2021 Fall Training Q&A		
Topic	**Questions**	**Answer**
Assessment	For members that are unable to reach/locate, for purposes of MMIS screening document entries, are there generic ICD-10 codes that we can use?	Care Coordinators may use the generic code: R68.89 Other general symptoms and signs. Included is a link to look up other ICD 10 codes as needed. https://icdcodelookup.com/icd-10/codes
Audit	In regards to the new guidelines around assessment refusals, will Blue Plus be auditing for the minimum required time frame during audits?	For all reassessments, CCs should be reaching out to members or authorized reps with a minimum of 2 weeks or more to allow time to schedule or offer an assessment in advance of the 365 day deadline or Blue Plus cut off date, whichever is sooner. This will also allow time to schedule assessments and/or complete required attempts in the event Care Coordinator is unable to reach the member. At this time there is no audit element to monitor this, however, upon our discretion it may be added as a systems audit.
Audit	With the new guidance around semi annuals and UTR for members enrolled on EW, does DHS allow the semiannual as an UTR?	For members opened to EW, Blue Plus requires 2 face-face visits per year. This process was implemented to allow timely documentation but does not change the requirements.
Audit	Can you share some examples of audit action plan interventions and final audit action plan status summaries?	The Partner Relations Team will review this request and determine a process to gather and share examples of completed audit action plans as time allows.
Bridgeview	Are there glitches in the Bridgeview system? There have been times when we enter an assessment and the date of the assessment or SA changes to the member's birthday.	Yes, on rare occasion, the Partner Relations Team has also experienced assessment dates changing to the member's date of birth. When this occurred our team reached out to Bridgeview and the information was reviewed and corrected. Delegate agencies should be reaching out to their Partner Relations Consultant when this occurs, include a screen shot of the error and the correct information so it can be further researched and corrected accordingly.
Caregiver Assessment	In regards to the clarification around offering/completing caregiver assessments, what is the expectation from Blue Plus if there are multiple caregivers identified?	Best practice is to review and document the member's identified caregiver(s). When a caregiver is identified, the Care Coordinator should discuss the importance of completing the caregiver assessment and determine the best way to offer and/or complete the caregiver assessment(s). As a reminder, a caregiver is an informal, unpaid individual that supports and provides assistance to the member. The caregiver assessment is used to assess caregiver(s) role and potential needs including their stress level and their ability to continue providing informal caregiving support for the member. Discussing a back up plan (formal or informal) with the member would be ideal in the event a caregiver is no longer able to provide this support.
Case Load recommendations	Will Blue Plus be reevaluating case load recommendations? The additional MSHO supplemental benefits will create more administrative work for Care Coordinators. Can the authorization of MSHO supplemental benefits be automated to reduce the administrative burden?	Yes, Blue Plus is currently reevaluating the recommended case load per worker. We acknowledge and understand that CMS and DHS requirements have increased over the years, independent of the required training and implementation of the Revised MnCHOICES. As a friendly reminder, if your agency is not already utilizing the case aide role (this role may have a different title at your agency) to assist with administrative activities, please reconsider this as it is a billable service when it is directly related to a member. We continue to evaluate our platforms & processes to simplify and increase efficiencies (i.e. Bridgeview, referral processes, etc.). Please reach out to your Partner Consultant if you have any ideas or suggestions.
Checklists	We often use the checklists for each of our members, would Blue Plus consider adding a reminder to complete the new requirement of documenting enrollment notifications in case notes on the checklists?	All of the member checklists have been updated with "Document date of first notification of enrollment in member case notes".
COVID	When did the wavier modification for obtaining expressed verbal approval for care planning/support planning signatures end?	The waiver modification for obtaining expressed verbal approval for care planning/support planning signatures ended on 8/30/2021. Effective 8/31/2021 Care Coordinators should resume the previous requirement of obtaining member/auth representative signature(s) for care planning/support planning documents.
Elderly Waiver Service Agreements	On occasion we have (EW) providers asking us for a printed service agreement letter. Knowing that Bridgeview does not generate EW service agreement letters, what is the best way to address this request?	Bridgeview does not send Service Agreement letters. If a provider would like to view and print a SA, they must log into Availity. Care Coordinator can refer EW providers to https://bridgeview.bluecrossmn.com/ or for EW Provider related questions contact EWProviders@bluecrossmn.com or call our Bridgeview office at 1-800-584-9488. Please reach out to your Partner Relations Consultant if you need additional assistance.
Enrollment/Bridgeview	Occasionally members enrolling in Blue Plus do not select a PCC and Bridgeview auto selects a primary care clinic (PCC), this can lead to incorrect Care Coordination Delegation assignment. Is there anyway to prevent this from happening?	At this time there is no way to prevent this from happening. When members do not select a PCC (Primary Care Clinic), Bridgeview is required to auto select a PCC before assigning a Care Coordination Delegate agency. Upon assignment, Care Coordinators should contact the member to confirm the member's demographics, this includes verifying the PCC & PCP. Delegate agencies can bill for the time provided for care coordination activities that were completed prior to reassignment to the correct delegate agency (following the process for reporting enrollment discrepancies).
Home Care Services	We have never needed to authorize OT/PT/ST under MA, why is this in the guidelines for us to authorize?	As you may be aware OT/PT/ST are skilled services, however, there may be times when a member does not have Medicare and requires these services to be authorized under their medical assistance benefit. In this case, the CC would be required to authorize these services under MA. As a reminder, Care Coordinators are not required to authorize Medicare skilled home care services.
Letters	Will Blue Plus consider adding a free form text area to the 8.50 Member Change letter so Care Coordinators can include details when there are changes to the care plan/support plan?	Yes, we are in the process of adding a free form text field to the 8.50 Member Change Letter. Since this is a member facing letter, this change must be submitted to DHS for review and approval. In the interim, you may choose to use one of the other member letters to communicate this information.
MnCHOICES	There will be many assessments completed in the previous MnA application by county lead agencies prior to launching the Revised MnCHOICES application, how will the waiver spans starting prior to the launch be documented in the Revised MnCHOICES application?	Currently the Revised MnCHOICES launch has been delayed. DHS continues to work on a transition plan. More information will follow as we get closer to launch.
MnCHOICES	Some contracted county delegate agencies have a limited number of community and nursing home Care Coordinators. In regards to the requirement that all Care Coordinators must be Certified Assessors, what is the expectation for coverage when the primary community care coordinator/certified assessor is out of the office for a longer period of time? Can contracted county delegate agencies have non Blue Plus Certified Assessor(s) provide coverage for the Primary Blue Plus Community Care Coordinator/Certified Assessor?	DHS requires all care coordinators to be certified assessors at the time of the Revised MnCHOICES launch in order to complete comprehensive and/or health risk assessments. To clarify, Blue Plus delegates may not have a separate assessor team from the care coordinator. In the event a care coordinator is out of the office, the delegate should follow their process for staff coverage. Staff providing coverage are required to complete the same Blue Plus specific trainings. Ideally, the person completing the assessment should be the person developing the care plan with the member/auth representative.
MnCHOICES	With the Revised MnCHOICES launch, if we complete a LTCC today and are not able to complete the CCP yet and the Revised MnCHOICES launches the following week, which care plan/support plan are we expected to complete?	DHS previously communicated a 45- day transition period. On January 19, 2022 an eList announcement titled "Status of MnCHOICES revision project" announced the Revised MnCHOICES launch date will include a full 60-day transition period. For more information refer to: https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-331607

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MnCHOICES	Are there specific sections of the MnCHOICES assessment that will auto populate into the support plan.	It was our understanding that the intention was to have specific sections autopopulate from the MnCHOICES assessment into the support plan. However, this may have changed. Please complete the updated MnCHOICES workflow: Support Plan and Rates (MCH921) courses now available. Your MnCHOICES mentor should have received an email from DHS with this update. If you are a MnCHOICES Mentor, have signed up for the MnCHOICES eList announcements and did not receive this information, please reach out to you Partner Relations Consultant to further research. **MnCHOICES eList announcements sign up**: https://tkearns86.wufoo.com/forms/mnchoices-elist-announcements-signup/ As of 1/11/2022 the **Revised MnCHOICES application: MnCAT instructions for lead agencies have been updated:** https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs-329820#
MnCHOICES	Upon launching the Revised MnCHOICES application, will annual community well health risk assessments need to be entered into MMIS?	It is our understanding, per the DHS training on 12/16/21, HRA-health risk assessment(s) (currently known as 3428H) will not be required to be entered into MMIS. We will continue to closely monitor this guidance. However, Care Coordinators will continue to enter the same information for the revised MnCHOICES comprehensive assessment as you currently do for the LTCC.
MSHO Enrollment Outreach	Does the MSHO Sales Specialist complete any outreach to our members aging in from PMAP/Families and Children? Are there any outreach efforts to our existing MSC+ members? If so, what is the frequency of the outreach?	Currently there are no outreach efforts being made proactively to our members aging in from Families and Children (previously known as PMAP). Referrals are primarily from Blue Plus Care Coordinators. Our MSHO Sales Specialist(s) currently completes monthly outreach to existing MSC+ members.
MSHO Supplemental Benefit	What happens if a member utilizing the MSHO Supplemental Benefit Music Therapy is unable to complete all of the authorized units prior to the end of the calendar year?	Members should try to use their authorized MSHO Supplemental Benefit Music Therapy units prior to the end of the calendar year, however like any other service if they do not use all of the units in the designated calendar year no further action is needed. If the member chooses to start the MSHO Supplemental Benefit Music Therapy in the new calendar year, the benefit will restart on January 1, 2022. Members will have up to 26 sessions in the 2022 calendar year.
MSHO Supplemental Benefit	For the new MSHO Supplemental Benefit Fitness tracker; Fitbit, are members required to sync it to a phone/smart phone?	For the new MSHO Supplemental Benefit Fitness tracker; Fitbit, members are **NOT** required to sync the device to any electronic devices.
MSHO Supplemental Benefit	If MSHO member(s) received a Garmin fitness tracker last year, does the member need to return the Garmin in order to receive the new Fitbit fitness tracker ?	No, there is no need for MSHO members to return the fitness tracker from the previous year to receive the new fitness tracker. MSHO members are allowed one activity tracker per year when the benefit is available.
MSHO Supplemental Benefit	How are the OTC CVS Catalogs being distributed to MSHO members?	MSHO members will receive one printed copy of the OTC CVS catalog in the mail. We recently received notification that there was a delay in printing, we anticipate the shipping of printed catalogs will be completed no later than mid February 2022.
MSHO Supplemental Benefit	What will the process be for the new CHW MSHO Benefit? Will the CHW be coordinating with the Care Coordinator? Will they be providing any communication to the Care Coordinator?	The process for the MSHO benefit CHW program will be communicated at the MSHO supplemental benefit training on 1/25/2022. The Care Coordinator and CHW should both be communicating and coordinating care together. The Blue Plus Care Coordinator remains the primary member contact for coordinating services for on-going needs.
MSHO Supplemental Benefits	Under the new OTC MSHO Supplemental Benefit, members can order Adult Care products such as Depends and Poise pads, when would it be appropriate to use this benefit instead of using incontinence supplies under their medical coverage?	Members should discuss incontinence needs with their PCP and access incontinence supplies under their medical benefit first. However, on occasional or short term basis there may be situations when members may choose to use the OTC MSHO Supplemental Benefit for their incontinence supplies as this does not require a prescription. Reminder that there is also a separate MSHO supplemental benefit for reusable incontinence under pads (Incontinence Package) not covered under their medical benefits.
MSHO Supplemental Benefits	EW has limitations on purchasing personal wipes when a member resides in CL unless they are for personal use. Can the personal wipes be purchased under the new OTC MSHO Supplemental Benefit? Should the personal wipes be purchased under the new OTC MSHO supplemental benefit prior to purchasing the personal wipes under EW?	Wipes are to be used for the members personal use only regardless of the payer source; EW or the MSHO supplemental benefit. Wipes are not intended to be used by the CL staff. If the CL facility is not being paid for continence care and the member is using the wipes, the MSHO Supplemental OTC benefit can be used. Members should use the MSHO Supplemental OTC benefit prior to EW. With that being said, there is no way for the Care Coordinator to monitor what the member is ordering under the MSHO Supplemental OTC benefit. Please keep in mind that like the $750 MSHO safety benefit, there is no splitting of the costs with EW.
MSHO Supplemental Benefits	If a MSHO member's OTC CVS items exceed the $50 per quarter, is the member responsible for the cost above the benefit amount?	Yes, the MSHO member is responsible for the amount that exceeds the $50 per quarter allowed for this benefit.
MSHO Supplemental Benefits	Can MSHO members choose to save and use all of their OTC CVS benefits at the end of the year?	No, the MSHO OTC CVS benefit does not allow stacking of the $50 per quarter to use at a later date. MSHO members will need to use the $50 per quarter. Unused amounts will be forfeited at the end of the quarter.
Nursing Home Assessment	What was the effective date for the new requirement of obtaining a copy of the nursing home care plan to review and pair with the NH/ICF assessment and care planning? The form was updated on 8/6/2021, however, the guidelines updates were not communicated until 10/4/2021.	The implementation date for this new requirement was 8/6/2021. Friendly reminder that Care Coordinators should be accessing forms from our Care Coordination website to ensure use of the most current form. If copies of the form were not obtained during your Nursing Facility Care Plan review, one must be made available upon Blue Plus request.
Refusals	On occasion, healthy community well members may make requests for "no contact" other than for their annual assessment and it is clearly documented in their file. Is there a process for handling these types of requests?	If you have members that request NO CONTACT, consult with your PR Consultant for further direction.
Resources	Our region is experiencing an increase in Karen speaking population. Even with the use of Karen interpreters, it is difficult to reach our members. Can we have member facing letters translated into Karen, specifically the Unable to Reach Letter?	We are in the process of evaluating our member facing letters. We will include this letter to be translated into Karen. Please continue to bring identified gaps forward to your PR Consultant for consideration.
Resources	Can the font size on the T2029 Guide be increased?	We have increased the font size on the T2029 Guide, however, due to the volume of information on the guide, when we increase the font size it will make the document length longer. Friendly reminder, users may view the document and adjust font size online as needed.

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Semiannual Contacts	How many attempts are required when reaching out to the member for their semi annual/mid-year contact? Is there a difference with Community & Elderly Waiver?	For community well members that already refused or declined their initial or annual reassessment, for the semi-annual or mid-year, the Care Coordinator must document a total of 4 attempts (3 attempts and a letter) in the member's case notes & send 8.40 Unable to Contact letter offering a health risk assessment. Do NOT enter this into BV or MMIS. For CW members who have had a HRA and for members open to Elderly Wavier, if the CC is unable to reach the member at their Semiannual or mid-year, CC must document a total of 4 attempts (3 attempts and a letter) in the member's case notes and send 8.40 Unable to Contact letter offering a health risk assessment. Do NOT enter this into BV or MMIS.
Semiannual Contacts - Refusals	For community well members that already refused or declined their initial or annual reassessment, when a Care Coordinator reaches out at the semiannual or midyear to offer a health risk assessment and member continues to refuse/decline, should these be entered into Bridgeview or MMIS?	The refusal at the semiannual/mid-year would not be entered into BV or MMIS, CC would only enter the refusal initially or annually in Bridgeview and MMIS. Care Coordinators should document this in the member's case notes.
Semiannual Contacts - UTR	For members that were UTR at their initial or reassessment and at the time of the semiannual they continue to be UTR, should we be entering the UTR into BV and MMIS at the semiannual/midyear?	The UTR at the semiannual/mid-year would not be entered into BV or MMIS, CC would only enter the UTR initially or annually in Bridgeview and MMIS. Care Coordinators should document this in the member's case notes.
Signatures	How many follow up attempts are required up on 8.50 Member Service Change letter if no signature is returned?	The requirements for obtaining the signed 8.50 Member Service Change Letter for CW or EW members are as follows: discuss changes with the member/auth representative, after letter has been mailed out for member signature and no signature is returned, documentation of one additional attempt via phone/letter is required.
TOC	If we are unable to reach a member for transitions, how many times should we be reaching out? Do you want us to follow the 3 attempts and a letter? If we are still not able to reach them should we just follow up at the Semiannual or next reassessment?	The goal of completing outreach with transitions of care is to reduce readmissions and fragmented care. Best practice- Make a minimum of one attempt per transition within 1 business day from notification. Members that have had an inpatient stay may have more acute needs, it is important to consider their reason for admission when determining the number of appropriate attempts to make. Members may be away at therapy or follow up appointments, continue to use best practice in completing follow up with the member to assess if their needs have changed. Each case may vary.
Training	Is the Model of Care Training required for MSC+ only Delegates?	Yes, the Model of Care is used as a foundation for our Care Coordination Model, which includes both MSHO and MSC+. In the future, the title of this section will be adjusted to be more inclusive of MSC+ only Delegates.
Transportation	Care Coordinators are experiencing longer than usual wait times when calling BlueRide. What options are available to improve this experience? Care Coordinators have used BlueRide portal in the past, however, it does not generate confirmations and this can lead to other concerns on the day of.	We are continuously working to improve BlueRide wait times and member/provider experiences . There are certain times of the month when the call volumes are higher, this may lead to longer wait times. If you are experiencing longer than expected wait times, you may contact your Partner Relations Consultant to report your experience and request their assistance. To expedite your request, please have the following information available: Member's first and last name Date of Birth ID number Date of Service Pick up address Drop off address Time of the appointment In Greater Minnesota, facilities/hospitals may contact in network STS providers directly to schedule non emergency medical rides. We continue to evaluate alternative options/processes to increase transportation access and better member/provider experiences. We recently hired 12 more BlueRide representatives that will be starting training in February.

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Transportation	BlueRide is requesting POA or authorized representative scheduling a ride for a signature. Is this a change in process?	As of 9/1/2021 DHS is resuming the requirement of obtaining member signatures on all non emergency medical ride "trip sheets". If an adult child, foster care parent/guardian or someone else representing the member needs to call on behalf of the member to schedule non emergency medical rides, they may need to provide supporting documentation. For County employees that are not on the Care Coordination List, the Approved Scheduler Request form may be completed and submitted to grant permission. Member's may also provide verbal authorization to BlueRide providing authorization for others to speak to BlueRide representatives on the member's behalf. Social Worker Case Manager Public Health Nurse
UTR	When making outreach attempts, are we required to leave a message with each attempt?	While we have no formal direction in our guidelines, best practice would be to leave a message so the member knows who is trying to reach them. At a minimum, provide your name and your contact number requesting a call back.