<tr>
<td>January 2021</td>
<td>12/22/20</td>
</tr>
</tbody>
</table>

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/MSC+ Community)
- Service Plan summary: select 18 (personal care) or 80 (home care nursing) with funding source code F (formal)

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

- Activity Type 01 (telephone screen) or 02 face to face
- Assessment Result 35 (MSHO/MSC+)
- Program Type 18
- Note: For members with a developmental disability that reside in an ICF, do not enter a SD into MMIS, follow the Nursing Home/Intermediate Care Facility Care Coordination Guidelines.

**CW Refusals**

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

- Activity type 07
- Refusal code 39
- Program Type 18

**CW Unable to Reach**

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

- Activity type 07
- Assessment Result 50
- Program Type 18

**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/MSC+)
- 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

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Transitional HRA for New Enrollee (includes product changes)</th>
<th>Transitional HRA for New Enrollee (includes product changes)</th>
<th>Change in Care Coordinator</th>
<th>Change in Care Coordinator</th>
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<td>Note: program type cannot be changed with 05 SD</td>
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</tr>
</tbody>
</table>
Comprehensive Care Plan (CCP)

Care Coordinators shall develop a comprehensive care plan in collaboration with the member, caregiver, and/or other interested persons at the member’s request, within 30 calendar days of 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 CSSP/CCP)
- Unable to Reach
- Community Well Refusal

The care plan options include the following:

- 6.02.01 Collaborative Care Plan: to be used following completion of the LTCC assessment DHS 3428 (refer to resource 6.02.02 Instructions for the Collaborative Care Plan)
- 3428H 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 or CW members who have agreed to completion of 3428H via telephonic.

Care Planning Requirements

The Care Coordinator must:

1. Complete all sections of the appropriate care plan.
2. Sign the care plan (see signature requirements below).
3. Obtain the member’s signature. Provide a complete copy of the care plan to the member and any care team members chosen by the member.
4. 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.
5. Send a copy of the care plan or care plan summary (8.29 Care Plan Summary Letter) to the member’s physician.
6. Obtain necessary provider signatures (see Provider and Member Signature Requirements in next section).
7. Create goals that are person-centered.
8. Evaluate and update any changes to the member’s condition and corresponding services and supports, at minimum every 6 months.
9. 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 reassessment.
**Signature Requirements**

Wet signatures are preferred. Blue Plus will allow electronic signatures when necessary, using these options:

- Electronically typed as:  /s/ Jane Doe
- Computer software (such as DocuSign or Adobe) which captures and date stamps electronic signatures

**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. This should include informed choices made by the member.
- Discussion of Medical Management telephonic programs. Members or their caregivers have access to additional case and disease management to receive education and support for 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 by sending in the MSHO MSC+ Case and Disease Management Referral Form available on the care coordination website.
- 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 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 (only if on EW). 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.

Members can choose to have their care plan shared with their service provider(s) or just a summary letter. Care Coordinators can use 8.52 Provider Care Plan Cover Ltr for members who agree to send the entire care plan or 8.51 Provider Care Plan Summary Ltr which includes information about individual services only.

If member chooses not to share any care plan information with any EW and PCA (if applicable) provider(s), the member should check the corresponding box on the care plan signature page.

Both letters need to be returned to the Care Coordinator with provider signatures.

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, which includes the following:
     - Update the budget worksheet and any other applicable sections of the care plan
     - Complete and send 8.50 Member Change Letter
     - Enclose a copy of the updated budget worksheet or the full care plan per member’s choice above
     - Send it to the member for their signature
     - Document this discussion in a case note
     - Share Care Plan Information with EW and PCA (if applicable) Providers/Provider Signatures.
       - If the member agreed to share this updated care plan information with the EW and/or PCA provider(s) if applicable, follow the steps for sending the information and obtaining provider signature as outlined above.
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) Service Planning tool. The CC can send the RS tool or ICLS Service Planning tool (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 Service Planning tool include a provider signature field.

**Signature Requirements**

Wet signatures are preferred. Blue Plus will allow electronic signatures when requested using these options:

- Electronically typed as: /s/ Jane Doe
- Computer software (such as DocuSign or Adobe) which captures and date stamps electronic signatures

### Home Health Care Authorization Processes

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

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

#### Medicare Skilled Home Care Services

Medicare billable skilled home care services do not require prior authorization or notification to Blue Plus Utilization Management (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 (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 prior authorization from Blue Plus. Both types of requests require the Care Coordinator to fax the Care Coordinator Request for Service Authorization Form to AGP UM Operations.

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.

State plan home care services include:

- Skilled Nurse visits (SNV)
- Home Health Aide visits (HHA)
- 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 re-assessment.

2. Send the Care Coordinator Request for Service Authorization Form to AGP UM Operations at 1-844-429-7763.

3. When an initial determination is made to authorize a service, Care Coordinators must provide notification to the requesting provider by phone and document the notification in their case notes.

4. Consider the following in your home care decision making process:

   - Follow the guidelines outlined in the Home Care chapter of the Community Based Services Manual (CBSM).
   - For members on another waiver (CAC, CADI, 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.
   - Authorization should coincide with the member’s current waiver span or assessment year if not on a HCBS waiver.

**Process for Care Coordinator Approval of Home Care Authorizations**

Care Coordinators may approve without UM review up to the following prescribed amounts. Care Coordinators will send in service authorization using the Care Coordinator Request for Service Authorization Form 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

**Home Care Nursing (formerly Private Duty Nursing/PDN):** Care Coordinators do not authorize. The home care provider will make the request directly to AGP UM for review and authorization.

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

**Blue Plus UM will:**
1. Notify member and home care provider of the authorization via letter
2. The Care Coordinator can view Authorizations in Member360 in the Member Care Summary tab.

**Process for Care Coordinator Request for Review for Blue Plus Home Care Authorizations**

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 select “Request for Review” on the Care Coordinator Request for Service Authorization Form for the following:

• Any visits exceeding notification limits above.
• Home Health Aide visits for members in Customized Living or Adult Foster Care (attach a copy of the member’s Residential Services (RS) tool)
• Home Health Aide in conjunction with PCA Services
• 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

**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. The Care Coordinator can view completed 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 faxing the Care Coordinator Request for Service Authorization Form to AGP UM Operations at 1-844-429-7763.

**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)

In addition to sending the UM authorizations to AGP, Care Coordinators must enter the grand total of these services in Bridgeview under MA Plan Services in the LTCC & Case Mix section. (including Care Coordination and Case Aide amounts). See the Bridgeview Manual for entry instructions.

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)

**Members who are on non-EW waivers (DD, CAC, CADI or BI) receiving state plan home care services**

Other waiver case managers may send DHS-5841 Recommendation for State Plan Home Care Services to Blue Plus to request authorization of MA state plan home care services. Blue Plus will:

- Forward the form to the assigned Care Coordinator for review. Care Coordinators should review the request and send the Care Coordinator Request for Service Authorization form to AGP UM, if agreed.
If the waiver CM is the same as the assigned Care Coordinator, do not send DHS-5841 to Blue Plus. Care Coordinators should always request authorization of MA covered state plan home care services using the Care Coordinator Request for Service Authorization form.

**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**

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/MSC+. 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 MSC+/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 MSC+ members receiving or requesting PCA services will be required to be assessed using the DHS tools:
- Personal Care Assistance (PCA) Assessment and Service Plan (DHS-3244-ENG) which must be completed by RN or PHN, or
- LTCC in conjunction with the DHS tool Supplemental Waiver Personal Care Assistance (PCA) Assessment and Service Plan (DHS-3428D-ENG) which can be completed by a social worker, RN or PHN. Blue Plus will not accept the LTCC Assessment tool without the supplemental form.

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.
- 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)

**PCA Services for members open to non-EW waiver:**

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 processes below. The Care Coordinator must coordinate/communicate with the other waiver case manager and Blue Plus.

The need for PCA services will be determined by the other Case Manager from their MnCHOICES assessment. The other waiver Case Manager should communicate the assessed PCA needs with the Care Coordinator who will request the authorization from AGP UM using the Care Coordinator Request for Service Authorization Form.

**New enrollees with existing PCA authorizations:**

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 fax the Care Coordinator Request for Service Authorization Form to AGP UM Operations.
- For PCA providers not in our network, Care Coordinator will fax the Care Coordinator Request for Service Authorization Form to AGP UM Operations. CC should note on the request the reason for the out of network provider, such as continuity of care. 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 fax the Care Coordinator Request for Service Authorization Form to AGP UM Operations. 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 fax the Care Coordinator Request for Service Authorization Form to AGP UM Operations. 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 will fax the Care Coordinator Request for Service Authorization Form to AGP UM Operations.

**PCA Temporary Start/Temporary Increase:**

If a member has immediate or acute PCA needs prior to being assessed or re-assessed, Care Coordinators can authorize up to 45 days of PCA. CC must fax the Care Coordinator Request for Service Authorization Form to AGP UM Operations.

**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 Bridgeview. 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.
**Enhanced PCA Rate**

Members who receive PCA services may qualify for a higher reimbursement rate for PCA for work that is both:

- Provided by a worker who has completed qualifying trainings
- Provided to a person who is eligible for 12 or more hours of state plan PCA per day and/or has the home care rating ‘EN’

PCA Choice agencies and FMS providers must pass on the enhanced rate percentage to the specific worker who completed the trainings in the form of wages and/or benefits. PCA agencies and FMS providers may find instructions for doing so in the MHCP PCA Manual.

**Service Authorization Errors**

If the Care Coordinator learns of a MA Home Care or PCA service authorization error, you must complete the Service Authorization Error Form and fax to AGP UM operations to make the correction.

**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 Bridgeview.

When an initial determination is made to authorize a service, Care Coordinators must provide notification to the requesting provider by phone and document the notification in their case notes.

**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 the Bridgeview website 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). For confirmation of a contract, please check with your supervisor or Partner Relations Consultant. We expect the need for this will be 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.

Enter Service agreements for Approval Option Services within Bridgeview.

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

**Service Agreements**

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

Care Coordinators will enter Service Agreements directly into Bridgeview. Care Coordinators are also responsible for EW Provider inquiries related to their Service Agreement entries.

**Service Agreement Errors**

If the Care Coordinator learns of a service agreement error after entering the authorization in Bridgeview, the Care Coordinator can modify it within Bridgeview.

**Waiver Obligation**

Information regarding a member’s waiver obligation, if they have one, will be displayed in Bridgeview. Waiver obligations may change retroactively, and any questions should be referred to the member’s county financial worker. Questions regarding which provider was assigned the waiver obligation for a specific month may be directed to Bridgeview.

Inquiries related to EW claims and Service Agreements should be directed to Bridgeview.
MA Services Included in EW Case Mix Cap

Care Coordiators 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)
   - 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 exceed:

- 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 Care Coordinator Request for DTR form and notify the member within 24 hours of determination.
- 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

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.

**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. EW Review Team will notify Bridgeview.

**The Care Coordinator must:**

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
• UM will issue a Denial, Termination, or Reduction (DTR) letter to the member and Care Coordinator within 10 business days/14 calendar days, whichever is sooner, of the receipt of all the required information/documents.

3. Notify the Care Coordinator within 24 hours of the determination.

**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 Bridgeview for the remainder of the EW span date after the withdrawal effective date.

**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 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, 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.
• 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.

• 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

• 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

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

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
   - UM will then issue a Denial, Termination, or Reduction (DTR) letter to the member and Care Coordinator within 10 business days/14 calendar days, whichever is sooner, of the receipt of all the required information/documents.
3. Notify the Care Coordinator within 24 hours of the determination.

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 Bridgeview for the remainder of the EW span date after the withdrawal effective date.

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 for additional information regarding CDCS. CDCS policy information can be found here.

**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
- Meet MHCP and waiver criteria
- Be member-specific and person-centered
- Include goal(s) for each identified service or support

**Care Coordinators must:**
- Be familiar with **Care Coordination/Case Management CDCS requirements**
- Approve and monitor CDCS plans
  - Approved CDCS community support plans must be signed and dated prior to start of services
- Make sure members comply with state and federal law
- Communicate CDCS budget increases with the 6633A CDCS Community Support Plan Addendum
- 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. Entry of CDCS service agreements is within Bridgeview. See the Bridgeview manual for entry details.

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.

5. PCA, HHA and SNV will be authorized under a separate home care service agreement, if applicable.

6. CDCS Background Checks (if applicable) should be separate service agreements from the CDCS service agreement in Bridgeview 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 and MA homecare if applicable).

8. The CDCS plan must include all services that will be paid out of the CDCS budget.
   • 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 Bridgeview manual 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 Bridgeview 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. If the member closes to EW prior to a full waiver span year, the budget is prorated to the number of months the member is enrolled in EW, affecting the annual budget. Therefore, the member must remain on EW for as many months as is necessary to accrue the budget that is sufficient to pay for the modification and care coordination services.

- Care Coordinators must use an enrolled HCBS provider or have a contract with Blue Plus to act as a billing “pass-through” for approval option service providers.

- It is recommended that the Care Coordinator obtains bids from a minimum of two contractors or vendors.

- All services must be provided according to applicable state and local building codes.

- If the Care Coordinator determines that all criteria are met and the bid for the work is reasonable, they should enter a line item and amount on the member’s service agreement in Bridgeview as allowed within the budget.

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

**EW Specialized Equipment and Supplies (T2029)**

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

1. Review MHCP Supplies/Equipment Coverage Guide
2. Review Medicare.gov for coverage determination
3. If an item can potentially be covered under Medicare/MA, the Care Coordinator should not enter a service agreement in Bridgeview until the CC has received confirmation the item is not eligible for coverage under the medical benefit.
4. Review DHS-3945 Long-Term Services and Supports Service Rate Limits to ensure item fits within member’s assessed case mix cap
T2029 Eligibility Coverage Guide

For assistance with determining utilization of T2029 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 and Bridgeview websites.

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 and CBSM Manuals, contact your Partner Relations Consultant.

Items marked as “No” in the “EW T2029 Eligible” column of the T2029 Guide cannot be approved or covered.

Items marked with an *asterisk* may be eligible for coverage. If the item meets the criteria for EW coverage per the MHCP and CBSM Manuals, the Care Coordinator must include in the service agreement:

1. a description of the item
2. if the item costs $500 or more, the service description must also include notes detailing the case was reviewed with Supervisor and/or Partner Relations Consultant and approved
3. If the DME provider says the member does not meet Medicare and/or Medicaid criteria for the item, the service description must also include the specific reason the member did not meet Medicare/Medicaid criteria.

- Example: EW member has an order for orthotic shoes but does not have one of the qualifying diagnoses per the DME provider. This specific reason must be indicated in the service description.

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 Bridgeview including a description of the item
2. If the DME provider says the member does not meet Medicare and/or Medicaid criteria for the item, the service description must also include the specific reason the member did not meet Medicare/Medicaid criteria.

- Example: EW member has an order for orthotic shoes but does not have one of the qualifying diagnoses per the DME provider. This specific reason MUST be indicated in the service description.
3. 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 should determine if the item is medically or remedially necessary and meets the criteria outlined in the CBSM manual. Care Coordinators must consult with supervisor and/or with Partner Relations Consultant prior to authorization. Coordinator should also:

1. Enter a Service Agreement in Bridgeview
2. Include a description of the item and notes detailing that the case was reviewed and approved by the Supervisor and/or Partner Relations Consultant and approved.
3. If the DME provider says the member does not meet Medicare and/or Medicaid criteria for the item, the service description must also include the specific reason the member did not meet Medicare/Medicaid criteria.
   - Example: *EW member has an order for orthotic shoes but does not have one of the qualifying diagnoses per the DME provider.* This specific reason MUST be indicated in the service description.
4. 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.

Authorization Process for Lift Chairs

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.

Lift Mechanism Process:

If the DME provider determines the member meets Medicare/Medicaid criteria for coverage of the lift mechanism portion of the chair, the DME provider must:

1. Submit a claim to the member’s medical benefit
2. If the cost of the lift mechanism is greater than $400, the DME provider must request prior authorization following the authorization process as outlined in the BluePlus Provider Policy and Procedure Manual.
3. If prior authorization is needed, 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:**

   Notification will be sent to:
   - The member
   - Durable Medical Equipment Provider
• Care Coordinator

UM will enter an authorization into the claims payment system.

If denied under Medicare benefit:

• UM will send a DTR to the member and the provider and will notify the Care Coordinator via secure email.
• The Care Coordinator may review for authorization of the lift mechanism under the EW benefit.
• If the Care Coordinator approves the lift mechanism under EW, the lift mechanism and chair portion should be entered as **two** service agreements in Bridgeview.

If the DME provider determines the member does NOT meet Medicare/Medicaid criteria for coverage of the lift mechanism portion of the chair, the DME provider must:

1. Provide the Care Coordinator detailed reason for not meeting criteria.
2. Care Coordinator should enter the service agreement in Bridgeview and include the provider’s reason in the service description:
   - **Example:** *EW member does not qualify for coverage under Medicare/MA as member is unable to ambulate once standing.* This specific reason **MUST** be indicated in the service description.

Chair Portion Process:

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 Bridgeview:

• If lift mechanism is being paid for by Medicare/MA benefits, authorize the total cost of only the chair portion in Bridgeview.
• If lift mechanism is NOT being paid by Medicare/MA benefits, authorize the total cost of both the lift mechanism and chair portion on two separate service agreements in Bridgeview.

If the chair portion of the lift chair costs over $950, the Care Coordinator must consult with their supervisor and/or the Partner Relations Consultant prior to authorizing in Bridgeview including notes in the service description the case was reviewed and approved by the Supervisor and/or Partner Relations Consultant.
**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. More information on Elderly Waiver Residential Services can be found on the [DHS page](https://www.dhs.state.').

**Nursing Facility Level of Care (NF-LOC)**

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—Coordination of Potential Denials, Terminations, and Reduction of Services.*

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

**Essential Community Supports**

Care Coordinators may continue to have members who qualified for ECS program following the NF LOC changes effective January 2015. Members can participate in ECS if they continue to meet ECS criteria and do not exit the ECS program.
Members may not receive ECS services if they are eligible for personal care assistance (PCA) services. A member must live in their own home or apartment as ECS cannot be provided in Board and Lodge, non-certified boarding care or corporate or family foster care.

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

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

**On-Going Care Coordination Responsibilities**

**Primary Care Clinic (PCC) Change**

Blue Plus must be notified when a member changes their Primary Care Clinic (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
   - Genevieve (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.
Transitions of Care (TOC)

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

***Transitions of Care engagement and follow up is required regardless of how or when the Care Coordinator learns of the transition. One way the CC may learn of the transition is through Blue Plus notice of inpatient admissions.

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

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

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

- **Outpatient procedures**: Care Coordinators that are notified of an outpatient procedure, at a minimum, should reach out to the member to discuss the member’s health status; the need for plan of care updates; and provide education and support for aftercare.

- **Unplanned transition**: Unplanned transitions are most often urgent or emergent hospitalizations.
Care Coordination TOC Documentation Responsibilities:

1. Outpatient procedures: Care Coordinators should document their outreach in the case notes.

2. Complete 6.22 Transitions of Care Log for all planned or unplanned admission transitions, outpatient procedures require documented outreach.

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

4. TOC logs are required if the CC learns of a transition while the member is in any phase of the transition process.

5. 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.

6. **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.

7. **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.

8. 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.

9. **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:

10. Care transition process including the role of the Care Coordinator. For MSHO members offer post discharge resources. Refer to Post Discharge Resources for SecureBlue Members.

11. 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.

12. The Care Coordinator shall address the “Four Pillars for Optimal Transition: Care Coordinators should refer to 9.12 TOC Resource Toolkit 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.

13. 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 AGP 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 AGP 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 AGP 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, AGP will make the referral to the county where the hospital or clinic is located for members with MI diagnosis, and the County of Financial Responsibility for those with DD diagnosis. For EW members the CC should make a referral to the same for OBRA level II evaluation if they determine a referral is appropriate.

Nursing Facility Level of Care must be re-established 90-days after Nursing Facility admission. Most frequently, this is done using the Minimum Data Set (MDS) completed by the Nursing Facility. If it cannot be determined using the MDS, a referral for an in-person LTCC assessment must be made, which is completed by the Care Coordinator. If, after the assessment, the member does not meet Nursing Facility Level of Care, the member is eligible for assistance with discharge planning by the Nursing Facility, through Transition support by Senior Linkage Line, Relocation Services Coordination, and Care Coordination as well as receiving a DTR submitted by the Care Coordinator to AGP.

Transfers

The term “transfer” refers to an existing Blue Plus enrollee who’s Care Coordination is transferring from one contracted Blue Plus Delegate to another contracted Blue Plus Delegate. This can be the result of a move, change in living arrangement, or a change in primary care.

New enrollees moving from straight Medicaid or another health plan and are new to Blue Plus are not considered transfers. Care Coordinators must follow the steps outlined in the Initial Contact with New MSHO and MSC+ Enrollee section of these guidelines.

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. Send form 6.08 Transfer in Care Coordination Delegation and all transfer documents (HRA, care plan, etc.) directly 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 previously 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 at the time of transfer, it is known the member’s MA is terming and 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)

2. 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.

3. If the PCC needs to be changed, follow the PCC change process as outlined in the Primary Care Clinic (PCC) Change section.

   **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. Send form 6.08 Transfer in Care Coordination Delegation and all transfer documents (HRA, care plan, etc.) directly 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
   - A copy of the Residential Services tool
• My Move Plan Summary
• The **transferring** Care Coordinator should communicate the following to the member’s financial worker:
  • Address change
  • EW eligibility
3. If the member is open to EW, the **transferring** Care Coordinator should:
  • Keep the waiver span open in MMIS if the member remains eligible for EW
  • Keep all active service agreement(s) in Bridgeview open, if services will continue with the same provider. Be sure to share this information with the new delegate.
  • Close service agreement(s) that are no longer applicable.
4. If a member enters an inpatient setting such as a hospital, Residential Treatment Center, etc. outside of the county the member resides in, the Care Coordination responsibility continues with the current Care Coordinator. Once it is determined the member will not be returning to the original county, the **transferring** Care Coordinator should proceed with 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.

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

2. The next face-to-face assessment date (within 365 days of previous assessment)

3. 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.

4. Communicate the following to the member’s financial worker via DHS 5181:
   - Address change
   - EW eligibility

5. If the member is open to EW, the Care Coordinator should:
   - Keep the waiver span open in MMIS if the member remains eligible for EW
   - Keep all active service agreement(s) in Bridgeview open until disenrollment date.
   - 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.

**Transfers of Care Coordination within your agency**

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

1. 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)

2. Update the Care Coordinator assigned in Bridgeview

3. Enter a Screening Document into MMIS

4. Notify the financial worker of the change in Care Coordinator.

5. Notify the physician using 8.28 Intro to Doctor Letter.

**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:**

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

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

- EW members who are permanently moving into a nursing facility
- CW members who are moving residences
- NH members who are moving residences and not going on EW

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

**The Care Coordinator is responsible to:**

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

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

- on the day of the move,
• within the first week of the move,
• within the first 45 days of the move,
• 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.

**EW re-assessments and Termination of MA Eligibility**

Care Coordinators are required to complete re-assessments 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 re-assessment 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:

• LTCC Screening Tool DHS 3428,
• Collaborative Care Plan, and
• 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
Case Closure Care Coordination Responsibilities

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

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

Term Due to a Move out of the Blue Plus Service Area
Refer to Moving out of the Blue Plus Service Area section of the guidelines

Term Due to a Move Out of State or Out of Country
1. Close member to EW in MMIS (EW only)
2. Close service agreements in Bridgeview (EW only).
3. Notify Financial Worker via DHS 5181

Term Due to Lapse in MA Coverage for Elderly Waiver (EW) Members
1. Keep case open as member may reinstate within 90 days
2. Keep waiver span open in MMIS and Bridgeview
3. Keep all service agreements open Bridgeview
4. Send DHS form #6037 to the County of Residence (COR) by Day 60 if MA has not been re-established and you anticipate the member will term by Day 90.
5. If the member is due for re-assessment during the lapse, see *EW re-assessments and termination of MA* section above.

- Refer to DHS resource 6037A Scenario 10 for more information
- If the member is reinstated:
- Enter assessment screening document, if applicable
- Adjust service agreement(s) as applicable
- If the member is not reinstated after 90 days, you can close the member’s case.
- Close member to EW in MMIS back to MA closure date
- Close Service Agreements in Bridgeview back to MA closure date
- Enter Screening Document into MMIS to exit member from EW

**Term Due to Lapse in MA Coverage for Community Well (CW) Members with State Plan Home Care Services**

**MSHO**

1. Continue Care Coordination activities if member is on MSHO through 90-day grace period.

2. Notify MA State Plan service Providers and member of the change in payer and the effective date.

3. Send DHS form #6037 and necessary transfer documents to the County of Residence (COR) by day 60 if member’s MA is not re-established and member is not reinstated to Blue Plus (MA active with no prepaid health plan).

**MSC+**

1. Notify MA State Plan service Providers and member of the change in payer and the effective date.

2. Send DHS form #6037 and necessary transfer documents to the County of Residence (COR) by day 60 if member’s MA is not re-established and member is not reinstated to Blue Plus (MA active with no prepaid health plan).

**MA Closing and Will Not Reopen**

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

2. Close service agreements in Bridgeview (EW only)

3. Refer member to Senior Linkage Line for assistance with finding other insurance or Part D prescription coverage if needed.
Term Due to Health Plan Change

1. Confirm health plan change in Mn-ITS
2. Send DHS Form 6037 to the new health plan
3. If on EW, do not close waiver span in MMIS
4. Close service agreements in Bridgeview (EW only)
<table>
<thead>
<tr>
<th>Reason for Term</th>
<th>Product</th>
<th>DHS Form 5181 Notification to Financial Worker required?</th>
<th>DHS Form 6037 Notification to County of Residence (COR) required?</th>
<th>Close Service Agreements in Bridgeview (EW only)</th>
<th>Close waiver span in MMIS (EW only)</th>
<th>Provider notification via phone</th>
<th>Other tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death</td>
<td>MSHO &amp; MSC+</td>
<td>Yes</td>
<td>No</td>
<td>Yes, back to date of death.</td>
<td>Yes</td>
<td>Yes</td>
<td>Share all documents with new CC including: HRA, care plan, RS tool, home care auth’s, etc. See Moving out of the Blue Plus service area above.</td>
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<tr>
<td>Move out of the BluePlus Service Area in MN</td>
<td>MSHO &amp; MSC+</td>
<td>Yes</td>
<td>Yes – send to new health plan/Care Coordinator</td>
<td>Yes, when member officially terms from Blue Plus.</td>
<td>No</td>
<td>Yes</td>
<td>Share all documents with new CC including: HRA, care plan, RS tool, home care auth’s, etc. See Moving out of the Blue Plus service area above.</td>
</tr>
<tr>
<td>Move out of state or out of country</td>
<td>MSHO &amp; MSC+</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Share all documents with new CC including: HRA, care plan, RS tool, home care auth’s, etc. See Moving out of the Blue Plus service area above.</td>
</tr>
<tr>
<td>Term due to lapse in MA coverage for members open to Elderly Waiver (EW)</td>
<td>MSHO</td>
<td>No</td>
<td>Yes, by day 60 if MA has not been renewed and its anticipated member will term by day 90.</td>
<td>Keep SA’s open in Bridgeview. Close if member does not reinstate.</td>
<td>No (unless MA is not renewed)</td>
<td>Yes</td>
<td>Member will show termed in Mn-ITS but enrolled due to 90-day grace period. CC tasks are required during the grace period.</td>
</tr>
<tr>
<td>MSC+</td>
<td>No</td>
<td>Yes, by day 60 if MA has not been renewed and its anticipated member will term by day 90.</td>
<td>Keep SA’s open in Bridgeview. Close if member does not reinstate.</td>
<td>No (unless MA is not renewed)</td>
<td>Yes</td>
<td>Member will show termed in Mn-ITS and on enrollment. If member is due for re-assessment, CC must complete an HRA to maintain EW</td>
<td></td>
</tr>
</tbody>
</table>
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.

Coverage during the 90-day grace period includes only Medicare covered services, Care Coordination, and MSHO Supplemental benefits. Medicaid covered services, including state plan covered home care, and Elderly Waiver services are not covered.
MSHO members in their 90-day grace period will show as termed in Mn-ITS but will continue to appear on your enrollment with a GRACE PERIOD ENDING MM-DD-YYYY future term flag.

Care Coordinators should:

1. Contact the member’s financial worker to determine the reason for MA disenrollment.
   a. If the financial worker indicates the member’s MA is closed and MA will not re-open, Care Coordinators should do the following:
      o Contact the member to assist with choosing a new Part D plan to maintain coverage for Medicare covered drugs. If the member needs assistance, they can call the Senior Linkage Line at 1-800-333-2433.
      o Enter Screening Document into MMIS to exit member from EW
      o Close service agreements in Bridgeview back to MA closure date
      o Notify all MA State Plan and Elderly Waiver Providers of MA closure
   b. If the financial worker indicates the member’s MA closed due to not completing timely renewal paperwork and MA will likely reinstate within 90 days:
      o Contact the member to assist with completion of MA renewal paperwork
      o Keep case open as member may reinstate within 90 days
      o Keep waiver span open in MMIS and service agreements open in Bridgeview
      o Notify all MA State Plan and Elderly Waiver Providers of potential MA closure and possibility of retro-reinstatement. Providers may choose to continue or discontinue services during this period of time.

         ❖ If the member is reinstated within 90 days:
           o Enter assessment screening document, if applicable (see #3 below)
           o Adjust service agreement(s) as applicable
           o Notify all MA state plan and EW providers of re-instatement to resume services

         ❖ If the member is not reinstated after 90 days:
           o Close member to EW in MMIS back to MA closure date
           o Close service agreements in Bridgeview back to MA closure date
           o Notify all MA state plan and EW providers of disenrollment (if any EW providers were paid for services provided during this time, Blue Plus may request to take back any claim’s payment)

2. Not send in a DTR. No DTR is needed since EW services are closing due to MA ineligibility.
3. Complete any assessments or re-assessments if the member has a product change or is due for reassessment during their 90-day grace period.

4. 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.

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

AGP 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 AGP UM, the service Provider and the member within 24 hours of a determination. AGP 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.

In addition to notifying AGP UM of the need for a DTR, the CC will need to complete the following:

- EW services agreements: Update any service agreements within Bridgeview with the effective date provided from AGP UM (typically 10 business or 14 calendar days from the date of determination).
- State Home Care Services and PCA reductions:
- AGP UM will automatically update any current service authorizations with the reduced amount.

**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 AGP UM operations of the need for a DTR using the Care Coordinator Request for 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 AGP UM operations of the need for a DTR using the Care Coordinator Request for 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, the CC must notify
AGP UM of the need for a DTR using the Care Coordinator Request for 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 AGP UM operations of the need for a DTR using the Care Coordinator Request for 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 AGP UM operations of the need for a reduction using the Care Coordinator Request for DTR form and fax it to AGP UM Operations at 1-844-429-7763.
## DTR Decision Guide

<table>
<thead>
<tr>
<th>Situation</th>
<th>Care Coordinator Request for DTR?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member’s Medical Assistance eligibility ends for any reason</td>
<td>Not required</td>
</tr>
<tr>
<td>Member moves out of the Blue Plus service area</td>
<td>Not required</td>
</tr>
<tr>
<td>Member switches to another health plan or fee-for-service</td>
<td>Not required</td>
</tr>
<tr>
<td>Member dies</td>
<td>Not required</td>
</tr>
<tr>
<td>Change in service provider (no change in authorized service or number of units)</td>
<td>Not required</td>
</tr>
<tr>
<td>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.)</td>
<td>Not required</td>
</tr>
<tr>
<td>(For additional details see Reference Guide for Hospital and Nursing Home Stays, below)</td>
<td></td>
</tr>
<tr>
<td>Member’s EW/State Plan services are on hold for more than 30 consecutive days</td>
<td>Required</td>
</tr>
<tr>
<td>(For additional details see Reference Guide for Hospital and Nursing Home Stays, below)</td>
<td></td>
</tr>
<tr>
<td>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</td>
<td>Not required</td>
</tr>
<tr>
<td>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</td>
<td>Required</td>
</tr>
<tr>
<td>Member/CC is making decision to terminate all EW services and close to EW</td>
<td>Required</td>
</tr>
<tr>
<td>Member/CC is making decision to reduce a currently authorized EW or state plan service</td>
<td>Required</td>
</tr>
<tr>
<td>Member/CC is making decision to terminate currently authorized EW or state plan service</td>
<td>Required</td>
</tr>
<tr>
<td>Member/CC is making decision to reduce a currently authorized MSHO Supplemental Benefit</td>
<td>Required</td>
</tr>
<tr>
<td>Member/CC is making decision to terminate currently authorized MSHO Supplemental Benefit</td>
<td>Required</td>
</tr>
<tr>
<td>Member elects to use less PCA than was assessed.</td>
<td>Required</td>
</tr>
<tr>
<td>Situation</td>
<td>Care Coordinator Request for DTR?</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>CC is making decision to reduce or terminate services (EW or state plan) or closing EW</td>
<td>Required</td>
</tr>
<tr>
<td>Customized Living/24 Hour Customized Living/Adult Foster Care rate is reduced due to a reduction or termination of a CL/AFC service</td>
<td>Required</td>
</tr>
<tr>
<td>Member no longer qualifies for EW due to no longer meeting NF Level of Care</td>
<td>Required</td>
</tr>
<tr>
<td>Home care agency provides services without Prior Auth from Care Coordinator. Provider requests the CC submits a request for PA after services are rendered and the CC does not agree that the services were necessary</td>
<td>Required</td>
</tr>
<tr>
<td>Member is requesting an item or service that is not covered by Medicare or Medicaid.</td>
<td>Required</td>
</tr>
</tbody>
</table>

**DTR Reference Guide for Hospital or Nursing Home Stays**

<table>
<thead>
<tr>
<th>Situation</th>
<th>Action Needed</th>
<th>Care Coordinator Request for DTR?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member goes into a hospital or nursing facility for an acute care stay less than 30 days</td>
<td>Notify providers of admission EW: close service agreements in BV back to admission date. State plan home care: Nothing required.</td>
<td>Not required</td>
</tr>
<tr>
<td>Members goes into the hospital or nursing facility for more than 30 consecutive days</td>
<td>EW: Close the waiver in MMIS and service agreements in BV back to the first admission date. State plan home care: AGP will auto close authorizations, if applicable, based on DTR.</td>
<td>Fax DTR form on day 31 or within 24-hours of the determination that the hospital stay, or nursing facility stay will exceed 30 consecutive days</td>
</tr>
<tr>
<td>Member goes into the hospital and then nursing facility, for more than 30 consecutive days combined (order of admission does not matter)</td>
<td>EW: Close the waiver in MMIS and service agreements in BV back to the first admission date. State plan home care: AGP will auto close authorizations, if applicable, based on DTR.</td>
<td>Fax DTR form on day 31 within 24 hours of the determination that the combined stay exceeds 30 consecutive days</td>
</tr>
</tbody>
</table>
PCA Denial, Termination, Reduction (DTR):

1. Reduction or termination in PCA services requires a 10-day notice prior to the date of the proposed action.

2. The Care Coordinator is required to notify the member and PCA Provider within 24 hours of determination.

3. If the DTR notification is due to a PCA re-assessment indicating a need for fewer hours, submit Care Coordinator Request for DTR to AGP within 24hr of the decision.

4. If services are reduced, the current authorization will be extended to accommodate the 10-day notification period. The new authorization will be entered for services beyond the 10 days with the new number of units approved.

If a member loses Nursing Facility (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 Request for 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. Notify the member and service Provider within 24 hours of the determination.

2. Send DHS 5181 to the Member’s Financial Worker.

3. Enter a screening document to exit elderly waiver into MMIS following instructions outlined in Bulletin 14-25-12

4. Close the service agreement in Bridgeview with the effective date provided by AGP UM.

BlueRide Transportation

All SecureBlue MSHO and Blue Advantage MSC+ members have coverage for transportation to medical appointments through BlueRide. See the BlueRide page on the Care Coordination website for information and forms.

Common Carrier:

- Common Carrier transportation is for members who can physically and mentally ride independently in a bus, taxi, or volunteer driver vehicle.
**Special Transportation (STS):**
- Special Transportation is for members who have a physical or mental impairment where Common Carrier transportation is not an option for them (i.e. wheelchair, severe cognitive impairment, etc.).
- A level of need assessment is required for most of our members which can be obtained through BlueRide or the BlueRide – Transportation Resources page on the Care Coordination website.

**Call BlueRide when transportation is needed for:**
- Medical, dental, and behavioral health appointments
- Prescription pick-up at your pharmacy
- Durable Medical Equipment (DME) supply pick-up
- Discharge from the hospital or nursing home
- SilverSneakers’ facilities up to one round trip per day
- Juniper Health and Wellness Classes 4 round trips per month (exception in place for increased transportation to Tai Ji Quan and Stay Active Classes)
- Transportation to Alcoholics Anonymous (AA), Narcotics Anonymous maximum 4 round trip rides per benefit per month

**Scheduling Rides:**
- Request a ride at least 3 business days prior to the appointment (if a ride is needed with less than 3 days-notice, the CC or member must call BlueRide directly).
- Will allow same day rides based on need or circumstances.
- For bus passes, please call at least 10 business days before an appointment to receive the pass.
- If the appointment changes, call BlueRide at least 4 hours before the pickup time to change or cancel your ride.
- Transportation to a Primary Care Clinic is up to 30 miles, and Specialty Care Clinic is 60 miles, one way. Call BlueRide or complete the BlueRide 30/60 Form for an exception as needed.

**Hours of Operation:**
To schedule, change or cancel a ride, call: 651-662-8648 or toll free 1-866-340-8648 (TTY: 711), Monday through Friday 7:00 am to 5:00 pm.
**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:**
- United Language Group 1-888-551-2014
- Contact your Partner Relations Consultant for the customer code.

**Face-to Face Care Coordination visits:**
- Interpreters are available through the Blue Plus interpreter network for your Care Coordination visits as needed. The contracted interpreter agencies will bill Blue Plus for services. Delegate agencies may contact the following directly:
  - **Arch Language Network, Inc.**
    651-789-7897
  - **The Bridge World Language Ctr.**
    320-259-9239
  - **The Language Banc**
    612-588-9410
  - **Itasca Interpretation Services**
    651-457-7400
  - **Intercultural Mutual Asst. Assoc.**
    507-289-5960
  - **Project FINE**
    507-452-4100

**Medical Appointments:**
- 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.
- All providers are responsible for arranging for interpreter services for Blue Plus MHCP members at the time the appointment is scheduled.
Relocation Targeted Case Management

As part of their usual role, Care Coordinators provide relocation services to members planning on returning to the community from a Nursing Facility. However, if a new member has been receiving Relocation Targeted Case Management services at the time of initial enrollment to Blue Plus, the member must be given the choice to continue to work with their current Relocation Targeted Case Manager. If the member chooses to continue to work with this individual, the Care Coordinator is expected to work with the Relocation Targeted Case Manager on the member’s plan of care. It remains the Care Coordinator’s responsibility to ensure all activities included in the Care Coordination Guidelines are completed within the necessary timeframes. If a member does not wish to work with their Relocation Targeted Case Manager, the Care Coordinator will provide all necessary relocation service coordination.

Moving Home Minnesota

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

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

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

MHM eligibility criteria:

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

See [MHM Program Manual](#) for more information.

**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 the [MAARC Mandated Reporter Form online](#).

   Vulnerable Adults Mandated Training Web-based training is available at no cost to all mandated reporters [here](#).

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.

6. The Care Coordinator should be coordinating with local agency case managers (mental health, developmental disabilities, adult protection, etc), financial workers and other staff as necessary to meet the member’s needs. This includes using the Case Manager/Financial Worker Communication Form (DHS # 5181) when:
   - A member requests waiver service
   - 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
7. Americans with Disabilities Act (ADA)--Please contact your Partner Relations Consultant if you need assistance with addressing member ADA needs.

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 Amerigroup within one business day of the receipt of the grievance. Care Coordinators may use the MSHO MSC+ Care Coordinator Verbal Appeal Grievance Form located on the Care Coordination website.

The information faxed to Blue Plus should include both the written grievance and all other pertinent information or documentation related to the grievance. Amerigroup 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 Amerigroup (except BlueRide). Amerigroup 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 AGP to participate in the hearing. AGP contact information will be included in the notice.
- State Fair Hearing Determinations—Informational only

**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.

**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 and Non-Elderly Waiver Care Planning Audit Protocol. They will also conduct audits for Nursing Home/ICF members using a Nursing Home/ICF Member Chart Review Audit Tool (if applicable).

**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.
**High Performers:** Delegates who attain no corrective action (CAP) in care plan audits for two consecutive years may be considered for Higher Performer status. As a high performer, the Delegate agency will be audited every other year if the agency maintains no CAP status for all products and meets the following criteria:

- Delegate must have a self-monitoring system in place to ensure that audit elements are being met by Care Coordinators in their work.
- Internal audit results will be maintained by the Delegate agency and provided to Blue Plus if requested
- Delegate will continue to participate in Blue Plus trainings and webinars during their gap year to stay informed on process and audit protocol changes that are developed in collaboration with DHS or to remain consistent with the Blue Plus Model of Care.

**Elderly Waiver:** 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/ICF:**

- Review of a random sampling of 5 records for each living arrangement. 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/ICF 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.

**Audit Action Plan**

If a problem or findings are identified during the audit, the Delegate will be required to respond to Blue Plus with an Audit Action Plan meaning a list of actions and an associated timetable for implementation to remedy a specific problem which includes measurable interventions, the person responsible for resolution, and a status summary and date for resolution.

- “Findings” are areas of Non-compliance based on CMS requirements and/or DHS audit protocols.
- “Mandatory Improvements” are required corrections for non-compliance with Care Coordination guidelines and annual Systems Audits.
- “Recommendations” are areas where, although compliant with requirements, Blue Plus identified opportunities for improvement.

An Audit Action Plan may be assigned to resolve Findings or mitigate compliance risks when one or more of the following apply:

- The 95% compliance standard for an element is not met
- Policies and procedures are not documented
- Beneficiary’s rights are impacted
- There is a repeat finding from a previous assessment or monitoring
- 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.