Nursing Home/Intermediate Care Facility Care Coordination Guidelines

Secure Blue - MSHO
(Minnesota Senior Health Options)

Blue Advantage - MSC+
(Minnesota Senior Care Plus)

Updated June 2020

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Contact Information

Department	Questions
Behavioral Health Crisis Line: 1-844-410-0745	• For members in crisis who need support from a clinician specializing in mental health
BlueRide Transportation **For members:** 651-662-8648 or 1-866-340-8648 **For Care Coordinators:** Access through Bridgeview Care Coordination website or https://blueride.bluecrossmn.com https://carecoordination.bluecrossmn.com/blueride/	• Contact to arrange medical transportation • Care Coordinator portal for scheduling medical or dental rides • BlueRide page on the Care Coordination website for info and forms
Bridgeview Company 1-800-584-9488 EWProviders@bluecrossmn.com	• Elderly Waiver service agreement questions • EW Claims Processing • https://www.bluecrossmn.com/healthy/public/bridgeview/home/
CaregiverCornerMN.com	• BCBS hosted site with helpful information and resources for caregivers
Care Coordination Website www.bluecrossmn.com/carecoordination	• Access to Care Coordination communications, guidelines, forms, letters, resources, and trainings • Links to Amerigroup resources
Delta Dental **For Members:** 651-406-5907 or 1-800-774-9049 **For Care Coordinators:** 651-994-5198 or 1-866-303-8138	• Assistance with finding dental providers • Scheduling assistance
Member Services **MSHO:** 651-662-6013 or 1-888-740-6013 **MSC+:** 651-662-5545 or 1-800-711-9862 **TTY:** 711	• Benefit questions • Interpreter services • Assistance finding an in-network providers • Billing questions/grievances

Department	Questions
Nurse Line **MSHO:** 651-662-6013 or 1-888-740-6013 **MSC+:** 651-662-5545 or 1-800-711-9862	• Health questions answered by an RN • Available 24 hours a day, seven days a week • Members need to choose "talk to a nurse" option when calling.
Partner Relations Consultant Team Stormy Church, Manager 651-662-1040 Kim Flom-Brooks, LSW 651-662-9647 Melinda Heaser, LSW, CCM 651-662-9533 Kim Pirkl, LSW, CCM 651-662-3074 Nissa Roberts, MA, MBA, MHP, LGSW 651-662-7613 Ricky Vang, RN, BSN, PHN, MHA 651-662-4523 Partner.Relations@bluecrossmn.com Fax: 651-662-0015	• Blue Plus liaison for MSHO and MSC+ Care Coordination contracts • Primary contact for care coordination program and process questions including but not limited to: • Member specific issues • LTSS/Elderly Waiver • Health Risk Assessment/Care Planning • Care Coordination audits • Care Coordination program operations
Pharmacist MSHO: Donna Boreen, Pharmacist Business Segment Director, Medicare Donna.boreen@bluecrossmn.com MSC+: Adrienne Matthews, Pharmacist Business Segment Director, Medicaid Adrienne.Matthews@bluecrossmn.com	Email a Blue Plus pharmacist about medication concerns Include the following information: • Member Name, ID, DOB • Name of medication(s) • Detailed description of the question/concern
Prime Therapeutics 1-800-509-0545	• Pharmacy assistance • Available 24/7 to assist with prior authorizations
Provider Services 1-866-518-8448	• Provider assistance (not including EW) • Contract/provider access questions

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

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

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

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

- **Delegate** is defined as the agency, such as counties, private agencies and clinics, that are contracted to provide Care Coordination services for Blue Plus. Delegates are responsible for

periodic reporting to Blue Plus as requested and needed to meet business requirements. Examples include but are not limited to monthly assessment tracking form, Quality Improvement Project reporting, enrollment report discrepancies, Hospice care plans, missing residential service living tools, and late screening document entry follow up.

- **Model of Care (MOC)** is Blue Plus's plan for delivering coordinated care to SecureBlue (MSHO) members. The Center for Medicare and Medicaid Services (CMS) requires all Special Needs Plans (SNPs) to have a MOC. The Model of Care (MOC) documents the staff, systems, procedures, and improvement activities Blue Plus utilizes to simplify access to healthcare and reduce fragmentation of care delivery for SecureBlue members. The MOC also describes how Care Coordination delegates work together with Blue Plus providers and staff to coordinate access and delivery of all preventive, primary, specialty, acute, post-acute, and long-term care services among different health and social service professionals and across health settings. Care Coordination delegates are required to complete annual training on the MOC included as part of Blue Plus's annual Fall Training.
- **New Enrollee** is defined as member who is newly enrolled in Blue Plus. Members who switch products within Blue Plus (i.e., MSC+ to SecureBlue (MSHO) or vice versa) are considered new enrollees. All requirements related to new enrollees is applicable in all these scenarios. Note: a change in rate cell only does not mean the member is newly enrolled even if it results in a change in Care Coordination.
- **Transfer** is defined as an existing (already enrolled) Blue Plus member who has been transferred to a new Blue Plus delegate.
- **Required Caseload per worker** for Community Well, Nursing Home/ICF, and Elderly Waiver is as follows: Elderly Waiver/Community Well mix = **40-70**, Nursing Home/ICF only = **90-120**, and Community Well only = **75-100**.
- **ID Prefix's** are now included in front of the members ID number. The prefixes are JTM for MSHO and LMN for MSC+. These prefixes are prior to the ID number. (i.e. JMN#######)
- **Bridgeview ID:** This number will be 8+PMI for identification in Bridgeview. This is not the 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)

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

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

In accordance with the Blue Plus Provider Service Agreement, all contracted providers agree to support the implementation of the Blue Plus Model of Care by adhering to the policies and procedures contained in the Blue Plus Policy and Procedure Manual and the Blue Plus Care

Coordination Delegation Guidelines. Care Coordination Delegates further agree to comply with all Minnesota Department of Human Services (DHS) requirements and Center for Medicare and Medicaid Services (CMS) rules and regulations related to the completion of a comprehensive initial health risk assessment of the beneficiary's physical, psychosocial, and functional needs, as well as annual health risk reassessment.

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

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

Special Needs Plans Model of Care (SNP-MOC) Training

The Centers for Medicare & Medicaid Services (CMS) requires all providers and appropriate staff who see beneficiaries of a Fully Integrated Dual Eligible Special Needs Plan (SNP) on a routine basis to complete initial and annual Special Needs Plan-Model of Care (SNP-MOC) training. Providers and appropriate staff required to complete the training include anyone who may participate in a SecureBlue member's Interdisciplinary Care Team, be responsible for implementation of the member's Collaborative Care Plan or manage planned or unplanned transitions of care.

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

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

To complete the training, simply review the presentation.

The SecureBlue SNP-MOC training is available online as a PowerPoint presentation. 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 have the same access and opportunity as all other members. A member's unique life experiences such as culture, ethnicity, language, religion, gender and sexual orientation should be embraced in the planning process to enhance the member's quality of life.

Person-centered practices apply to all but not be limited to:

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

Members and or their responsible party should be encouraged to:

- Direct their own services and supports, when desired
- Include preferences, strengths, skills, and opportunity to promote dignity and respect
- Include community presence, participation and connections

Delegate Responsibilities upon Notification of Enrollment

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

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

Full Detail: A comprehensive list of all members assigned to the Delegate agency for the month and includes the following flags:

- NEW: Enrollees who enrolled after the DHS capitation
- REINSTATED: Members who were going to term but were reinstated with no lapse in coverage
- TERMED: Coverage termed
- PRODUCT 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.

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 months Full Detail list to check for discrepancies and reports them to Secureblue.Enrollment@bluecrossmn.com no later than the 15th of the enrollment month.
3. Reviews the Daily Add report for discrepancies and reports them to Secureblue.Enrollment@bluecrossmn.com no later than 15 days from notification. The Delegate will receive an email if there's a Daily Add report and be directed to log into Bridgeview to access it. 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 facility. The Delegate should be aware of this and proceed as they would other Rate Cell D facility members.

Contact Requirements

1. One face-to-face visit per year at minimum.
    - If member is unable to fully participate in the assessment, the CC is required to reach out at a minimum one time to the member's guardian, POA, or responsible party**.** The Care Coordinator documents this contact on the 6.15 Nursing Home/Intermediate Care Facility (ICF) Member Annual Assessment-Care Plan Review form.

2. One semi-annual member contact per year at minimum.
    - This contact may be face-to-face or over the phone with the member or responsible party, or at a care conference.
    - If the member is unable to fully participate in the assessment, the CC is required to reach out at a minimum one time to the member's guardian, POA, or responsible party**.** The Care Coordinator documents this semi-annual contact on the 6.15 NH-ICF Member Annual Assessment-Care Plan Review form.

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

4. Contact for new facility admission/determination of long-term placement:

   The Care Coordinator shall conduct the 6.15 NH-ICF Member Annual Assessment-Care Plan Review when a member transfers from the community to long-term placement in a skilled facility. This assessment should be conducted:

   - Within **45** days of notification of long-term placement; or,
   - Within **45** days of the transfer effective date if the long-term placement results in a transfer of Care Coordination Delegation; or
   - Within **365** days of the previous assessment, whichever is sooner.

Physician Contact Requirements

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

Initial Contact with New MSHO and MSC+ Enrollee

New Enrollee is 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

Complete the following requirements for all new enrollees:

1. Verify member's eligibility prior to delivering Care Coordination services
2. Confirm the correct Primary Care Clinic (PCC).
3. Use optional checklist: MSHO MSC+ NH-ICF Checklist.

4. Inform the member of the name, number, and availability of the Care Coordinator within **10 calendar days** of notification of enrollment. This requirement can be met by sending the 8.22 Intro Letter.
5. Send welcome call/letter (8.22 Intro Letter) to member within 30 days after notification of enrollment. Optional resource: 6.01 Welcome Call Talking Points
6. Assign Care Coordinator to the member in Bridgeview.
7. Schedule a visit to the facility and complete the 6.15 NH-ICF Member Annual Assessment-Care Plan Review within **30 calendar days for MSHO or 60 calendar days for MSC+** of enrollment date, OR if delegate receives late notice of enrollment, within 30 or 60 calendar days of this notification.
8. Send Intro to Doctor Letter within 90 days of notification of enrollment
    - Send 8.28 Intro to Doctor letter; **OR**
    - Send 8.29.01 NH-ICF Post Visit Summary Letter-Intro to Doctor Letter. This letter can be used in lieu of 8.28 Intro to Doctor letter if sent following the assessment.

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

Initial Assessment Responsibilities

1. Complete the 6.15 NH-ICF Member Annual Assessment-Care Plan Review.

    The initial assessment should include but is not limited to the following:

    - Face-to-face assessment. Care Coordinators must engage the member in participation of the assessment. In addition, if the member is unable to fully participate, the CC is required to reach out **at least once** to the member's guardian, POA, or responsible party in attempts to complete the Member/Responsible Party Interview.
    - Review of the member's facility record including facility's care plan.
    - Review of the role of Care Coordinator.
    - Review explanation of Supplemental Benefits using 6.26 Explanation of Supplemental Benefits resource for MSHO members or discuss MSHO enrollment for MSC+ members. Document this discussion on the checklist(s) or in your case notes.
    - Interview facility staff. For member's residing in an Intermediate Care Facility (ICF), the Care Coordinator should contact the member's DD case manager and document this on 6.15 NH-ICF Member Annual Assessment-Care Plan Review form.
    - As a reminder, members residing in the facility do not have the ability to "refuse" Care Coordination.
2. Enter the assessment information into Bridgeview by the 10th of the following month. (see Bridgeview Manual for entry instructions)

3. Mailing of the following letters are required:
    a. Welcome letters:
        i. 8.22 Intro Letter within 30 days of product change **and**
        ii. 8.28 Intro to Doctor letter **or** 8.29.01 NH-ICF Post Visit Summary Letter-Intro to Doctor Letter (see below)

    b. Post-assessment letters (within 90 days following the assessment and within 90 days of notification of enrollment):
        i. 8.29.01 NH-ICF Post Visit Summary Letter-Intro to Doctor Letter (in lieu of sending 8.28 Intro to Doctor letter)
        ii. 8.35 Nursing Home-ICF Visit Summary Letter to the member or if member was unable to participate to the guardian, POA, or responsible party. Letter should additionally be sent to parties identified by the member.

            or
        iii. 8.35.01 Unable to Reach-NH-ICF Visit Summary Letter to the POA or Responsible Party. To be sent if the Care Coordinator has been unable to reach the POA or Responsible Party.

Nursing Home/ICF Product Change

When a member is defined as a new enrollee due to a product change within Blue Plus (i.e., MSC+ to MSHO or vice versa), Care Coordinators must complete the following:

1. Complete **one of the two** following Heath Risk Assessment options (within 30 days of notification of product change for MSHO and 60 days for MSC+):

- Perform a face-to-face visit and complete a new 6.15 NH-ICF Member Annual Assessment-Care Plan Review. The next annual assessment is due 365 days from the date of this assessment. **or**
- Perform a face-to-face visit and complete the section on the 6.15 NH-ICF Member Annual Assessment-Care Plan Review called VI. 6.28.01 NH-ICF Transitional Health Risk Assessment for Product Change. The next annual assessment is due 365 days of the date of the original assessment.
    i. This option requires a review of the current 6.15 NH-ICF Member Annual Assessment-Care Plan Review done in the last 365 days. In addition, the Care Coordinator must document any updates to the care plan and discussions with member and/or Responsible Party.

2. Enter the assessment information into Bridgeview by the 10th of the following month.
3. In addition, mailing of the following letters are required with product changes:
    a. Welcome letters:
        i. 8.22 Intro Letter within 30 days of product change **and**

ii. 8.28 Intro to Doctor letter **or** 8.29.01 NH-ICF Post Visit Summary Letter-Intro to Doctor Letter (see below)

b. Post-assessment letters (within 90 days following the assessment and within 90 days of notification of product change):
   i. 8.29.01 NH-ICF Post Visit Summary Letter-Intro to Doctor Letter (in lieu of sending 8.28 Intro to Doctor letter)
   ii. 8.35 Nursing Home-ICF Visit Summary Letter to the member or if member was unable to participate to the guardian, POA, or responsible party. Letter should additionally be sent to parties identified by the member.

   or

   iii. 8.35.01 Unable to Reach-NH-ICF Visit Summary Letter to the POA or Responsible Party. To be sent if the Care Coordinator has been unable to reach the POA or Responsible Party.

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

Review of Facility Plan of Care

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

The Care Coordinator facilitates the integration of these concepts into the plan of care if they are found to be missing upon review. The Care Coordinator should complete thoroughly all sections of the 6.15 NH-ICF Member Annual Assessment-Care Plan Review called while reviewing the facility care plan, the Care Coordinator can determine if the facility care plan is addressing all the required elements listed below:

1. The member's goals, interventions, and target dates for meeting their goals
2. The care plan should incorporate a preventive focus employing a thorough plan for addressing the health and safety needs of the members including, but not limited to diagnoses, medications, immunizations, nutritional needs, alcohol and tobacco usage, fall risk, etc. The care plan should have a person-centered focus and should include informal and formal supports as applicable.

3. The care plan or facility member record should indicate advance directive planning for the member. The Care Coordinator should be prepared to initiate ongoing discussion with the member and/or authorized family members or guardians when the lack of a documented advance directive is identified through the care plan review process. The Care Coordinator can enlist the assistance of the primary care physician in helping the member with advance directive planning as well. The Care Coordinator may also use the resource optional 9.19 BCBSMN Advanced Directive and cover letters.
4. The Care Coordinator works in partnership with the member, authorized family members or guardians, primary care physicians and in consultation with other specialists and providers in caring for the member. The Care Coordinator should provide documentation of this consultation in the member's file.

Semi-Annual Contact Responsibilities

The Care Coordinator's semi-annual contact may be face- to- face, a care conference or over the phone. If member is unable to fully participate the CC should reach out additionally to the guardian, POA or responsible party. CC is required to reach out at a minimum one time to the guardian, POA, or their responsible party. This should be documented as the Semi-Annual Contact on 6.15 NH-ICF Member Annual Assessment-Care Plan Review which includes a discussion of:

- recent acute episodes or hospitalizations
- significant changes in condition or level of care
- desires and/or ability to relocate back to the community or another facility
- unmet needs/care concerns

Reassessment Responsibilities

1. The Delegate is responsible to verify member's eligibility prior to delivering Care Coordination services.
2. Annual reassessments must be a face-to-face visit conducted within 365 days of the previous assessment. If member is unable to fully participate in the assessment the CC should reach out additionally to the guardian, POA or responsible party. CC is required to reach out at a minimum one time to the guardian, POA or their responsible party.
3. Complete 6.15 NH-ICF Member Annual Assessment-Care Plan Review. The annual assessment should include but is not limited to the following:
    - Face-to-face assessment
    - Review of the member's facility record including the facility's care plan
    - Review of the role of Care Coordinator

- Review explanation of Supplemental Benefits using 6.26 Explanation of Supplemental Benefits resource for MSHO members or discuss MSHO enrollment for MSC+ members. Document this discussion on the checklist(s) or in your case notes.
- Interview facility staff.

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

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

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

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

Transitions of Care (TOC) Activities:

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

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

If the member has an additional case manager (i.e. other 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 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 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.
6. **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.

7. **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.
8. **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.
9. **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.
10. 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.
11. **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:
12. 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.
13. Changes to health status.
14. 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.
15. 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:
16. Timely follow up appointment.
17. Medication Self-Management.
18. Knowledge of red flags
19. Use of a Personal Health Record

20. **Note:** Communication with the Customized Living or Nursing Facility staff does not replace the requirement to contact the member/member's representative.
21. Provide education about how to prevent unplanned transitions/readmissions. This education should be tailored to the member's specific needs, diagnoses, health issues, etc. and should be in a format that best works for the member based on their abilities. Members with chronic conditions who are frequently hospitalized can still benefit from educational discussions about their conditions, appropriate care, treatment options and relationship building with the Care Coordinator. Members in a nursing facility can benefit from an opportunity to reinforce or develop what is in their nursing facility plan of care.

Transfers

The term "transfers" 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 the member will not be reinstated, do **not** transfer the case. The current Care Coordinator should continue to follow the member until the member's coverage terminates.

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

1. Confirm the current and/or new PCC with the member, authorized rep, or customized living/nursing home/ICF. 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.

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
    - My Move Plan Summary
3. The **transferring** Care Coordinator should communicate the following to the member's financial worker:
    - Address change
    - EW eligibility

4. If a member enters an inpatient setting such as a hospital, Residential Treatment Center, etc. outside of the county the member resides in, the Care Coordination responsibility continues with the current Care Coordinator. Once it is determined the member will not be returning to the original county, the transferring Care Coordinator should proceed with the transfer process outlined here and change the PCC (if applicable).
5. Transitions of Care responsibility: If this transfer of Care Coordination is the result of a change in level of care (i.e. a permanent move from SNF to Customized Living, etc.), the **transferring** delegate will need to finish up the Transitions of Care (TOC) responsibilities. This includes documenting this move on the Individual Transitions Log.

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

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

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

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

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

Transfers of Care Coordination within your agency

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

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.

Moving out of the Blue Plus Service Area

Do not follow the Transfers process. Instead, please communicate directly with the new Care Coordinator to send appropriate documentation.

Implications of a move outside Blue Plus service area should be discussed with the member ahead of time if possible. Resource 9.01 Blue Plus Service Area Map can be used to determine if a move will take the member out of our service area. Member questions related to selecting a new health plan and/or Part D plan can be directed to either the member's county financial worker or the Senior Linkage Line at 1-800-333-2433.

Important:

- Blue Plus will continue to pay for services, until the member's disenrollment.
- The Blue Plus Care Coordinator is responsible for all care coordination activities until the case is transitioned and until the member is disenrolled from Blue Plus. This includes all assessments, care plans, and TOC activities unless coordinated in advance with the receiving county/agency.
- If the Blue Plus Care Coordinator needs assistance with determining who to contact to coordinate the transition at the new county, contact your Partner Relations Consultant for assistance.

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

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

- Communicate the following to the member's financial worker:
- Address change
- EW eligibility

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

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

Discharge Planning

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

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

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

The primary responsibilities of the Assessor are:

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

The Facility Care Coordinator should:

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

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

- Locate another living arrangement

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

Relocation Targeted Case Management

As part of their usual role, Care Coordinators provide relocation services to members planning on returning to the community from a 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.

My Move Plan Summary

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

The My Move Plan Summary must be offered when a member who is expected to go on EW (i.e. from the facility) is moving to a new residence.

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

1. EW members who are permanently moving into a Nursing Home/ICF
2. NH members who are moving residences and not going on EW

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

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

The Care Coordinator is responsible to:

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

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

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

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

- CC was not aware of the move, or

- Member declined to complete a move plan summary, or
- Other reason.

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

Case Closure Care Coordination Responsibilities

Activities required when closing a member's case depends on the reason for the termination. If you have any questions, always contact your Partner Relations Consultant. Here are some common "termination" scenarios (not all inclusive):

Term due to death:

1. No need to notify Blue Plus
2. Must send notification to the Financial Worker via DHS 5181

Term due to a move out of the Blue Plus Service area:

Refer to Moving out of the Blue Plus Service Area section of the guidelines

Term due to a move out of state or out of country:

Notify Financial Worker via DHS 5181

Term due to lapse in MA coverage:

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

MA closing and will not reopen:

Refer member to Senior Linkage Line for assistance with finding other insurance or Part D prescription coverage if needed.

Term due to health plan change:

1. Confirm health plan change in MN-ITS
2. Refer to Moving out of the Blue Plus Service Area section of the guidelines

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.

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:
      - 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.
      - Notify the facility 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:
      - Contact the member to assist with completion of MA renewal paperwork
      - Keep case open as member may reinstate within 90 days

        ❖ If the member **is reinstated** within 90 days:
          - Notify the facility of MA re-instatement

        ❖ If the member **is not reinstated** after 90 days:
          - Notify the facility of MA closure

2. Make an attempt to complete any assessments or re-assessments due per the member contact requirements if the member has a product change or is due for reassessment during their 90-day grace period.

3. 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.

BlueRide Transportation

All SecureBlue MSHO and Blue Advantage MSC+ members have coverage for transportation to medical appointments through BlueRide.

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 facility
- 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 2 business days prior to the appointment
- 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 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.**
    651789-7897
  - **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.

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.
3. **Vulnerable Adults Mandated Training** Web-based training is available at no cost to all mandated reporters here.
4. **Documentation:** The Care Coordinator shall document all activities in the member's contact notes.
5. 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 facility, 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. 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 assessment, 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 95.00% compliance standard for samples 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.