Community
Care Coordination Guidelines

Secure Blue - MSHO
(Minnesota Senior Health Options)

Blue Advantage - MSC+
(Minnesota Senior Care Plus)

Updated October 4, 2021

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Contact Information

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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://bridgeview.bluecrossmn.com/
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:** 1-866-303-8138	• Assistance with finding dental providers • Scheduling assistance
Member Services **MSHO:** 1-888-740-6013 **MSC+:** 1-800-711-9862 **TTY:** 711	• Benefit questions & interpreter services • Assistance finding an in-network providers • Billing questions/grievances

Department	Questions
Nurse Line **MSHO:** 1-888-740-6013 **MSC+:** 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 1-888-877-6424	• 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 Stacy Rogers, MSHO Sales Specialist, Stacy.Rogers@bluecrossmn.com 651-662-9598 Hanna Barr, MSHO Sales Specialist, Hanna.Barr@bluecrossmn.com 651-662-6119	Hanna and Stacy can assist with: • Answering all SecureBlue MSHO enrollment eligibility questions • Reviewing medication coverage. • Assist with completing enrollment application • Connect members losing Medicaid eligibility with a BCBS Medicare Sales rep to find an appropriate Medicare plan. • Email the Care Coordinator SecureBlue Referral Form to secureblue.referrals@bluecrossmn.com
SecureBlue MSHO Supplemental Benefits Kim Winter, Senior Product Consultant kim.winter@bluecrossmn.com	• Contact Kim Winter for vendor issues related to MSHO supplemental benefits. • Process questions should be directed to your Partner Relations Consultant.

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.

Recommended 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) and 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 may come from transferring Delegate, Blue Plus enrollment or 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.

Once a Delegate is notified of a new member, the Delegate must complete the steps below within the required timeframes:

Review the "New CAP" list to check for discrepancies and reports them to Secureblue.Enrollment@bluecrossmn.com no later than the 15th of the enrollment month. *See Importance of Reporting Enrollment Discrepancies section below*.

Compare 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. *See Importance of Reporting Enrollment Discrepancies section below.*

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.

Review the Daily Add report for discrepancies and reports them to Secureblue.Enrollment@bluecrossmn.com no later than 15 days from notification. *See Importance of Reporting Enrollment Discrepancies section below.*

a. 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.

Assign a Care Coordinator per Delegate's policy.

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

Enter the name of the Care Coordinator assigned in Bridgeview.

Document any delays of enrollment notification in case notes.

Complete the assessment requirements within the timeframes listed below. *See Contact Requirements* section.

Documenting Notification of Enrollment & Reporting Enrollment Discrepancies

Required tasks upon enrollment must be initiated upon notification in order to stay in compliance. It is important to document the date of first notification of enrollment in the member case notes. Notification may come through enrollment reports and the following:

- Bridgeview team
- Partner Relations team
- Enrollment team

Care Coordination Delegates must report all enrollment discrepancies and/or misassignment of Delegate to secureblue.enrollment@bluecrossmn.com as soon as possible so the enrollment team can research, resolve, and, if applicable, notify the appropriate Delegate assigned. This is important to ensure compliance with completion of timely Health Risk Assessments.

Examples of discrepancies can include (but are not limited to):

Discrepancy	Resolution
Incorrect address or County of Residence (COR) which may have resulted in misassignment of the Delegate	• CC notifies Blue Plus enrollment • Enrollment staff updates address, COR, and, if applicable, Delegate assignment in Bridgeview and notifies newly assigned Delegate. • Newly assigned Delegate notifies financial worker via DHS 5181.
Incorrect living arrangement which may have resulted in misassignment of the Delegate.	• CC notifies Blue Plus enrollment • Enrollment staff updates the living arrangement in Bridgeview and notifies newly assigned Delegate. • Newly assigned Delegate notifies financial worker via DHS 5181.
Incorrect product (i.e., Member is MSHO but is showing up as MSC+ or vice versa).	• CC notifies Blue Plus enrollment • Enrollment staff verifies product in Mn-ITS and corrects in Bridgeview.
PPHP Date in Bridgeview incorrectly reflects member had a gap in coverage or a product change.	• CC should verify in MnITs if the member had a gap in coverage or product change. • CC notifies Blue Plus enrollment • Enrollment staff verifies/corrects with DHS and BV and notifies CC of results.
Incorrect PCC resulting in mis-assignment to Essentia, Bluestone Physicians, Genevive, or Lake Region Health Care	• CC notifies Blue Plus enrollment • Enrollment staff reaches out to receiving delegate to confirm PCC

	• Enrollment staff updates PCC in Bridgeview and • Enrollment staff assigns to new Delegate, if applicable. • Enrollment staff notifies both Delegates
Transfers that haven't been reassigned in BV: (Transfer initiated but remains on initiating Delegate's enrollment)	• CC notifies Blue Plus enrollment • Enrollment staff researches, updates applicable BV fields, and assigns to the correct Delegate in Bridgeview. • Enrollment staff notifies both Delegates
Incorrectly termed	• CC notifies Blue Plus enrollment • Enrollment staff confirms eligibility via Mn-ITS and updates internal enrollment teams and Bridgeview • Enrollment staff notifies Delegate

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				
Contact/year	**MSHO CW**	**MSHO EW**	**MSC+ CW**	**MSC+ EW**
Initial Assessment* (includes product changes) *due after notification of enrollment*	CC contact info given w/in 10 days Face-to-Face w/in 30 days	CC contact info given w/in 10 days Face-to-Face w/in 30 days	CC contact info given w/in 10 days Face-to-Face w/in 60 days	CC contact info given w/in 10 days Face-to-Face w/in 30 days
Annual Assessment	Face-to-Face within 365 days	Face-to-Face within 365 days	Face-to-Face within 365 days	Face-to-Face within 365 days
Mid-year or semi-annual contact	Minimum—phone contact	Face-to-Face	Minimum—phone contact	Minimum—phone contact
New/Change in Care Coordinator	CC contact info given w/in 10 days of the change			
As Needed Contact	Contact for significant change in member's health status or as requested			

Physician Contact Requirements

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

- Send 8.28 Intro to Doctor letter **OR**
- Send 8.29 Care Plan Summary Letter – Intro to Doctor, which combines the Intro and Summary letter. This letter can be used in lieu of 8.28 Intro to Doctor letter if the face-to-face visit and this letter is mailed within 90 days of notification of enrollment.
- For clinic delegates, notification to primary care physician documented per clinic process.

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).
    - The mailing of all initial member and provider letters is required for product changes.

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

- The Delegate is responsible to verify member's eligibility prior to delivering Care Coordination services

Use the following optional checklists: MSHO CW EW Checklist or MSC+ CW EW Checklist.

Delegate will inform the member of the name, number, and availability of the Care Coordinator within 10 calendar days of notification of enrollment

Welcome call/letter (8.22 Intro Letter) to member within 30 calendar days after notification of enrollment

Explanation of Care Coordinator's role. Optional resource: 6.01 Welcome Call Talking Points.

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.

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: Fairview Partners and select metro M Health Fairview Clinics formerly HealthEast locations only)
- Essentia Health
- Genevive (MSHO only in select nursing facilities)
- Lake Region Health Care Clinic (MSHO members in 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.

Mid-Year or Semi-Annual Contact Requirements

Community-well members: Care Coordinators are required to reach out to CW members by phone, at minimum, at mid-year or semi-annually to review and document the member's progress towards their care plan goals. This discussion should include determining if the goal was met or not met and an evaluation of whether the goal will be discontinued, modified, or carried forward. This contact should be documented in the monitoring section of each goal on the member's care plan.

- If the CW member was previously an 'Unable to Reach (UTR)' member, the CC must offer to complete an HRA at each annual/mid-year/semi-annual contact.
- If the CC is still unable to reach the member at the mid-year/semi-annual contact, CC must again make a total of **four** attempts to contact the member via phone, e-mail, or letter to offer an HRA. See *Unable to Reach* section for more details.
- If the CW member was previously a 'Refusal' member, CC is still required to offer completion of an HRA. If the member refuses another HRA at the mid-year/semi-annual contact, CC must document this in their case notes. No BV or MMIS entry is required for mid-year/semi-annual contacts.

Elderly-waiver members: Care Coordinators are required to meet with EW members face-to-face for their mid-year/semi-annual contact to review and document the member's progress towards their care plan goals. This discussion should include determining if the goal was met or not met and an evaluation of whether the goal will be discontinued, modified, or carried forward. This contact should be documented in the monitoring section of each goal on the member's care plan.

- If the CC is not able to reach the EW member at the mid-year/semi-annual contact, CC must document their attempt in the member's case notes and in the monitoring section of each goal on the member's care plan.
- CC must send 8.40 Unable to Contact letter.

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 outlined in "*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 residing in a nursing facility. 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:

1. Contact other waiver CM via phone or mail 8.39 Intro Letter to Other Waiver CM2
2. Required contacts with member and physician
3. Completion of DHS 3428H and 3428H Care Plan every 365 days.
4. Enter assessment into Bridgeview.
5. Mid-year or semi-annual member contact and monitoring of goals completed on 3428H Care Plan
6. Transition of Care activities
7. 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.
8. MSHO supplemental benefit discussion (as applicable)
9. MSHO enrollment with MSC+ enrollees (as applicable)
10. Sign and date 3428H Care Plan
11. Obtain member/responsible party signature on 3428H Care Plan
12. Provide a copy of 3428H Care Plan to the member and other waiver Case Manager
13. Provide a copy of 3428H Care Plan or a care plan summary letter to the physician.
14. 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.*
15. Complete a new MN Health Risk Assessment Form (DHS 3428H) and 3428H Care Plan within 365 days.

- 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.

Health Risk Assessment Options & Requirements

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

See Care Planning Options & Requirements below for instructions on care planning after completion of the HRA.

Long Term Care Consultation (LTCC) DHS 3428

Required Health Risk Assessment tool for initial and annual assessments for:

- New enrollees
- Annual re-assessments (every 365 days)
- Elderly Waiver eligibility

Care Coordinator is required to:

- Complete the LTCC in its entirety. If a section is not applicable, enter N/A.
- Address all identified risks on the Collaborative Care Plan.
- Determine if there is a need for referrals which may include specialty care, other home care services, case management.
- Document any delays in scheduling of the assessment.
- Document any delays of enrollment notification.
- Enter the assessment type and date into the Bridgeview Company's web tool (refer to Bridgeview Care Coordination User Guide) 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.
- If member is unable to be reached at mid-year/semi-annual required contact, CC must send 8.40 Unable to Contact letter to member and/or responsible party and document attempt(s) in the member's case notes and the care plan goals section, if applicable. For mid-year/semi-annual contact, refer to *Mid-Year or Semi-Annual Contact Requirements* section above.

6.28 Transitional HRA

Health Risk Assessment option for:

- New enrollees and who have had an LTCC/MnCHOICES or a DHS 3428H within the previous 365 days.
- Product changes (MSHO to MSC+ or MSC+ to MSHO) who have had an LTCC/MnCHOICES or a DHS 3428H within the previous 365 days.

Care Coordinator is required to:

- Obtain and review most recent LTCC or MnCHOICES Assessment / DHS 3428H
- Obtain and review current care plan:
    - Collaborative Care Plan or
    - Coordinated Services and Supports Plan (CSSP) or
    - 3428H Care Plan
- Enter the assessment type and date into the Bridgeview Company's web tool (refer to Bridgeview Care Coordination User Guide) 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 LTCC/MnCHOICES assessment or the DHS 3428H **not** the date of the Transitional HRA.
- If member is unable to be reached at mid-year/semi-annual required contact, CC must send 8.40 Unable to Contact letter to member and/or responsible party and document attempt(s) in the member's case notes and the care plan goals section, if applicable. For mid-year/semi-annual contact, refer to *Mid-Year or Semi-Annual Contact Requirements* section above.

Additional notes related to use of the Transitional HRA:

- Product changes are considered new enrollees and mailing of all applicable letters is required. See **Initial Contact with New MSHO and MSC+ Enrollee** section above for requirements.
- 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 DHS 3428 LTCC assessment and care plan.

Minnesota Health Risk Assessment Form - DHS 3428H

Health Risk Assessment option for initial and annual assessments for members:

- on non-EW waivers (DD, CAC, CADI or BI)
- who are Community Well and do not receive Elderly Waiver or PCA services.

A DHS 3428H can be completed face-to-face or telephonically.

Face to Face DHS 3428H

For members who agree to a face-to-face assessment but declines to complete a full DHS 3428 LTCC, a DHS 3428H may be used when the Care Coordinator:

- Has encouraged the completion of DHS 3428 LTCC for all CW members who agree to meet face to face.
- Determines that the member does not need to be assessed for EW eligibility and EW services, or authorization of PCA. If during the DHS 3428H assessment the member is found to have a need for EW or PCA services, a comprehensive DHS 3428 LTCC must be completed.
    - Only state plan home care services (except PCA) can be authorized using DHS 3428H.

Care Coordinator is required to:

1. Enter a case note into the member's record stating that the member refused a full DHS 3428 LTCC face-to-face health risk assessment.
2. Complete DHS 3428H with the member or the guardian following the contact requirements.
3. Complete DHS 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 assessment type and date into the Bridgeview Company's web tool (refer to Bridgeview Care Coordination User Guide) by the 10th of the following month.
6. Complete an MMIS LTC Screening Document following instructions in section *Entry of LTC Screening Document information into MMIS*.
7. If member is unable to be reached at mid-year/semi-annual required contact, CC must send 8.40 Unable to Contact letter to member and/or responsible party and document attempt(s) in the member's case notes and the care plan goals section, if applicable. For mid-year/semi-annual contact, refer to *Mid-Year or Semi-Annual Contact Requirements* section above.

Telephonic 3428H

For members who refuse completion of a face-to-face full LTCC when offered and are not receiving EW or PCA services.

Care Coordinator is required to:

1. Enter a case note 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 assessment type and date into the Bridgeview Company's web tool (refer to Bridgeview Care Coordination User Guide) by the 10th of the following month.
6. Complete an MMIS LTC Screening Document following instructions in section *Entry of LTC Screening Document information into MMIS.*
7. If member is unable to be reached at mid-year/semi-annual required contact, CC must send 8.40 Unable to Contact letter to member and/or responsible party and document attempt(s) in the member's case notes and the care plan goals section, if applicable. For mid-year/semi-annual contact, refer to *Mid-Year or Semi-Annual Contact Requirements* section above.

Telephonic HRA 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.

Care Coordinator is required to:

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 assessment type and date into the Bridgeview Company's web tool (refer to Bridgeview Care Coordination User Guide) by the 10th of the following month.
5. Complete an MMIS LTC Screening Document following instructions in section *Entry of LTC Screening Document information into MMIS.*
6. If member is unable to be reached at mid-year/semi-annual required contact, CC must send 8.40 Unable to Contact letter to member and/or responsible party and document attempt(s) in the member's case notes and the care plan goals section, if applicable. For mid-year/semi-annual contact, refer to *Mid-Year or Semi-Annual Contact Requirements* section above.

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

Refusals

Refusals can only be made by the member or responsible party. Refusals are when a member is refusing to complete an HRA and care plan. Care Coordination is still required for refusals. Members cannot refuse an assessment and continue to receive services when:

- Member is receiving Elderly Waiver Services, they cannot refuse LTCC 3428 and care plan
- Members who have PCA services cannot refuse LTCC 3428, 3428D Supplemental PCA assessment and care plan
- If a face-to-face HRA is refused, offer the option of completing the DHS 3428H which can be done telephonically. The 3428H can be used to authorize only MA state plan home care services (not including PCA).

For annual re-assessments, the CC must reach out at a minimum of 2 weeks in advance of the 365-day deadline to allow enough time for scheduling with the member.

If a CW member refuses to meet with the CC timely due to personal obligations and can meet later, Care Coordinators should enter a refusal in Bridgeview and MMIS. The Care Coordinator is still required to complete the assessment on member's requested schedule.

If member is on EW and refuses their next annual health risk assessment, the waiver will expire at the end of the waiver span. CC should follow the DTR process.

If the member refuses both telephonic and face-to-face assessments, the CC is required to:

1. Document in the member record a case note stating that the member refused the health risk assessment.
2. Enter the assessment type and date into the Bridgeview Company's web tool (refer to Bridgeview Care Coordination User Guide) by the 10th of the following month.
3. Complete an MMIS LTC Screening Document following instructions in section *Entry of LTC Screening Document information into MMIS.*
4. Continue to reach out at minimum, at mid-year or semi-annually, either by mail or phone to offer an HRA.

Unable to Reach

Unable to Reach are members who the Care Coordinator has not been able to contact after multiple attempts. CC is required to make three contact attempts and send a letter (total of 4 contact attempts) to offer completion of an HRA both initially and annually, if applicable.

For annual re-assessments, the CC must reach out at a minimum of 2 weeks in advance of the 365-day deadline to allow enough time for required attempts and scheduling with the member.

If you are not able to reach the member or their authorized representative for their initial/annual assessment or mid-year/semi-annual contact, the Care Coordinator is required to:

- Make a total of **four** attempts to contact the member via phone, e-mail, or letter to offer an HRA.
    a. The fourth and final attempt must be mailing 8.40 Unable to Contact Letter to the member.
    b. If applicable, CCs may reach out to other contacts to obtain a working phone number and document those as attempts.
    c. Outreach attempts may occur on the same date.
- Document your outreach efforts in the member case notes.
- Document the dates for each of these attempts in Bridgeview following the process outlined in the Bridgeview Care Coordination User Guide for initial/annual. No BV entry required for mid-year/semi-annual contacts.
    a. The assessment date in BV should be the date of the 4th attempt which is the date of mailing the 8.40 Unable to Contact Letter.
    b. Enter the assessment type and date into the Bridgeview Company's web tool by the 10th of the following month.

Complete an MMIS LTC Screening Document following instructions in section *Entry of LTC Screening Document information into MMIS* for initial/annual. Not required for mid-year/semi-annuals.

If member is on EW and Unable to Reach at annual health risk assessment, the waiver will expire at the end of the waiver span. CC should follow the DTR process.

If the CC is Unable to Reach the member for mid-year/semi-annual contact, refer to *Mid-Year or Semi-Annual Contact Requirements* section above.

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

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 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:

When the first month of the waiver eligibility span is:	Last Day to enter timely screening document into MMIS is:
January 2021	12/22/2020
February 2021	1/21/2021
March 2021	2/18/2021
April 2021	3/23/2021
May 2021	4/22/2021
June 2021	5/20/2021
July 2021	6/22/2021
August 2021	7/22/2021
September 2021	8/23/2021
October 2021	9/22/2021
November 2021	10/21/2021
December 2021	11/18/2021
January 2022	12/21/2021

*Note: MMIS screening document entry cut off dates are one day earlier than the DHS capitation dates.

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 refuses completion of LTCC but agrees to face to face 3428H:

- Enter screening document type “H” using the following codes:
- Activity Type 02
- Assessment Result 35 (MSHO/MSC+)
- Program Type 18

CW Refusing face to face visit but consents to telephonic HRA

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

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

Instructions for updating MMIS Entry for Transitional HRA or Transfers only

The delegate is responsible for updating an existing LTC Screening Document in MMIS for either EW or CW populations when the member:

- moves from another Health Plan to Blue Plus

- switches products within Blue Plus (i.e., MSC+ to SecureBlue (MSHO))
- moves from FFS to Blue Plus
- when there is a change in Care Coordinator

Scenario	Transitional HRA for New Enrollee (includes product changes)	Transitional HRA for New Enrollee (includes product changes)	Change in Care Coordinator	Change in Care Coordinator
	Community Well	**Elderly Waiver**	**Community Well**	**Elderly Waiver**
Activity Type:	05	05	05	05
Activity Date:	Date Transitional HRA is completed	Date Transitional HRA is completed	Date delegate assumed Care Coordination responsibility	Date delegate assumed Care Coordination responsibility
LTCC CTY	BPH	BPH	n/a	n/a
Case Managers Name and UMPI Number	Use your MCO UMPI number	Use your MCO UMPI number	Use your MCO UMPI number	Use your MCO UMPI number
Assessment Result:	98	98	98	98
Effective Date:	Date Transitional HRA is completed	Date Transitional HRA is completed	n/a	n/a
Program Type Note: program type cannot be changed with 05 SD	18	03 or 04	n/a	n/a

Care Planning Options & Requirements

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
- Refusals

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:

- Complete all sections of the appropriate care plan.
- Sign the care plan (see signature requirements below).
- 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.
- 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.
- Send a copy of the care plan or care plan summary (8.29 Care Plan Summary Letter) to the member's physician. For clinic delegates, notification to primary care physician documented per clinic process.
- Obtain necessary provider signatures (see *Provider and Member Signature Requirements* in next section).
- Create goals that are person-centered.
- Care Coordinators are expected to monitor and document progress of the member goals. Review and document outcomes on each specific goal mid-year or semi-annually, as needed, and at re-assessment.

- Evaluate and update any changes to the member's condition and corresponding services and supports, at minimum mid-year or semi-annually. Follow process in next section *Updates to the Support Plan*.

Updates to the Care Plan

Updates to the Care Plan should be made when there are any changes to the needs and services. The care plan should be viewed as a living document to reflect on-going member needs and services.

When changes to the care plan 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) complete the following.

The Care Coordinator should discuss, with the member or representative, the change in service and what changes, if any, are made to the member's care plan information. This would include support plan instructions and member goals related to the service change and their decision to share pertinent care plan information and support instructions with EW and PCA (if applicable) providers following the process outlined in section *Provider and Member Signature Requirements*. The member should also decide whether they want to receive a copy of the updated care plan or just the budget worksheet. Inform the member that you will be sending them a letter that they need to sign and return acknowledging their agreement to the change. Complete the following steps:

- Update the budget worksheet as applicable.
- Update any other applicable sections of the care plan.
- Complete the 8.50 Member Service Change Letter.
- Enclose a copy of the updated budget worksheet or the full care plan per member's choice.
- Send it to the member for signature.
- Document this discussion in a case note.
- If the member agreed to share this updated care plan information with the EW and PCA (if applicable) provider, follow the steps for sending the information and obtaining provider signature as outlined in section *Provider and Member Signature Requirements*.

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 short-term Complex Case Management/Disease Management/Behavioral Health Case Management telephonic programs. Members or their caregivers have access to additional case 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 Complex-Disease-Behavioral CM 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.

If the member chooses to share any care plan information with any EW and PCA (if applicable) provider(s), the Care Coordinator must list all EW and PCA (if applicable) providers (refer to list below for exceptions). The Care Coordinator must make two attempts to obtain the applicable provider signatures following the current process and timeline for *Provider Signature* requirements.

Note: Provider signature requirements apply for members accessing the Housing Stabilization Service program. The collaborative care plan must include housing service details (i.e. My Supports and Services or goal) and must be shared with the Housing Stabilization Services Provider as part of the program eligibility determination process.

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

Provider 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.

- Provider 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 (formerly known as Tier 3)
- Consumer Directed Community Supports (CDCS)
- Individual Community Living Services (ICLS) Service Planning tool. The CC can send the 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. The 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:

- Determine need for state plan home care services (except PCA) by completing DHS 3428 LTCC for members open to EW or DHS 3428H for community well members not open to EW or PCA. For members receiving PCA, see PCA Authorization Processes section below.
- Coordinate service needs with the provider including initial authorizations, acute changes in a member's condition requiring additional services, or at re-assessment.
- For Skilled Nurse Visits (SNV), Care Coordinators must differentiate whether the nursing visits will be provided by RNs, LPNs or both. If the home care agency anticipates the member will receive visits from both, the CC must request two authorizations: RN using procedure code T1030 and LPN using T1031. CC may check the box on the authorization form allowing visits to be moved flexibly by Utilization Management staff as claims are submitted.
- Send the Care Coordinator Request for Service Authorization Form to AGP UM Operations at 1-844-429-7763.
- 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.
- 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

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.

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:

- 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.
- Request any necessary medical information needed directly from the home care agency. Submitting clinical documentation is the home care agency's responsibility.
- Contact the Care Coordinator if additional input from the Care Coordinator is required
- Make a coverage determination within 10 business days or 14 calendar days
- Notify member and home care provider of the decision via letter
- 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 Care Coordination User Guide 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.

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.

Blue Plus UM will:

- Notify member and home care provider of the authorization via letter
- The Care Coordinator can view Authorizations in Member360 in the Member Care Summary tab.

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 for initial or reassessment using the DHS tools:

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

  OR

- DHS 3244 Personal Care Assistance (PCA) Assessment and Service Plan which must be completed by PHN (an LTCC is still required every 365 days)
- DHS 3428H cannot be used to determine the need for PCA services.

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.
- Upon receiving a new member with existing PCA services, CC must review utilization of PCA authorization prior to enrollment:
    - If member has used portions of their authorized six-month span prior to enrollment, CC should adjust and only authorize SA for remaining units.
    - If member has unused units prior to enrollment and it is confirmed by the PCA provider, include the unused units in the total units authorized for the appropriate span. CC should note on the request the reason for additional PCA units.
    - The authorization requested dates and units should start with the member's enrollment date and should match the previous authorization span (i.e. PCA previously authorized for 4 units/day from 01/01/2020-06/30/2020 and 07/01/2020-12/31/2020. Member enrolls in Blue Plus on 3/1/2020. Blue Plus PCA authorization is effective 03/01/2020. The two 6-month date spans authorized is 03/01/2020-06/30/2020 and 07/01/2020-12/31/2020).

Current enrollees with new PCA authorization requests:

- 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.

- 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
- Prior to starting services, the CC/assessor must fax the Care Coordinator Request for Service Authorization Form to AGP UM Operations using two six month spans. The Care Coordinator should align the PCA date span with the EW date span, if applicable.

Re-assessment PCA Authorization Requests:

- Complete the PCA Assessment and Service Plan prior to the end of the authorization period.
- Provide a copy of the completed PCA Assessment and Service Plan to the member and PCA provider within 10 days of the assessment.
- 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 using two six month spans. The Care Coordinator should align the PCA date span with the EW date span, if applicable.

Change in PCA Provider:

- 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.
- 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. Care Coordinators should follow the instructions in the Bridgeview Care Coordinator User Guide.

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 should follow the instructions in the Bridgeview Care Coordinator User Guide.

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

- State plan home care services including:
  - Skilled Nurse visits (SNV)
  - Home Health Aide visits (HHA)
  - Personal Care Assistance (PCA) **and**
- Monthly Care Coordination **and**
- Case Aide billing, if applicable

Requests to Exceed Case Mix Budget Cap

If a member has a unique set of assessed needs that require care plan services above their EW budget cap, a request for a higher monthly case mix budget cap may be submitted to Blue Plus for review and consideration. It is expected that the Care Coordinator has a discussion with the member/authorized rep and has already considered reducing various services to keep all service costs within the Case Mix Cap before submitting a request. The Care Coordinator must consult with their supervisor if they decide they wish to submit a request to exceed. Care Coordinators may also consult with their Partner Relations Consultant prior to submitting the request.

Notes related to requests to exceeds:

- If the member has requested to exceed the EW Case Mix Cap and the Care Coordinator determines there is no assessed need, the Care Coordinator must request a DTR by faxing in the 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:

- Review the request within 10 business days/14 calendar days, whichever is sooner, of the receipt of all the required information/documents
- Confer with the Care Coordinator if the documentation provided does not support the requested level of service
- Consult with the submitting Care Coordinator to ask for clarification or request further documentation as needed
- Consult with the Medical Management Medical Director as needed
- Approve, deny, or recommend a change in the budget rate request
- 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:

- Send notification to Care Coordinator via email
- 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:

- 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.
- 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.
- 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:

- 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.)
- 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 of 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:

- Review the request within 10 business days/14 calendar days, whichever is sooner, of the receipt of all the required information/documents
- Confer with the Care Coordinator if the documentation provided does not support the requested level of service
- Consult with the submitting Care Coordinator to ask for clarification or request further documentation as needed
- Consult with the Medical Management Medical Director as needed
- Approve, deny, or recommend a change in the budget rate request
- 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:

- Send notification to Care Coordinator via email.
- EW Review Team will notify Bridgeview.

The Care Coordinator must:

- Place the full CAP amount (rather than the higher conversion rate) in the Case Mix/DRG Amount field on the LTC screening document.
- 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 <u>not</u> approved, the EW Review Team will:

- Advise the Care Coordinator on how to assist the member to look at other service options.
- Request a DTR
    - UM will then issue a Denial, Termination, or Reduction (DTR) letter to the member and Care Coordinator within 10 business days/14calendar days, whichever is sooner, **of the receipt of all the required information/documents.**
- Notify the Care Coordinator within 24 hours of the determination.

Process to withdraw 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:

- 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.)

- 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 found here.

Members can:

- Choose traditional or self-designed 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
- Specify the Financial Management Service (FMS) Provider of member choice
- 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
  - Review CSP plan for appropriateness
  - Follow current processes to authorize, deny, terminate, or reduce services (refer to Bridgeview CC User Guide, CDCS DTR Guide resource, and DTR section of the Guidelines for more information)
  - Upon receiving a new member with existing services, CC must evaluate service agreement(s) (SA) and usage of services/funds available prior to enrollment and authorize SA(s) accordingly:

    - If member has over used portions of their SA or service limit previously authorized, CC should adjust and only authorize SA for remaining available services/funds.
    - If member has unused services/funds prior to enrollment with Blue Plus and funds need to be added to the service agreement, contact your Partner Relations Consultant for further instructions. This must be confirmed by the provider (i.e. FMS or PCA Provider, etc.). Include the following:
        - Current CSP
        - CSP Addendums (if applicable)
        - Service authorizations
        - Spending reports

    - Approved CDCS community support plans must be signed and dated prior to the start of services. This includes documentation that CC reviewed health, safety and emergency plans, including services and budget.
- Provide oversight and education to ensure members comply with state and federal law
    - Encourage DHS CDCS Online Learning Module
    - Initiate Technical Assistance Process, if applicable (contact your Partner Relations Consultant for consultation and EW CDCS Technical Assistance Member Letter)
- Communicate CDCS budget increases with the 6633A CDCS Community Support Plan Addendum
- Be knowledgeable and comply with the CDCS Lead Agency Operations Manual DHS-4270
- Collaborate with the FMS Provider
- 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 EW CDCS:

- The CDCS plan must include all services that will be paid out of the CDCS budget.

a. In the event of a change to the member's budget (including COLA increases from DHS), the Care Coordinator is required to complete DHS-6633A CDCS Community Support Plan Addendum and provide to both the member and the FMS provider.

- Entry of EW CDCS service agreement entry is completed in Bridgeview. See the Bridgeview Care Coordination User Guide for SA entry details. There should not be any other separate service agreements authorized in combination with CDCS (besides mandatory CDCS Case Management, CDCS background, MA homecare and MSHO Supplemental Benefits, if applicable).

- There should only be 1 approved/active service agreement for the CDCS budget for the FMS provider for the waiver span. This will allow unused funds to be used throughout the waiver span.

    a. Any MA state plan home care services including PCA, HHA or SNV must be accounted for in the CDCS budget, if applicable.

    b. Authorize mandatory CDCS Case Management by creating a separate service agreement under code T2041. CDCS CM activities are billed under this service agreement. This is not included in the member's CDCS budget. Delegates with a Per Member Per Month (PMPM) contract will not bill against this CDCS CM service agreement.

    c. PCA, HHA and SNV will be authorized under a separate home care service agreement following the CC Request for Service Authorization process, if applicable.

    d. 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.

- Members enrolled in MSHO open to EW CDCS, accessing MSHO supplemental benefits may have separate service agreements authorized in combination with their CDCS service agreement (T2028) and are not included in the member's CDCS budget, if applicable.

- No additional service agreement authorization is required for Care Coordination and/or Case Aide. This service is not included in the member's CDCS budget and should not need to be included in the MA Plan Services field in Bridgeview.

- EW CDCS and Shared Services

    - When more than one person who uses CDCS lives in the same household and chooses to receive services from the same worker, all people must use the same FMS provider

- CDCS enhanced budget

    - Must meet all eligiblity criteria for enhanced budget (refer to CBSM CDCS Enhanced Budget Process and submit DHS 6633B to Partner.Relations@bluecrossmn.com for determination)

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 align with the CDCS community support plan created by the member or their representative. Care Coordinators must review the CDCS CSP plan to ensure the goals include language about how the goals will be implemented and the results will be measured.

Please refer to the Bridgeview Care Coordination User Guide and the CBSM 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.

Upon receiving a new member with existing services, CC must evaluate service agreement(s) (SA) and usage of services/funds available prior to enrollment and authorize SA(s) accordingly not exceeding the annual EAA service limit.

- If member has only used a portion of their EAA annual limit, and requests to use additional EAA funds within the same waiver year, CC should not exceed annual EAA service limit.
- If member's EEA project was approved prior to enrollment with Blue Plus and it is confirmed by the previous Care Coordinator and provider that the amount was not fully paid and remaining amount would exceed the adjusted annual case mix budget, contact your Partner Relations Consultant for further instructions.

- 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. We highly encourage that a home modification assessment is completed. 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 enough 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. Bids that are received should not be shared with other contractors.
- 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 section.

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 and the most cost-effective item to meet the member's need. Care Coordinators are not allowed to authorize a piece of equipment under EW due to a request from DME provider for any reason other than if the item is never covered or item is denied under the medical benefit. Reasons not allowed include:

- Request for higher reimbursement
- Payment guarantee
- Miscellaneous HCPCS codes (A9270, E1399, etc.)

For coverage determination complete the following steps.

Note: A DME Payor Determination Checklist, available on the care coordination website under Checklists and the Bridgeview tab, is a convenient place to document your efforts throughout this process. This checklist is required to be completed if you submit a request for consultation with the Partner Relations team.

1. Connect with DME provider to determine if a doctor's order is needed. If needed obtain a doctor's order for the item. If there is no doctor's order, follow up with member to assist in obtaining an order or submit a DTR if the doctor does not support item requested. Skip this step if the item does not normally require a doctor's order.

2. Use the following resources to determine if covered under medical:
    a. Ask DME provider for the Healthcare Common Procedure Coding System (HCPCS) code and ask whether it is covered under Medicare or Medicaid.
    b. Review CMS National Coverage Determination (NCD) for DME for Medicare coverage determination.
    c. Search for the item and/or HCPCS code MHCP Medical Supply Coverage Guide to confirm if item or similar item is covered under the Medicaid benefit.
    and/or
    d. Review additional resource MHCP Provider Manual for coverage of Supplies and Equipment under Medicaid benefit.

3. Determine if there is an alternative item available by discussing with member and primary care team.

4. If CC determines that it should be covered, CC should advise the DME provider to bill the item under the medical benefit.

If denied by DME provider or item is not covered under medical, review for coverage under EW:

1. Determine this item is not covered under the MSHO $750 Safety benefit.

2. Review DHS-3945 Long-Term Services and Supports Service Rate Limits to ensure item fits within member's assessed case mix cap

3. Review CBSM Specialized equipment and supplies

4. Review MHCP Provider Manual Elderly Waiver to determine if item meets EW eligibility criteria.

5. Review EW T2029 guide for Care Coordinators.

   For assistance with determining utilization of T2029 under EW, refer to the (T2029) Guide for Care Coordinators. 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.

   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.

6. If applicable, determine that item is not covered under DHS Telephone Equipment Distribution (TED) Program.

7. Care Coordinators should request a review from their supervisor for T2029 items for the following situations:
   - Item costs >$500 or
   - Item is **not** listed on the EW T2029 guide and CC is uncertain if it meets the EW Service Criteria as outlined in the MHCP and CBSM manuals
   - Coverage discrepancies.

8. If further review is necessary, request a review with your Partner Relations Consultant. Send a secure e-mail to partner.relations@bluecrossmn.com including:
   - Completed DME Payor Determination Checklist indicating that all applicable resources have been researched.
   - Any additional information to support the request.

9. When final determination is to cover the item under EW, enter a service agreement in Bridgeview. The Service Description must include:
   - a description of the item
   - notes detailing the case was reviewed with Supervisor and/or Partner Relations Consultant and approved, if applicable.

- the specific reason the member did not meet Medicare/Medicaid criteria if the DME provider says the member does not meet Medicare and/or Medicaid criteria for the item.
  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.

10. 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:

- Submit a claim to the member's medical benefit
- 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.
- 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:
  - Provide the Care Coordinator detailed reason for not meeting criteria.
  - 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:

- 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.
- 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.

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 (RS) 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. RS Providers serving Blue Plus members must also be registered with Bridgeview for claims payment.

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. Refer to the Bridgeview Care Coordination User Guide for service agreement entry information.

Care Coordinators are required to complete the DHS Elderly Waiver (EW) MnCHOICES Support Plan (MnSP) Residential Services tool (EW MnSP RS tool) for residential service

planning and rate-setting to calculate a rate for the RS Provider. Refer to the DHS website below for the details including DHS bulletins.

Care Coordinators must send a complete RS tool to the provider. Provider signature is not required on the RS Tool. Refer to Member and Provider Signature Requirements section for more details.

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.

Home and Community Based Service (HCBS) Rights Modification

The home and community-based services (HCBS) settings rule allows the following rights to be modified based on assessed needs to ensure health, safety, and the wellbeing of the person when people live in customized living, foster care or supported living service settings (provider owned and controlled residential settings):

- Have personal privacy (including the use of the lock on the bedroom door or unit door)
- Take part in activities that he/she chooses and have an individual schedule that includes the person's preferences supported by the service provider (this right can only be modified in HCBS residential settings; cannot be modified in customized living settings according to Minnesota Statutes 144D.04.)
- Have access to food at any time
- Choose his/her own visitors and time of visits.

The modification must be:

- Based on a specific and individualized assessed need that is justified in the support plan.
- Implemented in the least restrictive and most integrated setting and inclusive manner.
- Approved by the person through informed consent.

Rights modifications are managed by the care coordinator to ensure:

- Documentation is developed with the person and his or her person-centered planning team
- The person has been informed and consented to the rights modification.

If a need for modifications to the member's rights in a residential setting has been identified, Care Coordinators should work with the provider to complete the DHS 7176H HCBS Rights Modification Support Plan Attachment form (available on eDocs) and note its completion in the member's care plan. Keep a copy of the DHS 7176H in the member case file. More information including a tutorial can be found on the DHS website here.

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.

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.

- 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 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: Fairview Partners and select metro M Health Fairview Clinics formerly HealthEast locations only)
- Essentia Health
- Genevive (MSHO only in select nursing facilities)
- Lake Region Health Care Clinic (MSHO members in 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. Observation stays are not considered inpatient admission and therefore do not require a TOC log.

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:

- Outpatient procedures: Care Coordinators should document their outreach in the case notes.
- Complete 6.22 Transitions of Care Log for all planned or unplanned admission transitions, outpatient procedures require documented outreach.
- Use 6.22.01 Transitions Log Instructions for detailed information on the completion of the log.
- TOC logs are required if the CC learns of a transition while the member is in any phase of the transition process.
- 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.

- **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.
- **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.

- 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.
- **Member Returns to Usual Care Setting:** The Care Coordinator is required to reach out to the member or authorized representative within one business day after the member returns to their usual care setting or "new" usual care setting or within 1 business day of learning of the transition and should discuss the following:
- Care transition process including the role of the Care Coordinator. For MSHO members offer post discharge resources. Refer to Post Discharge Resources for SecureBlue Members.
- Changes to health status.
    - Discuss and update any changes to plan of care. If the member's usual care setting is a nursing facility, the Care Coordinator should confirm that necessary changes were applied to the care plan and offer input, if applicable, and provide support/reinforcement of the updated care plan.
- The Care Coordinator shall address the "Four Pillars for Optimal Transition: Care Coordinators should refer to 9.12 TOC Resource 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.
- 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.

Nursing Home Admission Requirements

CC Task	<30 days in NH	Short term but >30 days in NH	Planned long term stay >30 days in NH

OBRA Level I sent to NH	Yes	Yes	Yes
OBRA Level II requested (see PAS section)	Yes, as needed	Yes, as needed	Yes, as needed
Complete TOC required activities/log	Yes	Yes	Yes
Send DHS 5181 to Financial Worker	No	Yes, if on EW.	Yes
If on EW, close waiver in MMIS back to first admission date (see DTR Reference Guide for Hospital or Nursing Stays)	No	Yes	Yes
Fax DTR form for all State Plan Home Care or EW services	No	Yes, on day 31 or within 24 hours of notification	Yes, on day 31 or within 24 hours of notification
Transfer of case to new CC (see Transfers section)	No	No	Yes, if applicable
Assessment required?	No, unless member due for annual community HRA.	No, unless member due for annual community HRA.	Yes, nursing home assessment must be completed within 45 days of notification of long-term placement or within 365 days – whichever is sooner.

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.

OBRA Level II Evaluations are needed for members with serious mental illness and/or developmental disability. For members with serious mental illness, AGP will email the county of members location at time PAS. For members with developmental disability, the referral is sent to county of financial responsibility. 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:

- Confirm the new Care Coordination Delegate by referring to 9.07 Care Coordination Delegate Listing and Contact Table or contact your Partner Relations Consultant.
- Send form 6.08 Transfer in Care Coordination Delegation and all transfer documents (HRA, care plan, etc.) directly to the new Delegate. **Optional:** complete DHS-6037 HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form
- Update the member's address, county of residence and/or PCC in Bridgeview.
- Notify the member's financial worker by completing the DHS 5181.
- 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:

- 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: Fairview Partners and select metro M Health Fairview Clinics formerly HealthEast locations only)
    - Essentia Health
    - Genevive (MSHO only in select nursing facilities)
    - Lake Region Health Care Clinic (MSHO members in 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.
- 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:

- Send form 6.08 Transfer in Care Coordination Delegation and all transfer documents (HRA, care plan, etc.) directly to the new Delegate. **Optional:** complete DHS-6037 HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form
- 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
- Housing and Stabilization Service (HSS) documents and service plan, if applicable
- The **transferring** Care Coordinator should communicate the following to the member's financial worker:
- Address change
- EW eligibility

- 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.
- 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).
- 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 may receive notification of the transfer from Blue Plus enrollment or the transferring Delegate. The transferring Delegate will send 6.08 Transfer in Care Coordination Delegation form to the receiving Delegate.

- 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.
- Enter the name of the assigned Care Coordinator in Bridgeview following the process outlined in the Bridgeview Care Coordination User Guide.
- Update the Screening Document to reflect the change in Care Coordinator

- Notify the financial worker of the assigned Care Coordinator's name.
- Notify the physician using 8.28 Intro to Doctor Letter. For clinic delegates, notification to primary care physician documented per clinic process. 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.
- 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.
- 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.
- 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 Care Coordination User Guide 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:

1. Completed DHS-6037 HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form. Refer to DHS Bulletin 15-25-10 for complete details.
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 Bridgeview, the Care Coordinator should give the provider Bridgeview's contact information (ewproviders@bluecrossmn.com) 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. For clinic delegates, notification to primary care physician documented per clinic process.

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 <u>optional</u> 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

Refer to DHS 6037A HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form: Scenarios for People on AC, EW, or ECS for more information.

Case Closure Care Coordination Responsibilities

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

Term due to death

1. Must send notification to the Financial Worker via DHS 5181
2. Must enter date of death into Bridgeview under "Dates & PCA" by the 23rd of each month.
3. Close service agreements in Bridgeview back to the date of death (EW only)
4. 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 or change to straight Medicaid

1. Confirm health plan or coverage change in Mn-ITS
2. Send DHS Form 6037 to the new health plan or county
3. If on EW, do not close waiver span in MMIS
4. Close service agreements in Bridgeview (EW only)

Case Closure Care Coordination Responsibilities

Reason for Term	Product	DHS Form 5181 Notification to Financial Worker required?	DHS Form 6037 Notification to County of Residence (COR) required?	Close Service Agreements in Bridgeview (EW only)	Close waiver span in MMIS (EW only)	Provider notification via phone	Other tasks
Death	MSHO & MSC+	Yes	No	Yes, back to date of death.	Yes, back to date of death.	Yes	
Move out of the BluePlus Service Area in MN	MSHO & MSC+	Yes	Yes – send to new health plan/Care Coordinator	Yes, when member officially terms from Blue Plus.	No	Yes	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.
Move out of state or out of country	MSHO & MSC+	Yes	No	Yes	Yes	Yes	
Term due to lapse in MA coverage for members open to Elderly Waiver (EW)	MSHO	No	Yes, by day 60 if MA has not been renewed and its anticipated member will term by day 90.	Keep SA's open in Bridgeview. Close if member does not reinstate.	No (unless MA is not renewed)	Yes	Member will show termed in Mn-ITS but enrolled due to 90-day grace period. CC tasks are required during the grace period.
	MSC+	No	Yes, by day 60 if MA has not been renewed and its anticipated member will term by day 90.	Keep SA's open in Bridgeview. Close if member does not reinstate.	No (unless MA is not renewed)	Yes	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 eligibility.
Term due to lapse in MA coverage Community Well (CW) members	MSHO	No	Yes	N/A	N/A	Yes	Member will show termed in Mn-ITS but enrolled due to 90-day grace period. CC tasks are required during the grace period.
	MSC+	No	Yes	N/A	N/A	Yes	

Reason for Term	Product	DHS Form 5181 Notification to Financial Worker required?	DHS Form 6037 Notification to County of Residence (COR) required?	Close Service Agreements in Bridgeview (EW only)	Close waiver span in MMIS (EW only)	Provider notification via phone	Other tasks
MA closing and will not re-open	MSHO & MSC+	No	No	Yes	Yes	Yes	Refer member to Senior Linkage Line for assistance with finding other insurance or Part D drug coverage if needed.
Term due to health plan change	MSHO & MSC+	No	Yes, to the new health plan	Yes	No	Yes	

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:
        - 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.
        - Enter Screening Document into MMIS to exit member from EW
        - Close service agreements in Bridgeview back to MA closure date

- Notify all MA State Plan and Elderly Waiver Providers of MA closure
- Do not send in a DTR. No DTR is needed since EW services are closing due to MA ineligibility.

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
- Keep waiver span open in MMIS and service agreements open in Bridgeview
- 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:

- Enter assessment screening document, if applicable (see #3 below)
- Adjust service agreement(s) as applicable
- Notify all MA state plan and EW providers of re-instatement to resume services

❖ If the member **is not reinstated** after 90 days:

- Close member to EW in MMIS back to MA closure date
- Close service agreements in Bridgeview back to MA closure date
- 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. Complete any assessments or re-assessments 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.

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 within 10 business or 14 calendar days.

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

Situation	Care Coordination Notification of DTR
Member's Medical Assistance eligibility ends for any reason	Not required
Member moves out of the Blue Plus service area	Not required
Member switches to another health plan or fee-for-service	Not required
Member dies	Not required
Change in service provider (no change in authorized service or number of units)	Not required
Temporary change in payor source with no change or reduction in type, service or frequency for MA state plan home care services authorized by Care Coordinator to skilled Medicare episodic home care services	Not required
Member's EW/State Plan services authorized by the Care Coordinator are temporarily on hold for 30 consecutive days or less and the plan is for the member to resume services. (i.e., short term NF admission, vacation out of area, short term hospitalizations, etc.) (For additional details see Reference Guide for Hospital and Nursing Home Stays, below)	Not required
Member's EW/State Plan services authorized by the Care Coordinator are on hold for **more** than 30 consecutive days (For additional details see Reference Guide for Hospital and Nursing Home Stays, below)	Required
Denial/termination/reduction to services covered by the Medical benefit not authorized by Care Coordinator (i.e. services or supplies/equipment covered by medical benefit and Medicare services)	Not required
Assessment is completed for a CW member and it is determined that she/he is not eligible for EW and she/he is **not** requesting services	Not required
Assessment is completed for a CW member and it is determined that she/he is not eligible for EW and she/he **is** requesting services	Required
Member/CC is making decision to terminate **all** EW services and **close to EW**	Required
Reassessment is completed for a CW or EW member and a decision is made by member/CC to reduce service(s) and service(s) will be less in the new assessment/waiver span.	Required
Reassessment is completed for a CW or EW member and a decision is made by the member/CC to terminate service(s) and service(s) will not continue in the new assessment/wavier span.	Required

Situation	Care Coordination Notification of DTR
Member with existing service(s) previously authorized by the CC is due for reassessment and is unable to contact/ declines reassessment and service(s) end at the end of the current assessment/waiver span (does not apply to members with another HCBS waiver case manager).	Required
Member/CC is making decision to reduce a currently authorized EW or state plan service	Required
Member/CC is making decision to terminate currently authorized EW or state plan service	Required
Member/CC is making decision to reduce a currently authorized MSHO Supplemental Benefit	Required
Member/CC is making decision to terminate currently authorized MSHO Supplemental Benefit	Required
Member elects to use less PCA than was assessed.	Required
CC is making decision to reduce or terminate services (EW or state plan) or closing EW	Required
Customized Living/24 Hour Customized Living/Adult Foster Care rate is reduced due to a reduction or termination of a CL/AFC service	Required
Member no longer qualifies for EW due to no longer meeting NF Level of Care	Required
Home care agency provides services without Prior Auth from Care Coordinator. Provider later approach the CC requesting authorization for services rendered and the CC does not agree that the services were necessary	Required
Member is requesting an item or service that is not covered by Medicare or Medicaid.	Required

DTR Reference Guide for Hospital or Nursing Home Stays

Situation	Action Needed	Care Coordination Notification of DTR
Member goes into a hospital or nursing facility for an acute care stay less than 30 days	Notify providers of admission EW: close service agreements in BV back to admission date. State plan home care: Nothing required.	Not required
Members goes into the hospital OR nursing facility for more than 30 consecutive days	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.	Fax DTR form on day 31 **OR** within 24-hours of the determination that the hospital or nursing facility stay will exceed 30 consecutive days
Member goes into the	EW: Close the waiver in MMIS and service	Fax DTR form on day 31

hospital and then nursing facility, for more than 30 consecutive days combined **(order of admission does not matter)**	agreements in BV back to the first admission date. State plan home care: AGP will auto close authorizations, if applicable, based on DTR.	within 24 hours of the determination that the combined stay exceeds 30 consecutive days

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
- TransPerfect 855-886-2901
- Contact your Partner Relations Consultant for the customer code and pin information, as applicable.

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 directly for services. Delegate agencies may contact the following providers:

    - **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.

Housing Stabilization Services

Housing Stabilization Services is a new benefit to help people with disabilities and seniors find and keep housing. This is available to Medicaid enrollees as a state plan Home and Community-Based Service (HCBS) benefit available under Medical Assistance. No prior authorization or service agreement is needed from the Care Coordinator.

Goal:

- Support an individual's transition to housing
- Increase long term stability in housing
- Avoid future periods of homelessness or institutionalization

Eligibility:

- Have a disability or disabling condition or are 65 years or older
- Housing instability
- Need for services due to limitations caused by disability

Service options under the new HSS benefit:

<u>Consultation Services (Care Coordinator)</u>
New service available through Housing Stabilization that provides a person-centered plan for recipients not receiving case management. For our members, this service under the HSS benefit is ***provided by the Care Coordinator*** as part of the assessment and care planning process.

The assessment and planning for HSS rely on the same processes used by care coordinators for inclusion of *any* service in a coordinated care plan:

- Assessment and documentation of need for the service

- Choice by the enrollee to include the service in the plan
- Choice of available providers of the service
- Communication to the provider of service delivery expectation and preferences
- Sharing of the care plan or portions of the plan based on enrollee preference
- Provider and enrollee communication and signatures

Transition Services (HSS Provider)
Community supports that help people plan for, find, and move into housing. HSS providers will:

- Create a housing transition plan
- Assist with housing search and application process
- Assist with identifying and resolving barriers
- Securing additional services
- Organize the move to housing

Sustaining Services (HSS provider)
Community supports that help a person maintain housing. HSS providers will:

- Create a housing stabilization plan
- Education on roles, rights, and responsibilities of the tenant and property manager
- Coaching to develop and maintain key relationships with property managers and neighbors
- Advocacy with community resources to prevent eviction when housing is at risk
- Prevention and early identification of behaviors that may jeopardize continued housing
- Assistance with maintaining services and supports, including applying for benefits to retain housing

Care Coordinator role:
After completing the LTCC and determining eligibility for HSS, Care Coordinators should complete the required care planning components and referral to DHS approved provider. The Provider is responsible for completing all DHS requirements. Once Blue Plus receives an HSS Eligibility Notification from DHS, the Partner Relations team will notify the assigned Care Coordinator of the member's eligibility by secure email.

HSS Providers:
Providers must have all HSS services prior authorized by DHS. Approval must be obtained by following the requirements as published by DHS. Once services are approved, a notification will be forwarded to Blue Cross for claims processing purposes. Providers must enroll with DHS as a Housing Consultation provider prior to billing Blue Cross.

Refer to the DHS HSS policy page for more additional resources.

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. Since the Elderly Waiver covers transitional services, Blue Plus reserves MHM for members that do not have a community residence to return to or requires significant assistance in searching for a new qualifying residence. If the member meets the MHM eligibility criteria and is experiencing housing instability, refer to the *Housing Stabilization Services* section for more information.

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 Elderly Waiver. Members must enroll in the Elderly Waiver upon discharge to be eligible for MHM (exception of unforeseen circumstances prior to discharge). If the services under the medical benefit and Elderly Waiver can meet the identified transitional needs of the member, there is no need for MHM referral or intake. If the Care Coordinator is unsure, contact the Partner Relations Team to explore options.

The member must meet the MHM eligibility criteria below before applying for MHM. 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:

- Member resides for a minimum of 60 consecutive days (includes days covered by both Medicare and Medicaid) 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
- Member is on MA at least one day before discharge and throughout partcipation; **and**
- Member will open to the Elderly Waiver at the time of discharge; **and**
- 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 over which the individual or individual's family has domain and control; or

- An assisted-living residence apartment with separate living, sleeping, bathing, cooking areas and locakable entrance and exit doors
- A residence in a community based residential setting in which no more than four unrelated individuals reside.

After Blue Plus is notified of the MHM referral from DHS and MHM is deemed most appropriate, Blue Plus will notify the Care Coordinator of next steps. **Do not start MHM services until you receive confirmation from a member of the Partner Relations Team.** After the MHM provider has been selected and approved, the Care Coordinator will collaborate with the MHM Transition Coordinator to create a plan and arrange supports and services, ensuring no duplication in services. At a minimum, 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. Upon discharging from the qualifying institution, MHM services will end and the member will be transitioned to the Elderly Waiver program for any additional home community-based service needs (follow the current process for opening EW program).

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(s) Process

CDCS Audits

Blue Plus completes an audit on authorization and utilization of Consumer Directed Community Supports (CDCS) under Elderly Waiver. This is done on an annual basis with a randomly selected audit sample list.

Health Risk Assessment Audits (HRA)

HRAs are audited on a regular basis to ensure accuracy of entry into the Bridgeview system. The date entered into Bridgeview must be the date the member assessment was completed or the date the Unable to Contact Letter was sent. HRA information in Bridgeview are compared to the assessment documentation submitted. Delegates are audited on a monthly, quarterly or semi-annual basis. See Bridgeview Care Coordination User Guide for details on the audit process.

Pass-through Audits

Blue Plus is required to complete an audit of Delegate agencies that agreed to contract with Blue Plus in a "Pass Through" capacity for services delivered by non-enrolled Approval-Option service providers. This is done on an annual basis with a randomly selected audit sample list.

Managed Care (MSHO and MSC+) EW and Non-Elderly Waiver Care Planning Audit

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.