2022 BLUE PLUS
CARE COORDINATION WINTER WEBINAR

Government Markets Partner Relations Team

March 1st 2022

THE TEAM

BlueCross BlueShield Minnesota

Melinda Heaser

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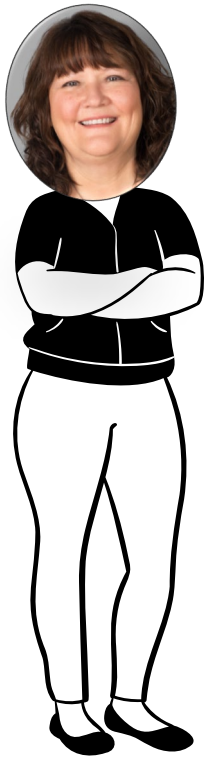
Kim Flom



Nissa Roberts

Janet Siegel

Becky Ridley

Kim Winter

Stormy Church & Karla Kosel
Our fearless leaders!

AGENDA

BlueCross BlueShield Minnesota

All Care Coordinators

- ❑ Mandatory Trainings and Onboarding
- ❑ Care Coordination Survey Results
- ❑ Pharmacy Program benefits and Medicare Reimbursement form
- ❑ Prioritizing initial outreach to new enrollees for Continuity of Care
- ❑ Term Future and Enrollment Reports
- ❑ Peace Time Emergency Protocols
- ❑ Facility Decompression Referral List
- ❑ Housing Stabilization Services

Community Only Care Coordinators

- ❑ Out of Network Process
- ❑ MnCHOICES
- ❑ Request to Exceed to Case Mix Budget Cap
- ❑ Safe Disposal of Medication
- ❑ DHS PCA Modifications
- ❑ New CMS Requirement
- ❑ MSHO Supplemental Benefit Resource

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MANDATORY TRAININGS AND ONBOARDING

MANDATORY TRAININGS AND ONBOARDING

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Starting in 2022, you will notice an increase in training opportunities.

Annual required trainings include:

- Winter Webinar
- Model of Care/Fall Training

We will be adding additional mandatory trainings throughout the year including:

- Race & Health Equity and Social Determinants of Health
- Annual Care Coordination Survey Results
- Process and product trainings
- And more as determined

MANDATORY TRAININGS AND ONBOARDING

BlueCross BlueShield Minnesota

The PR team will alert Delegates when a training is *mandatory* via a communication and the invite.

The trainings will be recorded for later viewing as needed.

Communication will include *prepopulated* attendance log with training name and all names of those that should attend. Attendance log should be returned same day.

If any staff are unable to attend, they should watch the webinar within 7-14 days and send back log/or provide explanation for lack of ability to attend to their Partner Relations Consultant.

MANDATORY TRAININGS AND ONBOARDING

Blue Plus New Care Coordinator Training Checklist has been modified to include "mandatory" vs "optional" training tasks.

New requirement: attestation to be returned to Partner Relations Consultant within 90 days of hire.

ATTESTATION:

Please electronically sign and return a copy of this checklist to Partner.Relations@bluecrossmn.com within 90 days of hire. By signing this checklist, the Delegate agency is attesting the new Care Coordinator has completed all mandatory training requirements outlined in the table above.

Blue Plus New Care Coordinator Training Checklist

This checklist is a training tool for new Care Coordinators. Care Coordinators must complete the mandatory training tasks and electronically sign the attestation, returning to their assigned Partner Relations Consultant within 90 days of hire.		
***Mandatory* Tasks requiring Attestation of Completion (below)**	**Care Coordination Website Review**	Visit: Blue Plus Care Coordination Website and review the following tabs: ☐ **Home Page:** Updated regularly with new information and upcoming trainings. ☐ **Care Coordination:** Includes guidelines, forms, letters, and helpful resources ☐ MSHO and MSC+ Community Care Coordination Guidelines ☐ MSHO and MSC+ Nursing Home Care Coordination Guidelines ☐ Review 6.02.02 Instructions for the Collaborative Care Plan ☐ Review 6.22.01 Transition Log Instructions ☐ **MSHO:** **SecureBlue MSHO Supplemental Benefits:** ☐ Review MSHO Supplemental Benefits Grid. **SecureBlue MSHO Enrollment:** ☐ Review MSHO and MSC+ Comparison Flier for a list of differences between products. ☐ **Communication:** History of previously sent Communiques. Communiques are sent via email from Blue Plus to update Care Coordinators on contract requirements, guidelines updates, operational/process changes, health promotion efforts and more! ☐ **Training:** Blue Plus facilitated and DHS Care Coordinator trainings and webinars. ☐ **Resources:** Includes various resources including Audits, CDCS, Dental, MHCP and DHS manuals, Member/Community resources, Person-Centered Planning, Provider and Pharmacy Directories, BlueRide, and other helpful links **Care Coordination Audits:** ☐ Review current DHS MCO Audit Protocols. **BlueRide – Transportation Resources:** ☐ Review the Care Coordinator BlueRide Portal Guide ☐ **Bridgeview:** Includes links to Bridgeview, Bridgeview Care Coordination User Guide, T2029 Guide for Care Coordinators, DME Payor Determination checklist. ☐ Bridgeview Care Coordination User Guide

BlueCross BlueShield Minnesota

2021 Care Coordination Satisfaction

Consumer Experience & Insights

February 2022

Care Coordination Satisfaction

Purpose of Research

BlueCross BlueShield Minnesota

The purpose of this research is to determine comparisons between SecureBlue and MSC+ members for:

1. The overall satisfaction with care coordination.
2. The frequency of visits with Care Coordinators among member groups: Community Well, Elderly Waiver, and Nursing Homes.
3. The frequency of contacts with Care Coordinators among member groups: Community Well, Elderly Waiver, and Nursing Homes.
4. The probability of recommendation of Blue Plus.
5. The impact of the Covid-19 pandemic on interactions with Care Coordinators.

Care Coordination Satisfaction

Methodology

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A survey was mailed to a random sample of SecureBlue and MSC+ members.

Data were collected from October 22, 2021 to December 2021.

A total of 864 responses were received – a 28% response rate.

(In 2020, a total of 955 responses were received out of 2,900 mailed – a 33% response rate.)

Sample Segment	Surveys Mailed	# of Responses	Response Rate
SecureBlue Members	**1,500**	**540**	**36%**
Metro	350	113	32%
Greater MN	1,150	427	37%
MSC+ Members	**1,600**	**325**	**20%**
Community Well + Elderly Waiver	1,163	258	22%
Nursing Home	437	67	15%
Total	**3,100**	**864**	**28%**

COMPARISON OF SECUREBLUE AND MSC+ MEMBERS

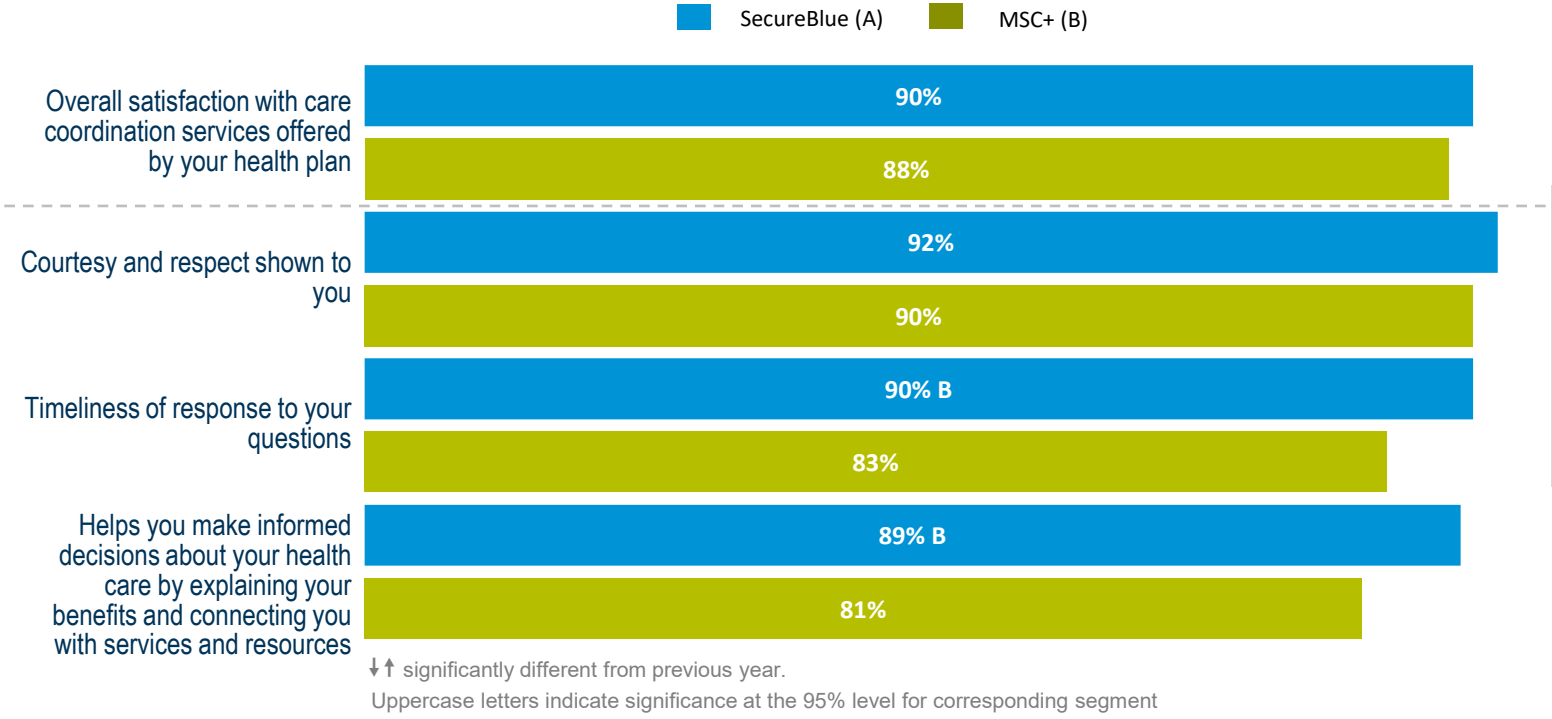
CARE COORDINATION SATISFACTION

OVERALL SATISFACTION

- Overall, SecureBlue members are slightly more satisfied than MSC+ members.
- However, SecureBlue members are significantly more satisfied than MSC+ on timeliness of response and helps to make informed decisions.
- No significant movement occurred since 2020.

Thinking about the services you receive from your care coordinator, how would you rate each of the following?

Top 2 Box Findings (Very Satisfied and Somewhat Satisfied)



Elderly Waiver respondents are significantly more satisfied than Nursing Home respondents timeliness and making informed decisions.

Elderly Waiver is also significantly stronger than Community Well for "Timeliness".

↓↑ significantly different from previous year.

Uppercase letters indicate significance at the 95% level for corresponding segment

Q1. Thinking about the services you receive from your Blue Plus care coordinator, how would you rate each of the following? (N=540, 321)

CARE COORDINATION SATISFACTION

FREQUENCY OF VISITS WITH CARE COORDINATOR

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- Compared to last year, significantly more SecureBlue and MSC+ respondents indicated they had a visit with their Care Coordinator in the last year.
- As seen in past years, Nursing Home respondents in both groups continue to be less likely to recall having a visit from their Care Coordinator.

		In the past year, how often did you visit with your Blue Plus care coordinator (by phone or in-person)					
		Total	Community Well	Elderly Waiver	Nursing Home	Member	Family
		n=531 (SB), n=318 (MSC)	n=270 (SB), n=115 (MSC)	n=232 (SB), n=137 (MSC)	n=29 (SB), n=66 (MSC)	n=347 (SB), n=164 (MSC)	n=103 (SB), n=127 (MSC)
Net: In past year	SecureBlue (A)	91% ↑	90%	93%	76%	93%	91%
	MSC+ (B)	87% ↑	90%	90%	76%	89%	87%
1 time per year	SecureBlue (A)	21%	25% EW	16%	28%	22%	17%
	MSC+ (B)	22%	31% EW	15%	20%	24%	17%
2 times per year	SecureBlue (A)	31%	36% EW, NH	27%	17%	31%	34%
	MSC+ (B)	31%	34%	29%	30%	31%	31%
3-4 times per year	SecureBlue (A)	24%	20%	30% CW	21%	24%	29%
	MSC+ (B)	24%	21%	29%	17%	23%	28%
5 or more times per year	SecureBlue (A)	14%	10%	20% CW	10%	15%	11%
	MSC+ (B)	10%	3%	17% CW	9%	11%	9%
Not in past year	SecureBlue (A)	9%	10%	7%	24% CW, EW	7%	9%
	MSC+ (B)	13%	10%	10%	24% CW, EW	11%	13%

Uppercase letters indicate significance at the 95% level for corresponding segment

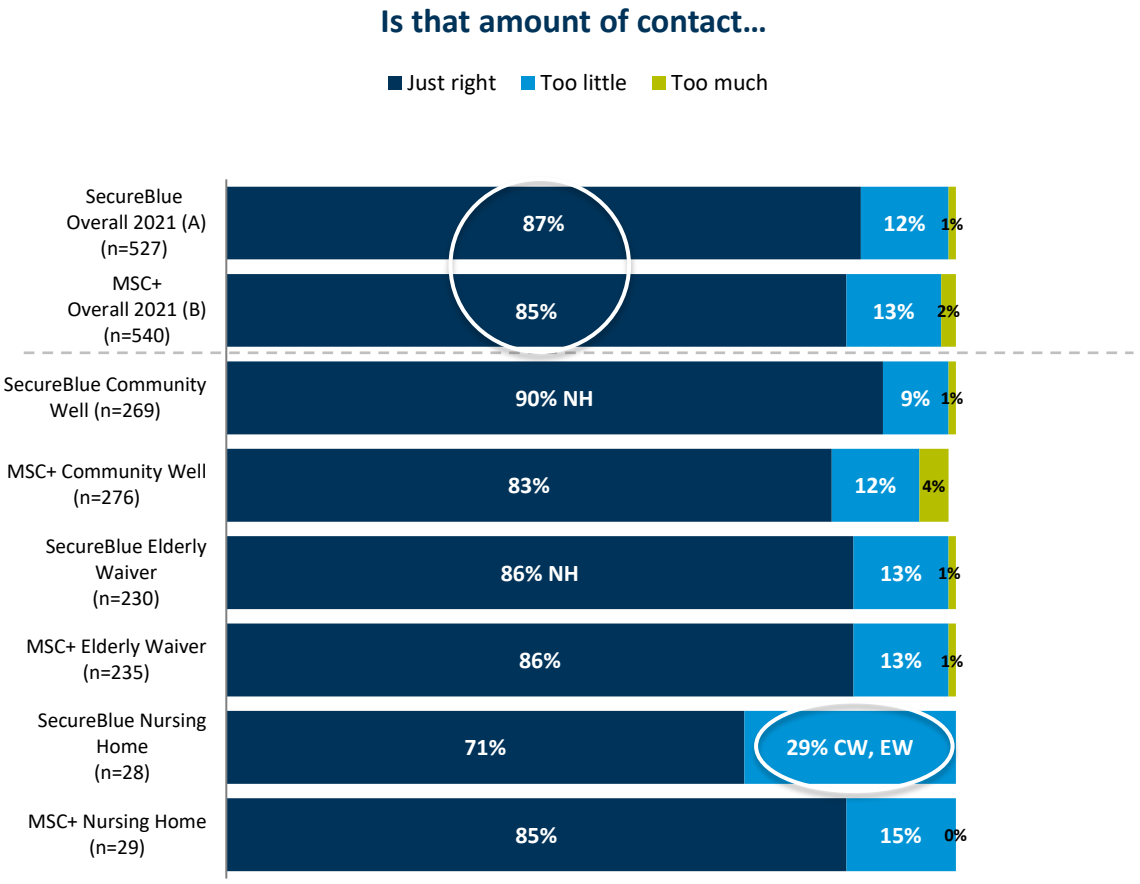
↓↑ significantly different from previous year.

Q2. In the past year, how often did you visit with your Blue Plus care coordinator (by phone or in-person)? (N=531, 318)

CARE COORDINATION SATISFACTION

IDEAL AMOUNT OF CONTACT WITH CARE COORDINATOR

- The majority of members (85%-87%) from both segments believe their amount of contact is “just right.”
- SecureBlue Nursing Home respondents are significantly more likely than their counterparts to perceive their contact as “too little.”
  - This is consistent with the percentage of Nursing Home respondents who indicated they don’t recall a visit last year.



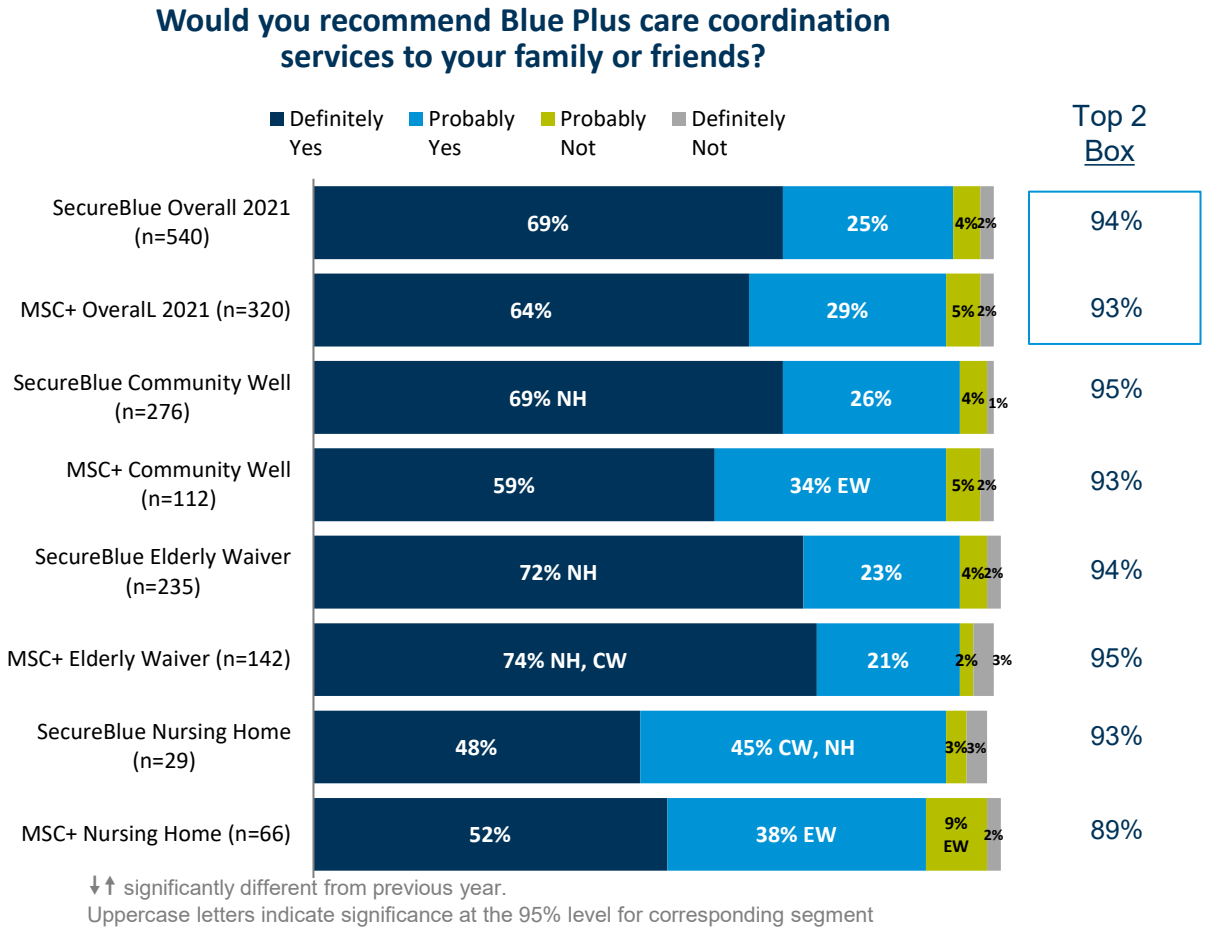
Uppercase letters indicate significance at the 95% level for corresponding segment

Q3. Is that amount of contact:

CARE COORDINATION SATISFACTION

WOULD YOU RECOMMEND BLUE PLUS CARE COORDINATION?

- Roughly nine out of ten SecureBlue and MSC+ respondents would recommend care coordination services to family or friends; few (6%-7%) would not.
  - There are no differences between the two segments.
- Nursing Home respondents are the *less likely to be a strong proponent, and more* likely to say they would "probably" recommend Blue Plus care coordination services to their family or friends.



Q4. Would you recommend Blue Plus care coordination services to your family or friends?

CARE COORDINATION SATISFACTION

LIKELIHOOD TO RECOMMEND PLAN/NET PROMOTER SCORE

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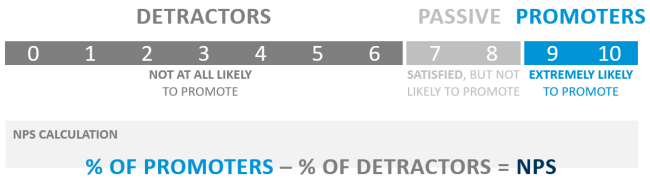
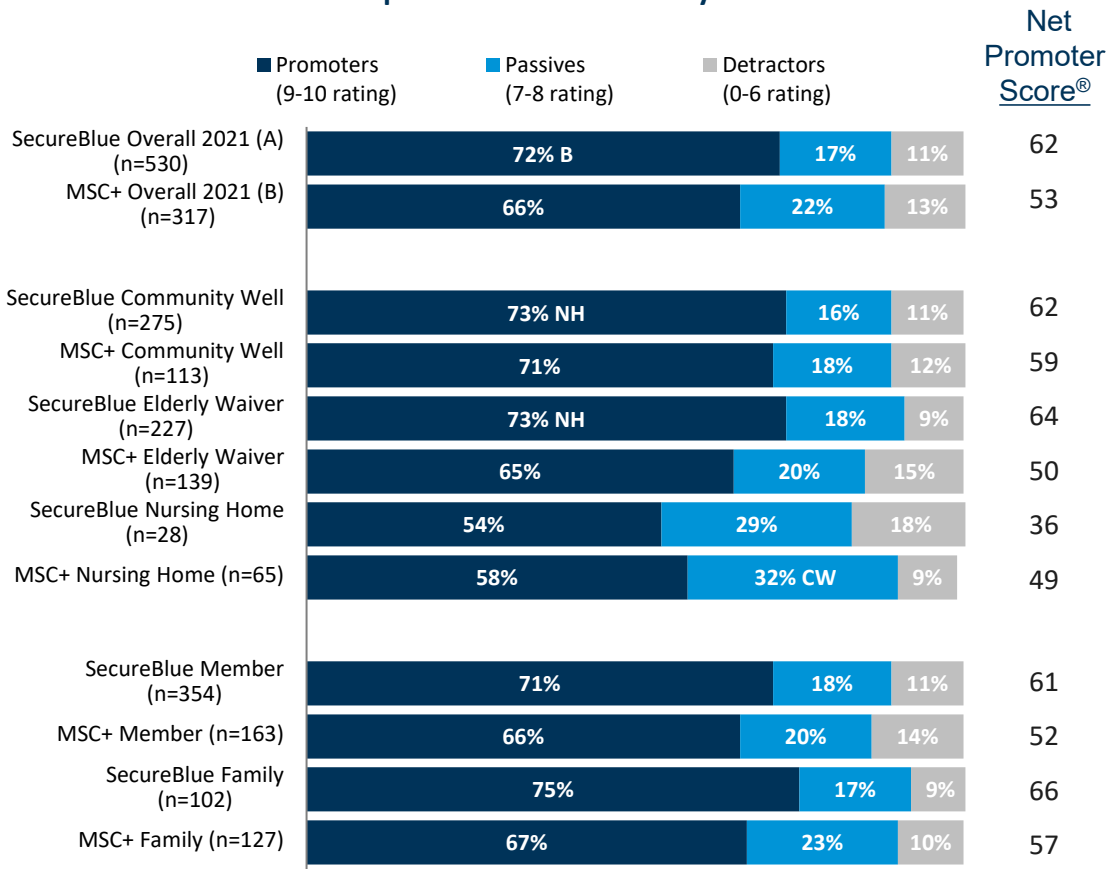
- SecureBlue are more likely than MSC+ respondents to be promoters of the Blue Plus health plan.
- Consistent with the previous metrics, SecureBlue and MSC+'s Nursing Home members are the least likely to be promoters of Blue Plus.
- Although both metrics are high, the Net Promoter Score® (NPS®) for SecureBlue outpaces MSC+ by 9 points.

Net Promoter Score (NPS):



How likely is it that you would recommend your Blue Plus health plan to a friend or family member?



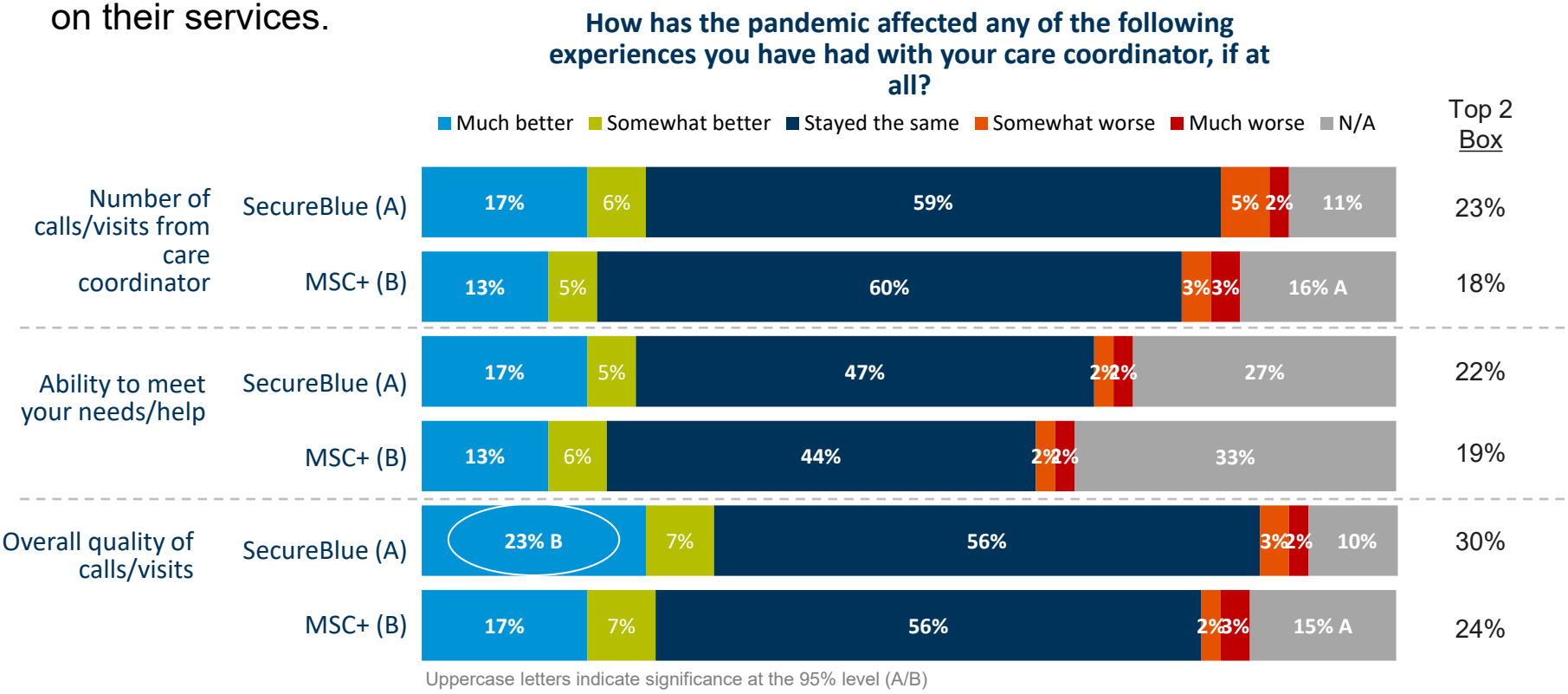
↓↑ significantly different from previous year.
Uppercase letters indicate significance at the 95% level (A/B)

Q5. How likely is it that you would recommend your Blue Plus health plan to a friend or family member?: 0=Not at all likely; 10=Extremely likely; NPS = % promoters minus % detractors

CARE COORDINATION SATISFACTION

COVID-19 IMPACT ON CARE COORDINATOR EXPERIENCE

- Most SecureBlue and MSC+ respondents believe COVID has had no impact on their care coordination services.
- SecureBlue members are more likely to suggest their overall quality of calls/visits has gotten "much better" compared to MSC+ members.
- Interestingly, more respondents believe COVID has had a *positive* than negative impact on their services.



Uppercase letters indicate significance at the 95% level (A/B)

Q6. How has the pandemic affected any of the following experiences you have had with your care coordinator, if at all? (Question added in 2020); N=530, 313)

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PHARMACY PROGRAM BENEFITS AND MEDICARE REIMBURSEMENT FORM

PHARMACY PROGRAMS

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MRP: Medication Reconciliation Post-Discharge (Tabula Rasa)

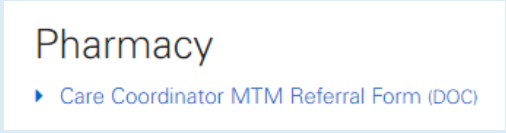
Program	Who qualifies	What to expect	Care Coordinator Role
MRP: Medication Reconciliation Post Discharge ***Provided by Tabula Rasa in-home or telephonic***	MSHO members only post-discharge from hospital or SNF	• Tabula Rasa pharmacist completes an in-home or telephonic visit post-discharge to review/compare medications prior to and after discharge and answer questions/concerns. • Member is provided with an action plan/medication schedule. • Pharmacist sends action plan to member's PCP	• Request discharge paperwork and medication list from facility • Send with form 6.35 In Home Pharm D Referral Form • See SecureBlue MSHO Supplemental Benefits page

PHARMACY PROGRAMS

MTM: Medication Therapy Management

Program	Who qualifies	What to expect	Care Coordinator Role
MTM: Medication Therapy Management program ***MTM services are provided telephonically by pharmacists who have advanced training in optimizing medication therapy*.** **The initial visit is called a Comprehensive Medication Review (CMR).**	All **MSHO** members **and MSC+** members (with no Part D coverage) meeting the following criteria are eligible for the MTM program at the beginning of the year and are scheduled to receive a CMR: • at least three of five conditions: CHF, COPD, hypertension, diabetes, dyslipidemia (high cholesterol) • at least 8 Part D prescriptions, • a minimum drug spend for those Part D medications as defined by CMS ($4,376 in 2021).	• Telephonic visit scheduled with internal MTM team. • MTM Pharmacist follows standard CMR delivery and documentation process to understand the member's medication experience and review medications and conditions to assess, resolve, and prevent any medication related problems. • MSHO members who live in an CL/SNF and have meds managed by nursing staff, pharmacist will complete CMR with facility staff. • MTM Pharmacist sends the member after-visit documents including medication list and action plan • MTM Pharmacist faxes a copy of documents to member's PCP	• Educate member on benefits of having CMR if contacted.

PHARMACY PROGRAMS – NEW CC REFERRAL OPTION

Program	Who qualifies	What to expect	Care Coordinator Role
MTM: Medication Therapy Management program **Provided by in house team telephonically**	Any **MSHO and MSC+** members (with no Part D coverage) can elect to have their medications reviewed by a pharmacist. These members can be referred by a care coordinator for MTM services. Examples of MTM referral criteria include: • Polypharmacy (4 or more meds) • Drug side effect/adverse drug event • Adherence issues • Medication interaction or dosing concerns • Chronic conditions • Frequent ER/hospital visits	• In addition, MTM Pharmacist will email referring CC visit info. • MTM pharmacist will follow up with members if there were any medication-therapy problems identified during the CMR to ensure recommendations made to the member and/or provider were accepted	• Care Coordinators should complete the Medication Therapy Management (MTM) Referral form and email to: Medicaid.MTM@bluecrossmn.com • Referral form on Care Coordination website under “Pharmacy”  

MEDICARE REIMBURSEMENT FORM

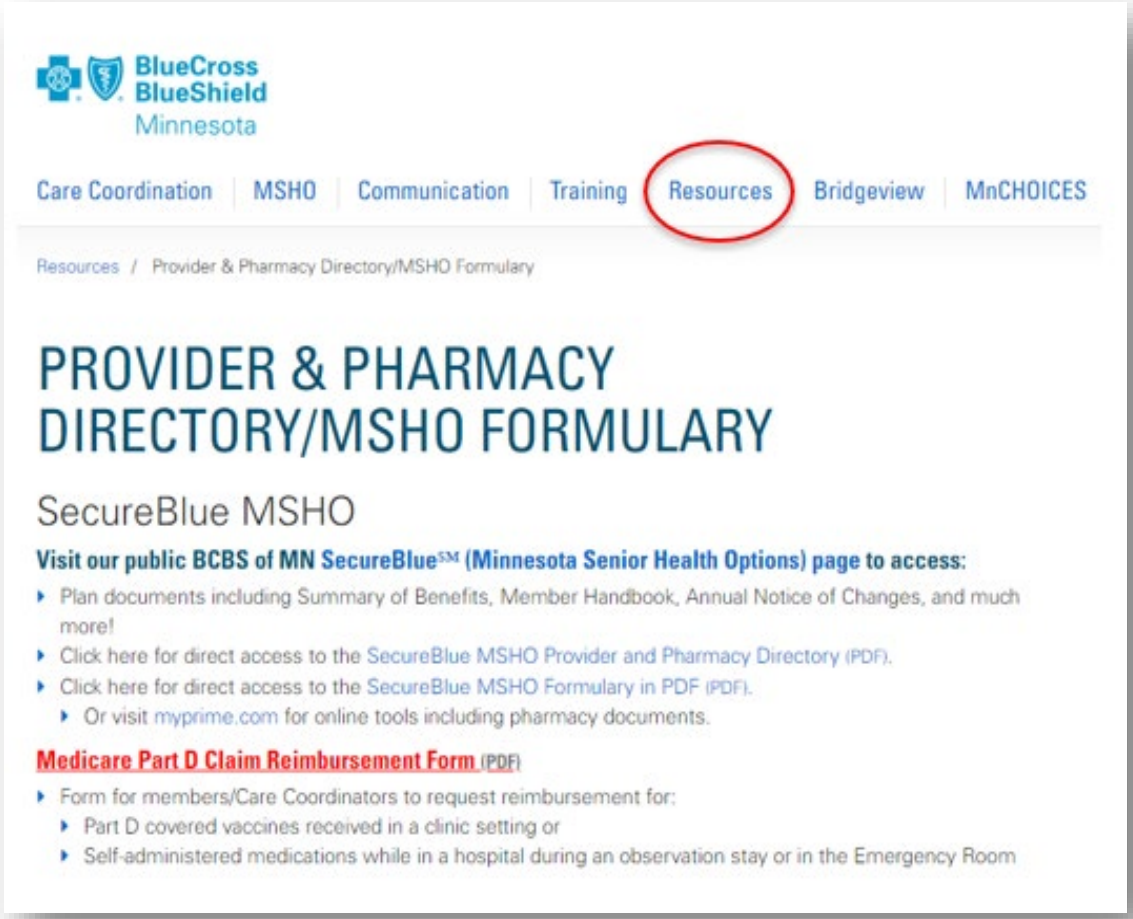
MSHO members may be billed for some Medicare Part D vaccinations received in a clinic setting or OTC medications self-administered in a hospital or ER setting.

- Part D covered vaccinations (examples are Zostavax for shingles or Tdap for tetanus) can be administered in a clinic setting. The clinic can bill Part B benefits for the administration of the vaccine but not Part D covered drugs since they are not a pharmacy.
- Members may be billed for medications that are self-administered while in the hospital during an observation stay or while in the Emergency Room. Medicare considers certain prescription and OTC medications normally take on your own as self-administered and are not generally covered by Medicare benefits during an outpatient, observation, or ER stay. (Examples include Ibuprofen and insulin, etc.).

MEDICARE REIMBURSEMENT FORM

Members receiving bills can do one of the following:

- pay the bill and submit the form for reimbursement **or**
- not pay the bill and submit invoice for reimbursement.
- form can be mailed to address on the form or faxed to 1-800-693-6703.
- Must include copy of paid receipt or unpaid invoice.



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PRIORITIZING INITIAL OUTREACH TO NEW ENROLLEES FOR CONTINUITY OF CARE

PRIORITIZING INITIAL OUTREACH TO NEW ENROLLEES FOR CONTINUITY OF CARE

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CMS requires us to define our most vulnerable members and how we tailor services to them, and both CMS and DHS require us to provide assessments, care planning, and Continuity of Care for our members.

We recognize that some newly enrolled members may come to Blue Plus with urgent needs requiring immediate follow up. In these circumstances, Care Coordinators should reach out to these members sooner to assure continuity of care.

We have updated our best practice requirements and are providing two additional tools to help CCs identify these members; engage quicker; and avoid gaps in care for the member.

PRIORITIZING INITIAL OUTREACH TO NEW ENROLLEES FOR CONTINUITY OF CARE

BlueCross BlueShield Minnesota

New section added to Guidelines: "Prioritizing initial outreach to new enrollees" includes the following:

- DHS New Enrollee Utilization Report: contains information about new BluePlus members who are new from FFS MA, SNBC, Families and Children or another health plan
- Transitional Health Risk Assessment
- Updated guidance on the use of the DHS 6037 - Universal Transfer Form

DHS NEW ENROLLEE UTILIZATION REPORT

This report is created by DHS and sent to Blue Plus monthly. It contains information about Minnesota Health Care Program recipients who are new to Blue Plus.

DHS New Enrollee Utilization Report	
Blue Plus will send this report to each Delegate within two Business days from date of receipt from DHS.	Of the twenty-eight areas, 4 areas are considered potential high risk. CCs should review these four areas to prioritize timing of initial outreach.
Care Coordinator (CC) should review for care planning and prioritization of initial contact with members. **For members residing in a nursing home, this report will be an FYI only.*	Care Coordinators should reach out to members with any needs in these 4 areas within one business week so that potential urgent needs are addressed: • 16: DME claims (FFS and MC) • 22: Pharmacy prior auths • 28: MH—Non TCM • 29: Inpatient Stays

DHS NEW ENROLLEE UTILIZATION REPORT

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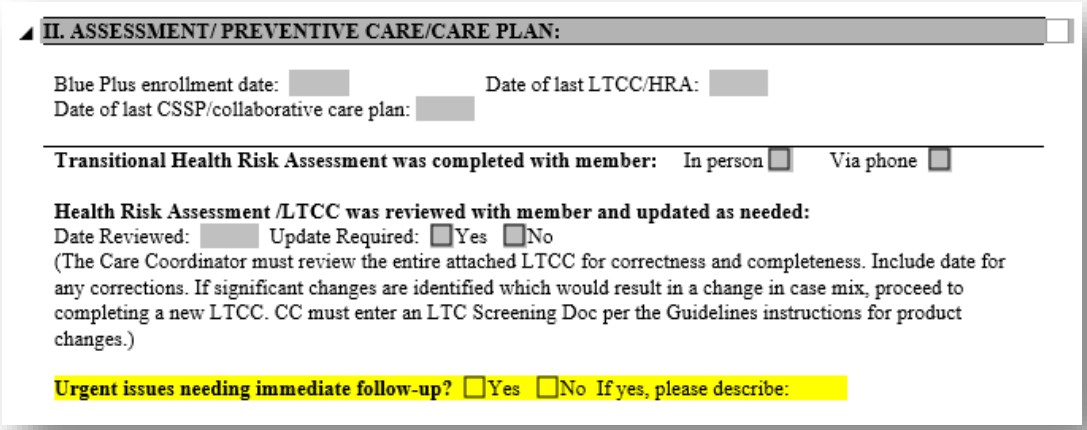
DME Claims	• Claims for Durable Medical Equipment during the previous 12 months • Review to assure continuity of current services/needs.
Pharmacy Prior Auths	• Prescriptions for certain drugs that were prior-authorized in the previous 4 months. • Review expiration dates of PA and assist with coordinating a new PA if needed.
MH Non-TCM	• Information on non-targeted case management mental health encounters during the previous 4 months (i.e., ACT Assertive Community Treatment, ARMHS Adult Rehabilitative Mental Health) • Helpful to determine if there needs to be a discussion with member about any mental health needs or services
Inpatient Stays	• All inpatient admissions and discharges within the previous 4 months. • Helpful to determine potential service needs

TRANSITIONAL HRA

6.28 Transitional Health Risk Assessment

Guidelines updated: For new enrollees (transferred from another health plan or fee-for-service) the CC should assess for any urgent needs that require immediate follow up.

Form updated: New question added to prompt discussion with a new member transferred from another health plan or fee-for-service about any urgent upcoming needs requiring prioritization. (i.e., the member may have acute health care needs, issues with providers, questions about current medications, network, PCP.



II. ASSESSMENT/ PREVENTIVE CARE/CARE PLAN:

Blue Plus enrollment date: Date of last LTCC/HRA:
Date of last CSSP/collaborative care plan:

Transitional Health Risk Assessment was completed with member: In person ☐ Via phone ☐

Health Risk Assessment /LTCC was reviewed with member and updated as needed:
Date Reviewed: Update Required: ☐Yes ☐No
(The Care Coordinator must review the entire attached LTCC for correctness and completeness. Include date for any corrections. If significant changes are identified which would result in a change in case mix, proceed to completing a new LTCC. CC must enter an LTC Screening Doc per the Guidelines instructions for product changes.)

Urgent issues needing immediate follow-up? ☐Yes ☐No If yes, please describe:

DHS 6037

Best Practice

Upon receipt of the *DHS 6037 HCBS Waiver, AC and ECS Case Management Transfer and Communication Form* the Care Coordinator should review for information that may indicate *swifter* CC outreach is needed due to acute needs of that member.

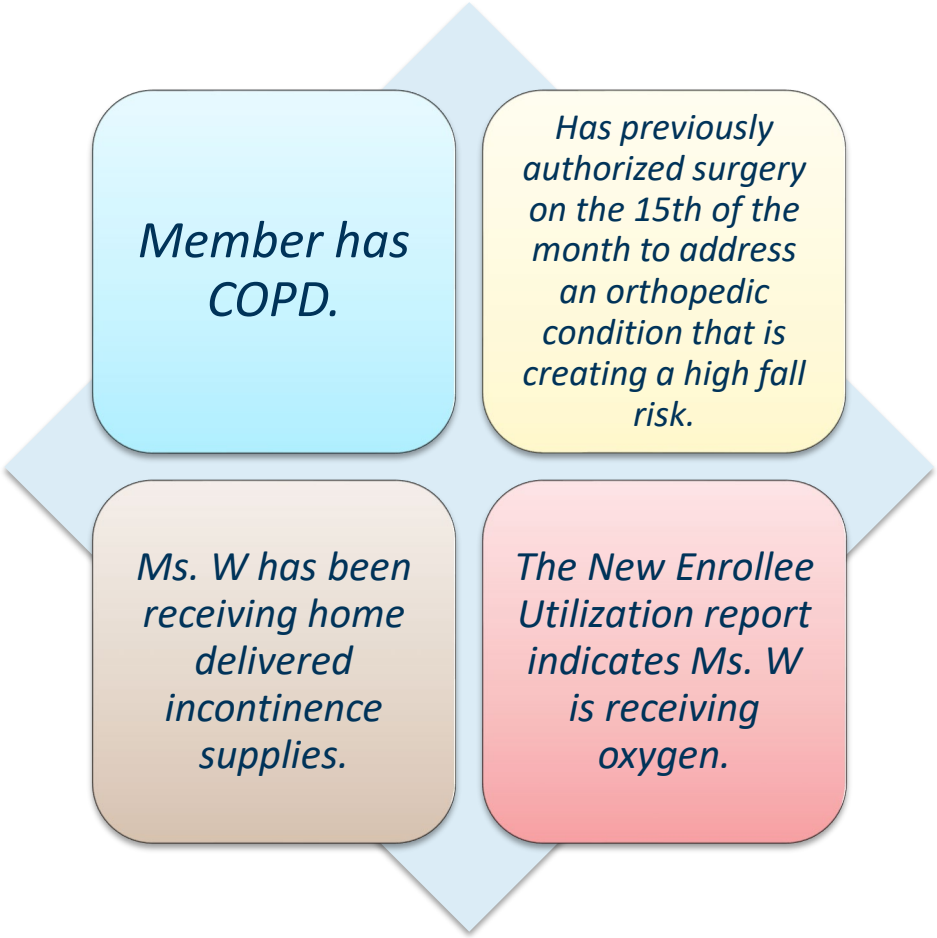
Things to look for:

- Do they have another Case Manager?
- What are their diagnosis? May need immediate attention?
- When was their last contact with a CC or CM? Has it been a while?
- Is there anything listed under current issues/considerations (upcoming appts, surgeries, DME /equipment needs, essential services listed)?

When a CC is transferring a case, it is best practice and best for member's continuity of care to include any information that needs immediate attention or may be of historical value to the next Care Coordinator via DHS 6037.

CASE EXAMPLE

Ms. W has just transitioned to Blue Plus from FFS on the first of this month. She is currently on the Elderly Waiver program and receives PCA services. The previous Case Manager noted some things which may require swifter follow up on the UTF form:



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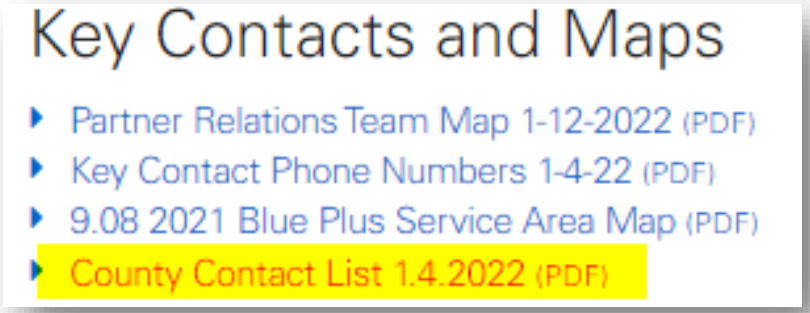
TERM FUTURE AND ENROLLMENT REPORTS

TERM FUTURE AND ENROLLMENT REPORTS

Term Future flag on enrollment reports means this member is scheduled to drop off Blue Plus at the end of the month or the end of the 90-day Grace Period if on MSHO.

What should the Care Coordinator do:

- As needed, watch the 9-minute training via the DHS website explaining the process for renewal
- Proactively contact the member or authorized representative.
- Educate member about what is happening (renewal), what it means, and why it is important to get their paperwork in.
- Contact member's assigned county financial worker to determine if the pending termination is due to a MA renewal or other reason.
- Assist member/authorized representative with renewal. Guide the understanding of the process and timing and assist to avoid an unnecessary lapse in eligibility and coverage.
- If member is on MSHO and loses MA eligibility, continue to work with the member during the 90-day grace period (s*ee Care Coordination Guidelines).*
- See new Medical Assistance (MA) Renewal section in Guidelines.



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PEACE TIME EMERGENCY PROTOCOLS

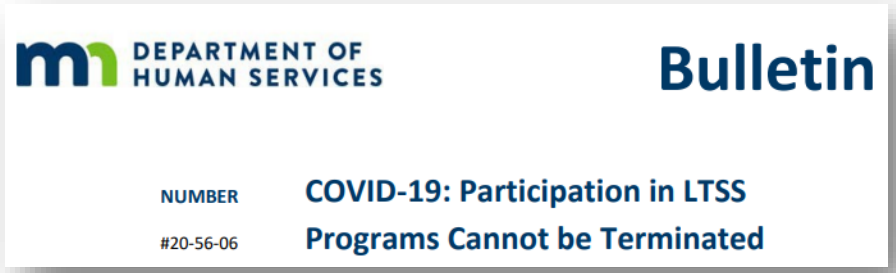
ELIGIBILITY

The Governor's executive order continues; members who receive long-term services and supports (LTSS) continue to have coverage and remain eligible for state public programs.

The Elderly Waiver cannot be closed except for the following reasons:

- The person chooses to exit the waiver/AC program.
- The person moves out of state.
- The person died.
- The person has an institution and/or facility stay for 30 consecutive days or greater.

#20-56-06


DEPARTMENT OF HUMAN SERVICES

Bulletin

NUMBER #20-56-06

COVID-19: Participation in LTSS Programs Cannot be Terminated

- Allowable MMIS termination codes
- Allowable program changes
- LTC Screening Document (steps to reopen previous LTSS programs for non-DD waiver)
- Admission to an institutional setting: LTC Screening Document for EW exit

EW SERVICES

During the peacetime emergency, follow these processes for Unable to Reach EW members due for reassessment. CC must make timely outreach to allow for 3 attempts & delivery of Unable to Reach letter and document accordingly.

When no contact is made at reassessment time:

- Enter UTR in Bridgeview
- Do **NOT** exit EW or enter UTR in **MMIS**
- Enter Screening Doc into MMIS to keep EW open
- Issue DTR's for services only (advanced notice to member and provider required)
- Close SA in BV (use DTR effective date from UM)
  - Do not continue services without an assessment
  - Do not authorize services in Bridgeview
- End current LTCC/Case Mix fields into Bridgeview
- Enter "new" LTCC/Case Mix field dates in Bridgeview using previous year's case mix/assessment info

When contact is made for reassessment, follow normal reassessment process:

- Close previous "new" EW span in Bridgeview to the day prior to the reassessment date
- Add new EW span in Bridgeview, start date based on completed assessment date
- Enter new assessment info in MMIS and Bridgeview based on assessment
- Add new Service Agreement(s) in Bridgeview, earliest date being the date of reassessment

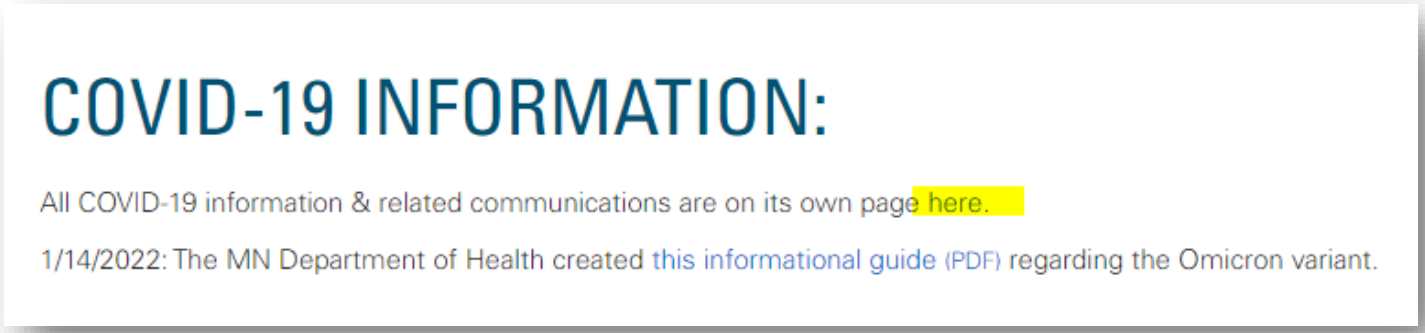
REMOTE ASSESSMENT

Until further notice, the ability to complete remote face-to-face assessments continue under the extended COVID-19 waiver modification.

Care Coordinators must continue to document in MMIS and Bridgeview as communicated in the following Communiques:

- 7/8/2021 Communique Regarding Face-to-Face Visits
- 3/24/2020 Blue Plus and DHS COVID-19 Emergency Protocol Updates (Community)
- 4/30/2020 Edits to 4-10-2020 COVID-19 Updates (NH)

**Reminder: All COVID-19 communications are located under COVID-19 Information on the home page of our website.*



SIGNATURES

Communique sent on 8/2/2021 to notify effective August 31st, 2021, Care Coordinators should have returned to the original practice of obtaining care plan and provider signatures and distributing documents.

COVID modifications that end Aug. 30, 2021:

Signatures Requirements:
Effective Aug. 31, 2021, Care Coordinators must return to the original practice of obtaining HRA assessment and support planning signatures and distributing documents.

- During the peacetime emergency, DHS allowed lead agencies to obtain verbal or expressed approval of documents that typically require in-person signatures. It also waived the requirement to provide LTSS-assessment and support-planning documents to people and providers.
- For more information on COVID-19 timelines, review Bulletin 20-56-10: LTSS policy amendments related to COVID-19 peacetime emergency (PDF).

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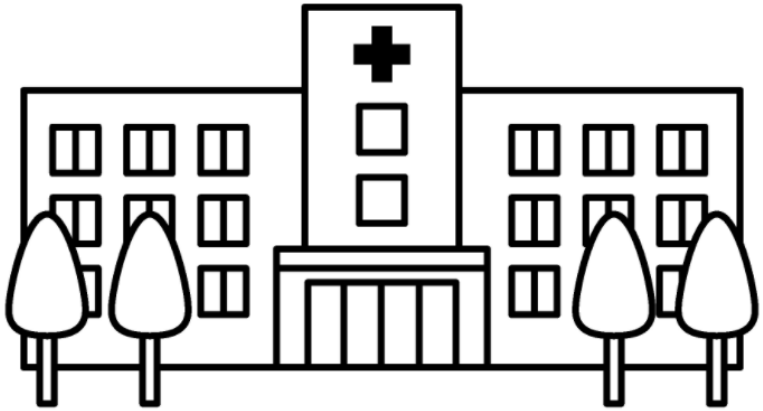
NURSING HOME DECOMPRESSIONS REFERRAL LIST

NURSING HOME/HOSPITAL DECOMPRESSION

As part of our commitment to DHS in supporting hospital decompression to relieve COVID-19 hospital capacity, CC's may receive a request from the PR Team to reach out to members identified as potentially eligible for MHM or Return to Community.



CC's will be provided the member's name, ID, and NH location. Minimally, CC should contact the member and facility social worker to discuss the member's desire and ability to safely return to the community.

NURSING HOME/HOSPITAL DECOMPRESSION

BlueCross BlueShield Minnesota

Next steps may include:

- Return to community assessment & care planning
- MHM Referral *
- EW open
- Complex Disease/Behavioral/Case Management Referral
- Coordination of
  - MA and/or EW services
  - Other EW transitional services

Additionally, due to the shortage of hospital and NH bed availability, Care Coordinators may be asked to assist with coordination of services for members discharging from acute care to home vs. nursing home rehab.

**All MHM referrals must be sent to Partner.Relations@bluecrossmn.com*

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HOUSING STABILIZATION SERVICES

HOUSING STABILIZATION SERVICES

BlueCross BlueShield Minnesota

Effective 1/1/2022, formal Housing Consultation services may be provided to an MSHO/MSC+ member if the member refuses to engage in their Care Coordination benefits, by way of declining their comprehensive health risk assessment (LTCC).

The HSS Provider must document they confirmed with the BP Care Coordinator that the member declined their comprehensive assessment prior to initiating Consultation services. Claims without this documentation may be denied.

Care Coordinators should document completion of this verification process in case notes. If Care Coordinators learn of a Housing Consultation Provider providing services in error, reach out to your Partner Relations Consultant.

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OUT-OF-NETWORK PROCESS

GAPS IN HOME CARE PROVIDER NETWORK

For PCA and other State Plan Home Care agencies, Care Coordinators should reach out to their Partner Relations Consultant if they become aware of any of the following:

- a lack of available providers in their region.
- a lack of available providers providing culturally specific services needed in their region.
- Are aware of an agency who fulfills regional cultural gaps but not currently in our network. Provide name of the agency and contact information if available.

The Partner Relations team will forward this information on to our Contracting department for outreach to the provider.

OUT-OF-NETWORK (OON) PROCESS—*CURRENT* MEMBERS

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CC's should determine if the Home Care Service provider is in the Blue Plus network by verifying with the provider directly or calling Member Services.

When a current member is requesting to use a provider out of the Blue Plus network due to either of the following:

- The out-of-network provider has immediate availability
- The agency is meeting a cultural need that cannot be met by an in-network provider

New process: Prior to starting services, the CC should confirm that provider is enrolled with DHS.

Not enrolled with DHS	• CC must find an in-network provider or at a minimum, another provider who is enrolled with DHS.
Enrolled with DHS	• CC can request authorization by faxing the Care Coordinator Request for Service Authorization Form noting in the comments the provider is OON and enrolled with DHS.

OUT-OF-NETWORK (OON) PROCESS—*NEW* ENROLLEES

BlueCross BlueShield Minnesota

Care Coordinators should determine if the State Plan Home Care Service provider is in the Blue Plus network.
If the agency is not in network, the CC may continue with authorizing the out -of-network (OON) provider as follows:

Confirm whether the OON provider is enrolled with DHS.

CC should fax the Request for Service Authorization Form to AGP. CC must add in comments that this is a new member, and the provider is OON and enrolled with DHS or indicate if they report they are not enrolled with DHS.

If provider is not enrolled with DHS, the CC will be contacted by Blue Plus if there are service authorization date parameters that are set for a provider.

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MNCHOICES

MNCHOICES

Current timeline for MnCHOICES revision project is after first quarter of 2022. Update on progress of the project will be by March 1, 2022.

For more information on updates and upcoming trainings, go to MnCHOICES.

What we do know:

- There will be a 60-day transition period when we launch.
- Webinars for Developing a Support Plan are planned for the last Wednesday of each month in 2022. Information and registration is available on TrainLink page
- Trainings on Support Plan and Rates (MNCH921) are available now on TrainLink
- Bridgeview related tasks will remain the same, until MnCHOICES capabilities are determined. (ie. service agreements, assessments, enrollment, etc)
- MnCHOICES MnCAT trainings in Trainlink are no longer supported in Internet Explorer.

MNCHOICES

Reminders:

- All Care Coordinators must be certified assessors to complete comprehensive and health risk assessments at time of launch.
- MnCHOICES trainings should continue so all Care Coordinators/Certified Assessors are ready at time of launch.
- Delegates should track new staff needing MnCHOICES access that were not included on initial onboarding. Requesting MnSP access does not equate to MnCHOICES access once launched.
- Delegate agencies must track completion of required assessor training and recertification and have available upon request.
- Report changes for Blue Plus users including change in Mentors, MnSP users, name changes, termination of users, etc. to BluePlus.

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REQUEST TO EXCEED CASE MIX BUDGET CAP

REQUEST TO EXCEED CASE MIX BUDGET CAP

BlueCross BlueShield Minnesota

A request to exceed may be considered if a member has a unique set of assessed needs requiring care plan services above their EW budget cap:

- when a member has an acute short-term need for increased services
- EAA home/vehicle modifications costing more than budget allows (must not exceed the $20k EAA annual limit)

A request to exceed should not be discussed with the member at reassessment until CC has discussed with their supervisor or Partner Relations Consultant that a request is appropriate.

Reminder: CC must assure all services are within member's EW Budget CAP prior to entering any service agreements.

REQUEST TO EXCEED CASE MIX BUDGET CAP

- CC should discuss alternate options to remain within the budget prior to submitting a Request to Exceed, including the possibility of other service options or DTR.

Supplemental benefits (MSHO)

- Qmedic PERS
- Dose Health
- $750 Safety Benefit
- OTC Supplemental benefit
- Fitness Supplemental Benefit

All members

- Member currently has adult day care 3x a week but now needs nursing - discuss reducing ADC?
- Member has homemaker, chore, and/or PCA - discuss reducing one of them?

REQUEST TO EXCEED CASE MIX BUDGET

BlueCross BlueShield Minnesota

Reminders:

- If the member has requested to exceed their EW Case Mix Cap and the CC determines there is no assessed need, CC must request a DTR within 24 hours of determination.
  - Do not send a Request to Exceed.
  - Member and provider must also be notified.
- Requests to exceed published Customized Living or 24 Customized Living rate limits (including EW CDCS rate limit) 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.

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SAFE DISPOSAL OF MEDICATION

SAFE DISPOSAL OF MEDICATION

New CMS requirement: Both the Safe Disposal of Medication flyer and Drug Take Back sites must be furnished to all MSHO Community Members seen face-to-face initially and annually and document compliance in case notes.

- Drug Take Back locations are from the Drug Enforcement Administration (DEA).
- CC must provide 2 names from list or other sites available in area.
- Members do not need to use a location on the provided list – they may go to and use any site they prefer.

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DHS PCA MODIFICATIONS

DHS PCA MODIFICATIONS

As of January 1, 2022, Personal Care Assistance (PCA) enhanced payment eligibility reduced from 12 to 10 hours per day for PCA & Consumer Directed Community Supports (CDCS).

PCA workers may qualify for a higher reimbursement rate for work that is both:

- ❑ Provided by a worker who has completed qualifying trainings
- ❑ Provided to a person who is eligible for 10 or more hours of state plan PCA per day and/or has the home care rating 'EN' (EN: vent dependent for 6 hrs. a day min of 30 days)

DHS PCA MODIFICATIONS

Rates:

State Plan PCA: Complex, 1:1 15 Minutes T1019 TG $5.27

Elderly Waiver PCA: Complex, 1:1, Extended 15 Minutes T1019 TG UC $5.27

PCA Choice agencies and CDCS 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.

Individual PCAs are allowed to work 310 hours per month under the COVID authority. This modification was made permanent during Special Session in October 2020.

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NEW CMS REQUIREMENT

NEW CMS REQUIREMENT

- Due to implementation of certain Provisions of the Bipartisan Budget Act of 2018 that pertain to Special Needs Plans (MSHO), we are adding a reminder to the guidelines.
- When Care Coordinators are offering members a Face-to-Face visit and member refuses, CC **must case note** the face-to-face attempt based on this CMS requirement below.

Face-to-Face Annual Encounters (Pg 5875-8)
CMS proposed a requirement of a face-to-face encounter between each enrollee and a member of the enrollee's interdisciplinary team or the plan's case management and coordination staff on at least an annual basis, beginning within the first 12 months of enrollment, as feasible and with the individual's consent. A face-for-face encounter must be either in person or through a visual, real-time, interactive telehealth encounter.

Finalized as proposed, with delay in effective date to contract year 2023.

Regarding feasibility, CMS noted plans should document the basis or reason that a face-to-face encounter is not feasible in order to demonstrate that where there are no face-to-face encounters in the year, that failure is not a violation of the regulation (e.g. if an enrollee doesn't consent to the encounter).

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MSHO SUPPLEMENTAL BENEFIT RESOURCE

NEW MSHO SUPPLEMENTAL BENEFIT RESOURCE

BlueCross BlueShield Minnesota

New resource for Care Coordinators:

- In order of HRA health & wellness domains
- Assists CC with determining referrals to supplemental benefits and other internal programs after completing HRA and while developing care plan
- On the MSHO Supplemental benefits page

2022 Supplemental Benefits – HRA Crosswalk

Blue Plus 2022 Supplemental Benefits and Identified HRA Needs Crosswalk

Health & Wellness Areas	Identified Needs	Referral/Resource Recommendations
Physical Activity	• Interest in exercise or physical fitness • Concerns about balance, falling and or flexibility	• Silver Sneakers Fitness (+ transportation) • Juniper Health & Wellness classes (+ transportation) • Fitness Tracker
Nutrition/Food Support	• Eating and meal preparation • Assistance with access to healthy food	• Transportation to the grocery store • Medically-tailored meals & nutrition education
Emotional/Behavioral Health Support	• Additional emotional or mental health support • Managing mental health diagnosis (i.e. depression, anxiety, etc.) • Struggling with social isolation/social support	• Juniper Health & Wellness classes (+ transportation) • Short-term case management • Music therapy (nursing home only) • Animatronic cat or dog

ATTENDANCE SHEETS

- Please return your signed attendance sheets via email. Electronic signatures are acceptable.

- For staff not in attendance today, they are required to review the slides and complete & return an attendance sheet within 7 bs days. Date of review must be included.

Thank you for your time today and for all you do for our members!

QUESTIONS?

When will we see you next?

- MSSA ~ March 16th – 18th
- On-site Care Coordination Audits

Appendix

APPENDIX

DEPARTMENT OF HUMAN SERVICES

Bulletin

NUMBER

#20-56-06

DATE

June 19, 2020

OF INTEREST TO

County directors

Social services supervisors and staff

Managed care organizations

Tribal agencies

Service providers

ACTION/DUE DATE

Immediately

EXPIRATION DATE

June 19, 2022

COVID-19: Participation in LTSS Programs Cannot be Terminated

TOPIC

DHS will ensure that people who receive long-term services and supports (LTSS) continue to have coverage and remain eligible for state public programs throughout the national public health COVID-19 emergency period. Minnesota will allow for continued coverage under recently issued CMS guidelines.

PURPOSE

To inform lead agencies of the federal guidance and provide operational information to continue program and service eligibility for people

CONTACT

DHS.AASD.HCBS@state.mn.us for aging-related programs/services
DSD.ResponseCenter@state.mn.us for disability-related programs/services

SIGNED

DAN POLLOCK
Assistant Commissioner
Continuing Care for Older Adults Administration

GERTRUDE MATEMBA-MUTASA
Assistant Commissioner
Community Supports Administration

MATT ANDERSON
Assistant Commissioner and State Medicaid Director
Health Care Administration

TERMINOLOGY NOTICE

The terminology used to describe people we serve has changed over time. The Minnesota Department of Human Services (DHS) supports the use of "People First" language.

COVID COMMUNIQUES

BlueCross BlueShield Minnesota

See Communiques for updates on COVID-19 here:

- 8-2-2021 Communique- Information on COVID-19 Waiver Modification Wind Down (DOCX)
- 7-8-2021 Communique Regarding Face To Face Visits (DOCX)
- 6-3-2021 Communique Covid Updates Adult Day Services and Face-to-face visit guidance (DOCX)
- 03-12-2021 Communique Member Outreach COVID-19 Project (DOCX)
- 2.05.2021 Communique Covid-19 Outreach (DOCX)
- 9-18-20 Communique COVID-19 Updates (DOCX)
- 8-10-20 Communique DHS updates Extension to COVID-19 and continuation of LTSS eligibility (DOCX)
- 5-20-2020 Communique CDCS Updates and COVID-19 Peacetime Emergency Modifications (DOCX)
- 5-6-2020 Temporary waiver service changes COVID-19 (DOCX)
- 4-30-20 Edits to 4-10-2020 COVID-19 Updates (DOCX)
- 4.24.2020 Juniper Virtual Program_Communique (DOC)
- 3-27-2020 MSHO Supplemental Benefits – Messages from our vendors during COVID-19 (DOCX)
- 3-27-2020 Communique Re MMIS Screening Documents and Reassessment Dates (DOCX)
- 3-24-2020 Blue Plus and DHS COVID-19 Emergency Protocol Updates (PDF)
- 3-16-2020 Member Information COVID-19 (DOCX)
- 3-16-2020 Delegate Information COVID-19 (DOCX)
- 3-12-2020 Communique Re MN Nursing Home and Assisted Living Facility Visitor Restrictions (DOCX

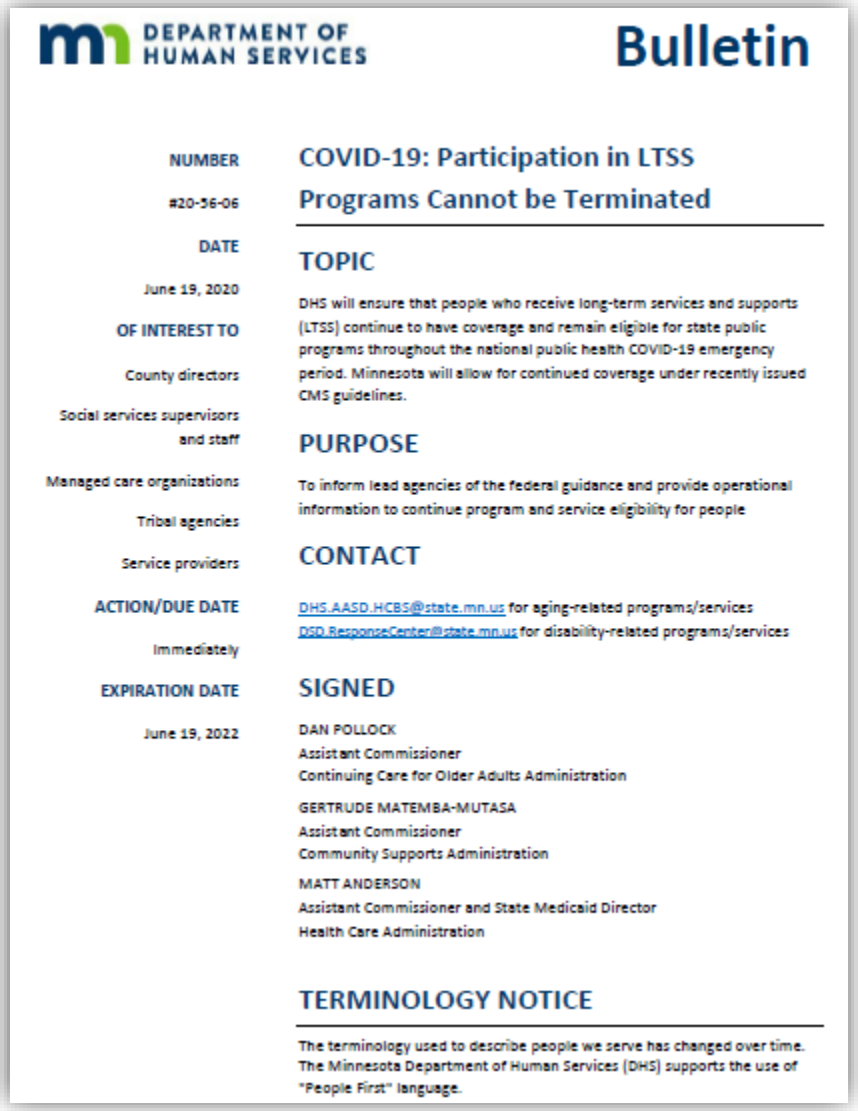
APPENDIX- ACCESS TO DHS BULLETIN

https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=BULLETINS_2020

DISABILITY SERVICES DIVISION (56)

20-56-01	**Employment services and the right to make informed choices during the peacetime emergency** Availability and use of home and community-based services (HCBS) waiver employment services during COVID-19 peacetime emergency and emphasis that people with disabilities have the right to make informed choices about returning to work. 6/9/20
20-56-02	**Amended: Temporary expansion of remote support for home and community-based services (HCBS) waivers** Policy modification to allow several HCBS waiver services to be delivered remotely (via phone or other interactive technology medium) temporarily during the COVID-19 pandemic. 6/11/20
20-56-03	**Early Intensive Developmental and Behavioral Intervention (EIDBI) changes for telemedicine, coordinated care conferences and individual treatment plans** Temporary policy modifications to EIDBI services to ease limitations on using more accessible communications technology. 5/5/20
20-56-04	**Non-electronic public notice requirement waived for the CADI Waiver renewal** Change to the method DHS will use to provide public notice for the Community Access for Disability Inclusion (CADI) Waiver renewal 5/18/20
20-56-05	**Flexibility for PCA qualified professionals to provide remote oversight and to increase the number of hours a PCA agency can bill for an individual worker** Provide instructions to implement temporary policy modifications to PCA services that will ensure people have their health and safety needs met for the duration of the COVID-19 peacetime emergency. 6/17/20
20-56-06	**COVID-19: Participation in LTSS Programs Cannot be Terminated** DHS will ensure that people who receive long-term services and supports (LTSS) continue to have coverage and remain eligible for state public programs throughout the national public health COVID-19 emergency period. Minnesota will allow for continued coverage under recently issued CMS guidelines. 6/19/20

APPENDIX- DHS BULLETIN #20-56-06



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MMIS SCREENING DOCS - APPENDIX

BlueCross BlueShield Minnesota

Allowable termination codes: Long Term Care (LTC) Screening Document, DHS-3427

Use the following allowable assessment result and exit-reason codes, when applicable:

- Assessment Result 23-“Person exited, chose to leave program” combined with any code 02-06, 29 or 98
- Assessment Result 24-“Person exited for other reason(s)” combined with 30-“Person died”
- Assessment Result 24-“Person exited for other reason(s)” combined with 98-“Other” (*only when person has moved out of state*)
- Assessment Result 33-“Person exit because of AC estate claim recovery” combined with any other code (this is an AC participant’s choice)
- Assessment Result 34-“Person exited because of AC fee changes” combined with any other code (this is an AC participant’s choice).

MMIS SCREENING DOCS - APPENDIX

EW exits due to facility-based services/reasons, follow these instructions:

At reassessment for Activity Type 06

Using Activity Type 06 – Reassessment, a person may choose facility-based services at reassessment. To document that choice:

1. Use Assessment Result 23 (choice) and Exit Reason 04, 05, 06, 07, 08 or 09.
2. The Effective Date of the exit must be at least 10, and not more than 60 days, from the Activity Type Date, to support advance notice.
3. Complete a DTR

Outside of reassessment; Using Activity Type 07

Activity Type 07, Administrative Activity, is also used to exit a person when the length of stay in an institution is 30 days or more. To document:

1. Use Assessment Result 22 (not 24) – the person no longer meets LTSS program criteria (of living in the community) and Exit Reason 04, 05, 06, 07, 08 or 09.
2. The Effective Date will be the date of admission and will always be prior to the Activity Type Date.
3. Complete a DTR