Community
Care Coordination Guidelines

Secure Blue - MSHO
(Minnesota Senior Health Options)

Blue Advantage - MSC+
(Minnesota Senior Care Plus)

Updated April 6, 2023

Table of Contents

Contact Information

Department	Questions
Behavioral Health Crisis Line: 1-844-410-0745	• For members in crisis who need support from a clinician specializing in mental health
BlueRide Transportation **For members:** 651-662-8648 or 1-866-340-8648 **For Care Coordinators:** Access through Bridgeview Care Coordination website or https://blueride.bluecrossmn.com https://carecoordination.bluecrossmn.com/blueride/	• Contact to arrange medical transportation • Care Coordinator portal for scheduling medical or dental rides • BlueRide page on the Care Coordination website for info and forms
Bridgeview Company 1-800-584-9488 Bridgeview.Service.Agreements@bluecrossmn.com	• Elderly Waiver service agreement questions • EW Claims Processing • https://bridgeview.bluecrossmn.com/ • EW Provider questions can be directed to EWProviders@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
Delta Dental **Give this number to Members:** 651-406-5907 or 1-800-774-9049 **For Care Coordinators only:** 1-866-303-8138	• Assistance with finding dental providers • Assistance scheduling dental appointments.
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 *Identify yourself as a Blue Cross Care Coordinator and that you are on the Care Coordinator List (SDL)*

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, LSW 651-662-9647 Melinda Heaser, LSW, CCM 651-662-9533 Cate Ness 651-662-9214 Kim Pirkl, LSW, CCM 651-662-3074 Wendy Schultz, RN, BSN, PHN, CCM 651-662-4539 Jill Scott, RN, PHN, CCM 651-662-5099 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 Donna.boreen@bluecrossmn.com MSC+: Palwasha Hassas, Pharmacist Business Segment Director, Medicaid palwasha.hassas@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

Department	Questions
Provider Services 1-866-518-8448	• Provider assistance (not including EW) • Contract/provider access questions
SecureBlue MSHO Enrollment secureblue.referrals@bluecrossmn.com	• 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 Jenna Rangel, Senior Product Consultant Jenna.Rangel@bluecrossmn.com	• Contact Jenna Rangel 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.

For Blue Plus, the initial preference for an individual Care Coordinator is that they are licensed as a:

- social worker
- public health nurse
- registered nurse
- physician assistant
- nurse practitioner

Subsequently, Delegate agencies may hire an individual who meets social work standards through the state Merit System.

These individuals can be merit eligible through either the hiring County or who contracts with an MCO as a Care Coordinator and meets the DHS requirements for the provision of case management. The DHS requirements are the following: graduation from an accredited four-year college with a major in social work, psychology, sociology, **or** a closely related field **or** from an accredited four-year college with a major in any field and one year of experience as a social worker/case manager/care coordinator in a public or private social service agency and can perform and have the skills for the job."

When possible, the Care Coordinator should remain the same across all living arrangements for continuity. Delegates of Blue Plus should employ Care Coordinators who speak the languages of the members their team supports.

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 must 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.

Certified MnCHOICE Assessor: Person who completes training and obtains certification from DHS and performs Long Term Care Consultation assessments. For MSHO and MSC+, all Care Coordinators except physician assistants, nurse practitioners, and physicians acting as Care

Coordinators for members in nursing homes must be Certified Assessors providing both the assessment and ongoing case management functions for Enrollees, including support planning.

Communications: quick notifications sent via email to share information such as training opportunities, Bridgeview web issues, service area specific pilots and/or initiatives. Communications are not posted on the Care Coordination website.

Communiques: formal notification sent via email to share information on any changes and updates on DHS, CMS, and/or Blue Plus policies and programs, guidelines, process changes, benefits, contract requirements, and Model of Care updates, etc. These notifications are official and posted on our Care Coordination website for up to two years.

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 preventives, 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**.

Care Coordinator & Other Staff Onboarding

In addition to each Delegate agency's responsibility to train staff working on behalf of Blue Plus members, the Partner Relations Team has created the following checklists:

- Blue-Plus-New Care Coordinator-Lead-Supervisor-Orientation-Checklist
- Blue-Plus-Support Staff -Orientation-Checklist

These includes both Mandatory and Optional tasks to be completed by the staff, as applicable.

When hiring a new Blue Plus Care Coordinator/Lead/Supervisor/or Support staff, the agency supervisor must:

1. Email the *Bridgeview User Access Request Form* to notify Blue Plus of the new staff and request access to Bridgeview and MnSP RS Tool (if applicable).
2. After sending the *Bridgeview User Access Request Form*, new Care Coordinators will be sent a "Welcome to Blue Plus" email from their Partner Relations Consultant. This email includes the checklist and links to the website, guidelines, and other resources.
3. New Staff are required to complete the "Mandatory" tasks on the checklist within 90 days of hire. Once complete, the new staff must electronically sign the attestation on the checklist and email it to Partner.Relations@bluecrossmn.com.

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 must 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 service plans and support 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.

1. **New CAP report:** 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.

2. **Full Detail report:** 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:** Brand new enrollees who enrolled after DHS capitation
    - **REINSTATED:** Members who were going to term but were reinstated with no lapse in coverage
    - **TERMED:** Coverage termed for reasons listed on the report.
    - **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 must follow up to determine if the reason for disenrollment requires mediation (i.e., MA paperwork not submitted yet). See *Medical Assistance (MA) Renewals* section for more information.
    - **GRACE PERIOD ENDING:** Lists Month/Date/Year which will be 90/60/30 days out from the month of the enrollment report. 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.

3. **Daily Add report(s):** 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:

1. Review applicable Enrollment report.

    - Review "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 Documenting Notification of Enrollment & Reporting Enrollment Discrepancies section below.*

    - Compare "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 Documenting Notification of Enrollment & 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 Daily Add report(s) for discrepancies and reports them to Secureblue.Enrollment@bluecrossmn.com no later than 15 days from notification. *See Documenting Notification of Enrollment & 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 must be followed for timely assessment within 30 or 60 days of notification, as applicable.

2. Assign a Care Coordinator per Delegate's policy.
3. Inform the member of the name, number, and availability of the Care Coordinator within **10 days** of notification of enrollment.
4. During initial phone contact, CC must confirm the member's PCC.

    a. If the PCC indicated does not match what is listed in Bridgeview, see *Primary Care Clinic (PCC) Change* section for next steps.

    b. If the PCC indicated is also a contracted Care Coordination Delegate (Essentia Health, Bluestone Physicians, or Genevive), the CC must inform the member they will be contacted by another Care Coordinator from XYZ Delegate. See *Primary Care Clinic (PCC) Change* section for next steps.

5. Enter the name of the Care Coordinator assigned in Bridgeview.
6. Document any delays of enrollment notification in case notes.
7. For new enrollees (transferred from another health plan or fee-for-service) the CC must assess for any urgent needs that require immediate follow up. *See Prioritization of Initial Outreach to New Enrollees*
8. 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 must 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, or Genevive	• 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

Primary Care Clinic (PCC) Change

When an MHCP applicant completes their MHCP application, if they do not designate a PCC, the PCC is auto-assigned to them based on several factors including historical claims data (if applicable) or zip code.

Care Coordinators must confirm the member's PCC is accurate in Bridgeview. This is especially important if the PCC change also results in a change in Care Coordination delegation.

1. To change a member's PCC:
    a. 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.
    b. If the member's PCC is not listed in Bridgeview, it may not be in our Primary Care Network. Please contact Member Services or your Partner Relations Consultant with any PCC network questions.
2. Determine if change in PCC requires a change in Care Coordination:
    a. 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.
        i. Send notification to SecureBlue.Enrollment@bluecrossmn.com for enrollment miss-assignments.
        ii. If PCC change is for an existing member resulting in a transfer to another Delegate, see *Transfers in Care Coordination to another Delegate* which includes sending in form 6.08 Transfer in Care Coordination Delegation.

iii. Changing the PCC in Bridgeview alone will not transfer care coordination.

b. 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.

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, Hennepin County members not assigned to Genevive)
- Essentia Health
- Genevive:
  - MSHO and MSC+ only in select nursing facilities
  - Genevive (MSHO and MSC+ members in Hennepin County with Allina PCC)

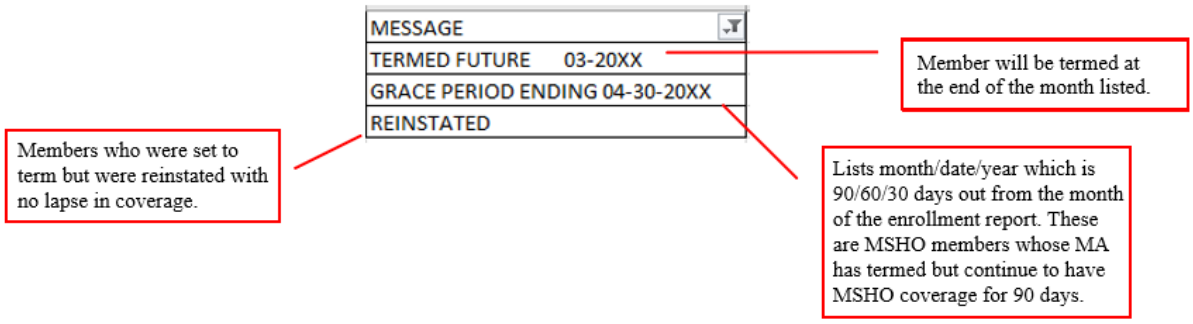
Medical Assistance (MA) Renewals

Minnesota Health Care Program (MHCP) enrollees must verify that they continue to meet the program's eligibility requirements at the end of each year to continue their coverage into the following year. MHCP enrollees are sent a notice by DHS and must complete the renewal paperwork within 45 days from the date printed on the notice.

Care Coordinators should assist Blue Plus enrollees with completing their renewal to avoid any lapse in coverage. To learn more about the MA renewal process, visit our training page on our Care Coordination website and view the 9-minute video and FAQ published by DHS.

Care Coordinators must follow these steps when assisting members with their MA renewals:

1. Review your monthly FULL DETAIL enrollment report. If your agency's report has a member listed with a TERM FUTURE or GRACE PERIOD ENDING flag, it is possible their disenrollment is due to not completing their MA renewal. CC must follow up to determine if the reason for disenrollment requires mediation (i.e., MA paperwork not submitted yet).



2. Proactively contact the member and/or their authorized representative to assist with answering any questions and assure they send in necessary renewal paperwork.
3. Educate the member about the importance of completing their MA renewal (to avoid lapse in coverage and continue services, if applicable).
4. Contact the member's financial worker (see list of county contacts under Key Contacts on the Care Coordination page) to determine if termination is due to MA renewal needed.
5. Send DHS 5181 to member's financial worker with a note in section D requesting to be added to "social work panel". This will allow the assigned CC to receive annual MA renewal notices.

Care Coordinators may reference this resource when assisting members with their renewal: Renewal Tips for Care Coordinators

Contact Requirements

Member Contact

Assessments required for:

- Initial
- Annual
- 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

Care Coordinators must document that for all assessments a face-to-face visit was offered.

Contact/year	MSHO CW	MSHO EW	MSC+ CW	MSC+ EW
Mailing of Intro Letter	CC must mail product specific Intro Letter within 30 days of enrollment.			
Initial Assessment (including 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 contact	Phone contact	Face-to-Face	Phone contact	Face-to-Face
New/Change in Care Coordinator	CC contact info given w/in 10 days of the change			
Member Request or As Needed	• Contact for significant change in member's health status or as requested • Member request for HRA (LTCC) must be completed within 20 calendar days of the request			

Primary Care Provider Contact Requirements

New Member: Send Intro to Primary Care Provider letter within 90 days of notification of enrollment

- Send Intro to Primary Care Provider letter **OR**
- Send Care Plan Summary Letter - Intro to Primary Care Provider, which combines the Intro and Summary letter. This letter can be used in lieu of Intro to Primary Care Provider if the face-to-face visit and this letter is mailed within 90 days of notification of enrollment. **OR**
- Send the UTR/Refusal Support Plan Summary-Intro to Primary Care Provider Letter for members who have been UTR or Refused an initial or reassessment.
- For clinic delegates, notification to primary care provider documented per clinic process.
- For members who are Unable to Reach (UTR) and the PCC is unknown:
    - CC should attempt to confirm correct PCC is listed in Bridgeview by reviewing the DHS New Enrollee Report or M360. If PCC can be identified in one of these

areas, CC should send the UTR/Refusal Support Plan Summary-Intro to Primary Care Provider Letter.

- If clinic cannot be determined and letter cannot be sent, CC must case note.
- For members who are Refusals and declined to validate or confirm they have no PCC, Care Coordinator must case note and is not required to send an UTR/Refusal Support Plan Summary-Intro to Primary Care Provider Letter.

Re-assessment and Significant Changes:

- For reassessments only, send the UTR/Refusal Support Plan Summary-Intro to Primary Care Provider Letter for members who have been Unable to Reach or Refusal.
- Send Care Plan Summary Letter - Intro to Primary Care Provider or a copy of the care plan.
- 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 provider documented per clinic process.

Prioritizing Initial Outreach to New Enrollees

Many new members come to Blue Plus with urgent needs which require prioritization and quick action with care planning and initial contact. The following are additional ways to identify high-risk members who need immediate follow-up:

1. The Care Coordinator must review the *"New Enrollee Utilization Report"*. Blue Plus will send this report to each Delegate within two business days from date of receipt from DHS. This report includes information about MN Health Care Program (MHCP) recipients who are new to Blue Plus (i.e., new from FFS MA, SNBC, Families and Children, or another health plan).

   Care Coordinator is required to reach out to members with any needs in these areas within one business week so that potential urgent needs are addressed. If initial contact has already taken place the Care Coordinator must review to determine if additional outreach is required.

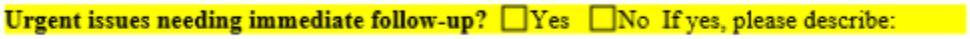
   - DME Claims—claims for Durable Medical Equipment during the previous 12 months.
     - This should be reviewed for continuity of current services/needs.
   - Pharmacy Prior Auths—prescriptions for certain drugs that were prior authorized in the previous 4 months.

    - Review expiration dates of PA if applicable and assist with obtaining new PA if needed.
- MH Non-TCM (Mental Health Non-Targeted Case Management)—information on non-targeted 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.
- Care Coordinators should pay close attention to #27 Eligibility Review Date information. This will allow CC to assist members with Medical Assistance paperwork as needed. Follow guidance in *Medical Assistance (MA) Renewals* section.

In addition, the report also includes the following, if applicable, to the new member (refer to instructions included with the report):

Mental Health Targeted Case Management (MH-TCM)	Special Transportation	ADL and Behaviors
Restricted Recipient	Dental	PCA
HCBS Waiver Recipients	Durable Medical Equipment (DME) claims	Nursing Facility stays
Diagnoses	Pharmacy claims	Other waiver home care services
Prior authorizations	Home Care	Eligibility review date

2. Additional question added to the 6.28 Transitional HRA (see *6.28 Transitional HRA section for details*), to prompt discussion of any urgent upcoming needs.



3. When the CC receives *DHS 6037 HCBS Waiver, AC and ECS Case Management Transfer and Communication Form* from the previous health plan or county, the CC must review it for information which may require urgent/immediate discussion with the member including:
    a. Does the member have another case manager?
    b. What is their primary diagnosis? (ie: Dementia, Cancer, ESRD)
    c. Has the member recently been hospitalized?
    d. Has it been awhile since they've had contact with a CM or CC?

e. Is there anything listed under "CURRENT ISSUES/CONSIDERATIONS" needing immediate attention (Ie. upcoming appts, surgeries, DME /equipment needs, essential services listed)?

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

1. The Delegate is responsible to verify member's eligibility prior to delivering Care Coordination services
2. Use the following optional checklists: MSHO CW EW Checklist or MSC+ CW EW Checklist.
3. Delegate will inform the member of the name, number, and availability of the Care Coordinator within 10 calendar days of notification of enrollment
4. Welcome call/8.22 Intro Letter to member within 30 calendar days after notification of enrollment
5. Explanation of Care Coordinator's role. Optional resource: 6.01 Welcome Call Talking Points.
6. Review and confirm with the member correct demographic information as displayed in Bridgeview. If any are incorrect, the CC must update in Bridgeview, if allowed, and send DHS 5181 to the financial worker. Refer to Bridgeview Care Coordination User Guide).

   Review the following:

   a. Residential and mailing address – discrepancies impact mailings from Blue Plus and DHS (ie. Medicaid Renewals)

      i. Residential: where member currently resides

      ii. Mailing: may be different than residential if member has mail go to an authorized rep or guardian

b. Living arrangement (community or nursing home)

c. Rate cell – example: if a member resides in 24 hour CL but displays as Rate Cell A instead of a Rate Cell B, this is a red flag to check your MMIS Screening Document entry.

d. Waiver begin date/end date

e. Primary Care Clinic.

i. See *Primary Care Clinic (PCC) Change* if the PCC listed is incorrect.

7. Complete and send DHS 5181 to member's financial worker with request in *Section D – Comments* to be added to the "Social Worker Panel".

8. Review current services authorized by the Care Coordinator to determine if change in service provider is required. See *Blue Plus Network* section.

9. 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/support plan if available.
- Required for MSHO members - Safe Disposal of Medications: When seen face-to-face at both initial and annual visits, provide community members with Safe Disposal of Medications flyer. Also provide the member with, at least two sites from either:

  i. the Drug Take Back list (Blue Plus uses the DEA source of sites to meet CMS requirement)

  ii. or any other 2 local options

  Members may use any site they prefer. Case note the date of discussion and information provided.

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/support plan if available.
- Information about enrollment, including resources, can be found in the MSHO enrollment link on the care coordination website.
- Optional for MSC+ members - Safe Disposal of Medications. When seen face-to-face at both initial and annual visits, provide community members with Safe Disposal of Medications flyer. Also provide the member with, at least two sites from either:

- the Drug Take Back list (Blue Plus uses the DEA source of sites to meet CMS requirement)
- or any other 2 local options

Members may use any site they prefer. Case note the date of discussion and information provided.

10. 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, Hennepin County members not assigned to Genevive)
- Essentia Health
- Genevive:
  - MSHO and MSC+ only in select nursing facilities
  - Genevive (MSHO and MSC+ members in Hennepin County with Allina PCC)

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 Contact Requirements

All members, regardless of living arrangement/rate cell, are required to have a mid-year contact. As part of the mid-year contact, if the Care Coordinator has not already notified the financial

worker, the Care Coordinator should complete and send the DHS 5181 to member's financial worker with request in *Section D - Comments* to be added to the "Social Worker Panel". This will ensure the Care Coordinator receives important notices from the county, such as MA renewals, etc.

Community-well members:

Care Coordinators are required to reach out to CW members by phone, at minimum, at mid-year to review and document the member's progress towards their care plan goals. See *Mid-year and reassessment care plan review* section for details.

Unable to Reach:

If member has an existing HRA/care plan:

For members with a current LTCC/3428H assessment and care plan and the CC is not able to reach the member at mid-year, CC must document their attempt(s) in the member's case notes and in the monitoring section of each goal on the member's care plan.

- CC must also send the General Unable to Reach Letter.

If member was previously an 'Unable to Reach (UTR)' at initial or reassessment:

If contact is made with member at mid-year, CC must offer to complete:

1. A face-to-face DHS 3428 LTCC and care plan.
2. If declined, the CC must then offer to complete a face-to-face DHS 3428H and care plan.
3. If declined, the CC must offer, as a final option, telephonic completion of DHS 3428H and care plan.
4. If member refuses assessment offerings, see *Refusals* section.
    - The CC should document this in Bridgeview and MMIS as a refusal, this will reset the 365-day span.

If no contact is made with member at mid-year, CC must:

1. Make a total of **four** attempts to contact the member via phone, secure e-mail, or letter to offer an HRA.
2. The fourth and final attempt must be mailing UTR Member Support Plan Letter. See *Unable to Reach* section for more details.

Refusals

If member was previously a refusal:

If the CW member previously refused the CC's HRA offerings, CC must offer to complete:

1. A face-to-face DHS 3428 LTCC and care plan.

2. If declined, the CC must then offer to complete a face-to-face DHS 3428H and care plan.
3. If declined, the CC must offer, as a final option, telephonic completion of DHS 3428H and care plan.

Care Coordinators must clearly document in their case notes offering all HRA options listed above. The case note must state the member refused the face-to-face and telephonic HRA offerings. For example, "Offered both face-to-face HRA options and member refused. Offered telephonic HRA option, member still refused."

No MMIS or Bridgeview entry is required.

Elderly-waiver members:

Care Coordinators are required to meet with EW members face-to-face for their mid-year contact to review and document the member's progress towards their care plan goals and review of services. See *Mid-year and reassessment care plan review* section for requirements.

- If the CC is not able to reach the EW member at the mid-year contact, CC must document their attempt(s) in the member's case notes and in the monitoring section of each goal on the member's care plan.
    - CC must also send General Unable to Reach 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 must 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 must be assessed following these community guidelines.

Care Coordinators are not required to offer completion of DHS 3428 LTCC for members open to a non-EW waiver. Care Coordinators must offer completion of a face-to-face DHS 3428H. If the

member or guardian refuses a face-to-face visit, CC's must offer to complete 3428H telephonically. If both HRA options are refused, follow the steps outlined in the *Refusals* section.

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 must 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 CM
2. Required contacts with member and Primary Care Provider
3. Completion of DHS 3428H and 3428H Care Plan every 365 days
4. For members who are asking to change to EW, the Care Coordinator must complete a DHS 3428 LTCC if one hasn't been completed.
5. Enter assessment into Bridgeview. CC does not need to enter the date of the other waiver CM's assessment.
6. Mid-year member contact and monitoring of goals completed on 3428H Care Plan
7. Transition of Care activities
8. Blue Plus Care Coordinator is responsible for authorizing state plan home care services, including PCA. The CC must review and approve the assessment(s) provided by the other waiver case manager and follow the processes outlined in the *Home Health Care Authorization* and *PCA Services for members open to non-EW waiver* sections.
9. Share MSHO supplemental benefits (as applicable)
10. Discuss MSHO enrollment with MSC+ enrollees (as applicable)
11. Sign and date the member's care plan.
12. Obtain member/responsible party signature on care plan.
13. Provide a copy of 3428H Care Plan to the member and other waiver Case Manager
14. Provide a copy of 3428H Care Plan or a care plan summary letter to the Primary Care Provider.
15. Enter Screening Document(s) following the directions as outlined in DHS Instructions for Completing and Entering the LTC Screening Document in MMIS for the MSHO and MSC+ Programs (DHS-4669).
    a. Refer to section: *Entry of LTC Screening Document information into MMIS*.
16. Complete a new DHS 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, /or PCA authorizations, and MSHO Supplemental Benefits and enter into Bridgeview.

Health Risk Assessment Options & Requirements

See *Contact Requirements* above for HRA timelines and required member and Primary Care Provider 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 (within previous 365 days)
- To determine Elderly Waiver eligibility for anyone requesting Elderly Waiver.
- Significant changes (members who had a change in their health status and require a change in their EW case mix)

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 LTC 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 required contact, CC must send General Unable to Reach 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 contact, refer to *Mid-Year 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:

1. 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.
2. Obtain and review most recent LTCC or MnCHOICES Assessment / DHS 3428H.

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

3. Obtain and review current care plan:
   - Collaborative Care Plan or
   - Coordinated Services and Supports Plan (CSSP) or
   - 3428H Care Plan

4. Assessments/care plans can be reviewed either in person or telephonically to ensure the information has not changed and the care plan is addressing the member's needs. Care Coordinators must document if a face-to-face visit was offered. 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 or DHS 3428H and care plan.
5. Complete form 6.28 Transitional HRA including goal section. Create new goals; review and pull over from the previous care plan; or can leave them on the current care plan and document on the Transitional HRA form to "see goals on care plan".
6. When completing a Transitional HRA for either a new enrollee or when an existing member has a product change, the Transitional HRA must be entered by the 10th of the following month into Bridgeview Company's web tool. (refer to *Bridgeview Care Coordination User Guide*)
7. Enter an LTC Screening Document in MMIS (*See Entry of LTC screening document information into MMIS section*)
8. For new enrollees the reviewed LTCC/MnCHOICES or DHS 3428H assessment done prior to enrollment must be entered in Bridgeview as a Fee for Service entry. (refer to *Bridgeview Care Coordination User Guide*)
9. Re-assessment is due within 365 days of the last full HRA, Fee for Service LTCC/MnCHOICES assessment or the DHS 3428H **not** the date of the Transitional HRA.
10. Goal monitoring including mid-year and end of year outcome documentation must be documented on either the current care plan or if goals were transferred over to the Transitional HRA form, then goal progress and outcomes must be documented there.

11. If member is unable to be reached at mid-year required contact, CC must send General Unable to Reach 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 contact, refer to *Mid-Year Contact Requirements* section above.
12. For members who refuse completion of a 6.28 Transitional HRA, refer to the *Refusals* section.

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 based on the guidance below. Care Coordinators must document that a face-to-face visit was offered.

Face-to-Face DHS 3428H

This option is used for members who agree to a face-to-face assessment and the Care Coordinator determines 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 which must be completed face-to-face.

Care Coordinator is required to:

1. Complete DHS 3428H with the member or the guardian following the contact timeline requirements.
2. Review MSHO Supplemental Benefits using 6.26 Explanation of Supplemental Benefits resource for MSHO members or discuss MSHO enrollment for MSC+ members. Document this discussion on the checklist(s) or in your case notes.
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. Enter an LTC Screening Document in MMIS (*See Entry of LTC screening document information into MMIS section*).

7. If member is unable to be reached at mid-year required contact, CC must send General Unable to Reach 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 contact, refer to *Mid-Year Contact Requirements* section above.

Telephonic 3428H

For members who refuse completion of a DHS3428H or HRA-MCO in MnCHOICES when offered and are not receiving EW, state plan home care services, 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 or HRA-MCO over the phone with the member or the guardian following the contact requirements.
3. Review MSHO Supplemental Benefits using 6.26 Explanation of Supplemental Benefits resource for MSHO members or discuss MSHO enrollment for MSC+ members. Document this discussion on the checklist(s) or in your case notes.
4. Complete 3428H Care Plan or Support Plan-HRA.
5. 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.
6. 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.
7. Enter an LTC Screening Document in MMIS (*See Entry of LTC screening document information into MMIS section*).
8. If a member is unable to be reached at mid-year required contact, CC must send General Unable to Reach 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 contact, refer to *Mid-Year Contact Requirements* section above.

Refusals

Refusals can only be made by the member or responsible party. Refusals are when a member is refusing to complete the following assessments in order of offering:

1. A face-to-face DHS 3428 LTCC and care plan.
2. If declined, the CC must then offer to complete a face-to-face DHS 3428H and care plan.
3. If declined, the CC must offer, as a final option, telephonic completion of DHS 3428H and care plan.

Care Coordinators must clearly document in their case notes offering all HRA options listed above. The case note must state the member refused the face-to-face and telephonic HRA offerings. For example, "Offered both face-to-face HRA options and member refused. Offered telephonic HRA option, member still refused."

Offering all assessment options outlined above is required for initials, reassessments, and must also be offered at each mid-year contact.

Care Coordination is still required even if the member refuses completion of an assessment.

Members cannot refuse an assessment and continue to receive services when:

- Member is receiving Elderly Waiver Services. They cannot refuse DHS LTCC 3428 or and care plan.
- Members who have PCA services cannot refuse DHS LTCC 3428, 3428D Supplemental PCA assessment or and care plan.
- The 3428H can be used to authorize MA state plan home care services (not including PCA) only if completed face-to-face.

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 must enter a refusal in Bridgeview and MMIS and send the Refusal Member Support Plan letter. 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 must follow the DTR process.

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

1. Mail the Refusal Member Support Plan Letter to the member.
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, either by mail or phone to offer a face-to-face HRA.
5. See *Primary Care Provider Contact Requirements* for provider notification requirements.
6. If a member is Unable to Reach at annual, then connects with Care Coordinator sometime after and refuses the assessment, the Care Coordinator should enter the refusal in MMIS and Bridgeview. This will reset the 365-day date span.

Member request for no contact:

In the infrequent event that a member has communicated to the Care Coordinator verbally or in writing that they want **no verbal contact** from the Care Coordinator they may document this request and send the Refusal Member Support Plan letter to the member which includes Care Coordinator contact information.

If the member requests that they want **no verbal AND mail contact** from the Care Coordinator and the CC has assured the member has the CC contact information, they may document this request and **are not** required to send the Refusal Member Support Plan letter to the member. The CC should inform the member they will not be contacted unless outreach is requested from the member or responsible party.

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 contact, the Care Coordinator is required to:

1. 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 UTR Member Support Plan 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.
2. Document your outreach efforts in the member case notes.
3. Document the dates for each of these attempts in Bridgeview following the process outlined in the *Bridgeview Care Coordination User Guide*. No BV entry required for mid-year contacts.
    a. The assessment date in BV must be the date of the 4th attempt which is the date of mailing the UTR Member Support Plan letter.
    b. Enter the assessment type and date into the Bridgeview Company's web tool by the 10th of the following month.
4. 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.
5. See *Primary Care Provider Contact Requirements* for provider notification requirements.

6. If a member is Unable to Reach at annual, then connects with Care Coordinator sometime after and refuses the face-to-face and telephonic assessments, the Care Coordinator should enter the refusal in MMIS and into Bridgeview. This will reset the 365-day date span.

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 must follow the DTR process.

If the CC is Unable to Reach the member for mid-year contact, refer to *Mid-Year 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 service 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 service 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. If the need for increased services continues beyond 3 months, a reassessment is needed.

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).
- When the temporary need for increased services is reduced, a DTR is required.
- 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.

Significant Change Assessments

A significant change assessment must be completed when a member is experiencing a health change expected to be long-term and member may need a higher EW case mix for increased service needs. Care Coordinators must complete a new LTCC. Refer to the *Long Term Care Consultation (LTCC) DHS 3428* section.

In addition to following all tasks associated with completing a new LTCC assessment, Care Coordinators must:

- Create new care plan following the *Care Planning Requirements* and section including Service *Provider and Member Signature Requirements*.
- 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 LTC screening document information into MMIS section*)
- In Bridgeview, end:

        - Current LTCC Case Mix span
        - Current service agreements
    - In Bridgeview, add:
        - New LTCC/Case Mix span (must align with DHS EW span)
        - New service agreements
- Create new RS tool (if applicable) for those residing in a residential setting
    - Re-assessment is due within 365 days of the date of this LTCC

Assessment due while member inpatient

Care Coordinator must attempt to reach the member/responsible party. If the member and/or responsible party refuses the assessment while inpatient, document a refusal. Inform the member/responsible party of Care Coordinator's role in assisting with the transition to include completing an assessment and discharge planning for necessary services post-discharge.

SecureBlue In-Home and Virtual Wellness Assessments (MSHO only)

Blue Plus identifies MSHO community members to receive targeted outreach via mail and phone by our In-Home and Virtual Wellness vendor, Signify. Outreach will be ongoing throughout the year. Members are identified for targeted outreach if they:

- have an open risk gap or gap in care, such as needing to follow up with their PCP for an underlying condition or is in need of annual preventive care screening(s)
- have been referred by an entity such as Case Management, Care Coordinator, Customer Service, Medication Therapy Management, or a Retail Service Center

Either visit type will include an appointment with a nurse practitioner to talk about:

- General health questions, including how to stay safe from COVID-19
- Health and medical history
- Family medical history
- Care they are receiving from specialists and other health care providers
- Review of their medications — both prescription and over the counter — as well as any supplements or vitamins
- How to live safely in their living environment

Additionally, members who choose the in-home assessment will have the opportunity to complete medically appropriate screenings and labs such as:

- Microalbumin kidney screening

- HBA1c screening
- Colorectal screening kit
- Osteoporosis bone scan
- Diabetic retinal eye exam
- Peripheral arterial disease screening

After the visit is complete, the member and member's PCP will receive a recommended plan of care including appropriate referrals, a summary of what was discussed during the visit, and satisfaction survey.

**Only the above criteria will result in a member receiving the targeted outreach from our vendor. However, all SecureBlue members can participate by calling Signify Health at 1-844-226-8218 (TTY 711), 7 a.m. to 6 p.m., Central Time, Monday – Friday.

PHI & Validation of Decision Makers

Personal Health Information (PHI)

Individuals have the right to authorize the release of their Protected Health Information or PHI.

PHI is defined as the identifiable information related to an individual's past, present, or future physical or mental health or condition, or the past, present, or future payment for the provision of health care to an individual. Covered entities, including our Care Coordination Delegates, are required to comply with valid authorizations.

PHI can be released to someone authorized by the member to receive PHI. A member can authorize another person via a written or verbal authorization:

- Written
    - The authorization must clearly state what information may be released, and to whom.
    - Under MN State law, authorization cannot be effective more than one year from signature date and may have a shorter duration noted by the member.

- Verbal
    - Verbal authorizations are valid only during the phone call/e-visit/on-site visit during which the authorization is made.
    - The member making the verbal authorization must have their identity validated, and must state what information may be released, and to whom.
    - Verbal authorization needs to be documented in case notes.

Authorized Representatives & Decision Makers

Care Coordinators must validate if the member has an authorized representative. An authorized representative means a person who is authorized by an applicant or participant to act on their behalf in matters involving the application for assistance or participation in the program. See DHS Manual for more details on authorized representatives.

The different types of authorized decision makers include:

- Authorized Representative Designation appendix on MN MA Application
    - When someone applies for Medicaid in the State of MN using DHS form 3876 – they can choose to designate someone to act on their behalf as an authorized representative. The application has an appendix where the applicant can name their authorized representative including a signature from both parties. Care Coordinators may request this information from a financial worker if validation is ever needed.
- Financial Power of Attorney (POA)
    - A Short Form/Financial POA does not allow for release of specific medical information to the person named but would allow for the release of information including benefits, eligibility, or financial matters.
- Health Care Power of Attorney (POA)
    - A Health Care POA or Health Care Directive specifically allows for the release of medical information and may also designate someone to make medical decisions (health care agent).
    - A Health Care POA may be conditional, based on member's medical condition. It does not become effective until conditions are met.

Nature of Request	Financial POA	Health Care POA
Address change	Yes	Yes
Claims status	Yes	Yes
Eligibility information	Yes	Yes
Medical information	No	Yes
PCC change	No	Yes
Financial decisions	Yes	No
Healthcare decisions	No	Yes

- Conservatorship
    - Court appointed to manage another person's financial affairs.
- Guardianship
    - Court appointed to manage another person's health care decisions

Both Conservators and Guardians are used when a person becomes incapacitated or impaired that he or she is unable to make financial or personal decisions and has no other viable option for delegating these duties to another (e.g., through a durable power of attorney, living trust, or some other means). Using these standards, conservatorships or guardianships might be established for people who are in a coma, suffering from advanced stages of Alzheimer's disease, or have other serious injuries or illnesses. Any person can petition the court for conservatorship and/or guardianship of an incapacitated individual.

Care Coordinators should validate POA, Conservatorship, Guardianship, or authorized representative status for anyone requesting PHI related information on a member.

If none of these are available, an ROI must be completed and signed by the member.

- Any form of an ROI is good for one year from the date of signature or earlier if designated specifically by the member.

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.

All EW Screening Documents (SD) must be entered into MMIS by these cut-off dates each month:

When the first month of the waiver eligibility span is:	Last Day to enter timely screening document into MMIS is:
January 2023	12/21/2022
February 2023	1/23/2023
March 2023	2/17/2023
April 2023	3/23/2023
May 2023	4/20/2023
June 2023	5/22/2023
July 2023	6/22/2023
August 2023	7/21/2023
September 2023	8/23/2023
October 2023	9/21/2023
November 2023	10/23/2023
December 2023	11/20/2023
January 2024	12/20/2023

*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.

*Disclaimer: There are several required fields for each MMIS SD not specified below.

Community Well members
For CW members assessed using LTCC and not receiving PCA or home care nursing:

- Enter SD type "H"
- Activity Type 02 face to face
- Assessment Result 35 (MSC+ or MSHO health risk assessment)
- Program Type 18
- Service Plan Summary 30 – Not receiving formal services
- Service Plan Summary 35 – Case Management

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 Blue Plus 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

*For newly enrolled members and existing Blue Plus members that have not had a comprehensive assessment completed by a Blue Plus Care Coordinator who agree to complete a 6.28 Transitional Health Risk Assessment (THRA), the Care Coordinator will not be able to use the instructions below to enter their THRA SD in MMIS due to the limitations of activity type 05 if the previous SD does not have program type 18, 03 or 04. The Care Coordinator must enter their THRA SD following the instructions above based on assessment type and services authorized, as applicable.

Scenario	Transitional HRA for New Enrollee (includes product changes)	Transitional HRA for New Enrollee (includes product changes)	Change in Care Coordinator for existing BP members	Change in Care Coordinator for existing BP members
	Community Well	**Elderly Waiver**	**Community Well**	**Elderly Waiver**
Activity Type:	05	05	05	05
Document Type:	H	L	H	L

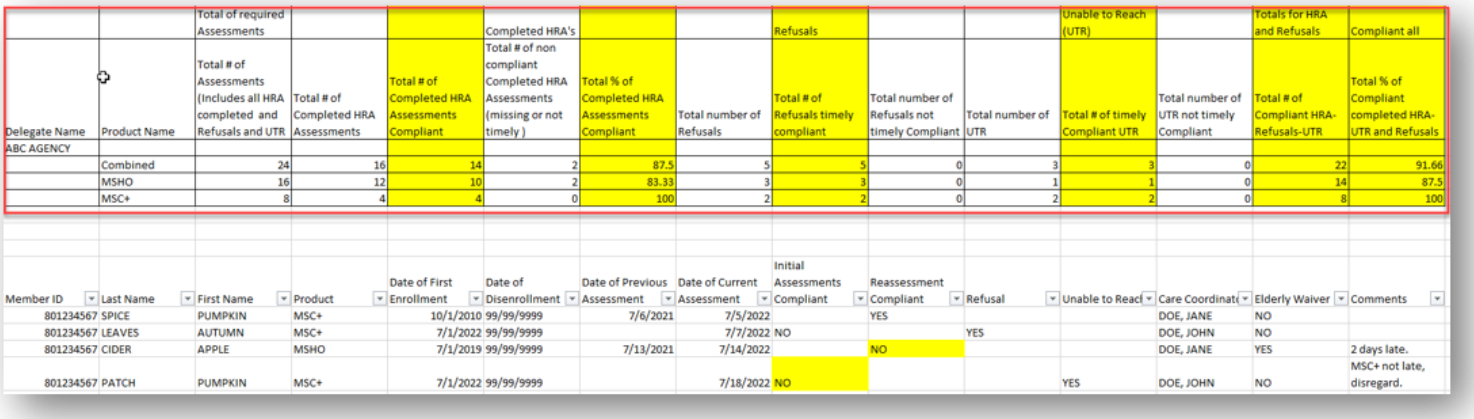
Activity Date:	Date Transitional HRA is completed	Date Transitional HRA is completed	Date delegate assumed Care Coordination responsibility	Date delegate assumed Care Coordination responsibility
LTCC CTY	BPH	BPH	BPH	BPH
Case Managers Name and UMPI Number	Use your MCO UMPI number	Use your MCO UMPI number	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	Date of Care Coordinator change	Date of Care Coordinator change
Program Type Note: program type cannot be changed with 05 SD	18	03 or 04 OR 18 (respectively)	Remains the same	Remains the same

Delegate HRA Performance Reports

Performance reports are generated and sent to delegates on a monthly basis to evaluate timeliness of completion of Health Risk Assessments (HRA's) per CMS and DHS requirements as outlined in the *Contact Requirements section* of these guidelines. The requirements are for Blue Plus to achieve equal to or greater than 90% on the total percentage of timely initial assessments and 100% timely reassessments – this does not include members who are documented as a 'refusal' or 'unable to reach'. These reports include both MSHO and MSC+ members and are meant to help delegates monitor timely completion of health risk assessments and timely entry into Bridgeview in addition to reviewing for issues of non-compliance, trends, and staff educational opportunities.

Data on the report is pulled from the HRA's entered into Bridgeview by the 10th of the following month. Delegates will receive an email from Partner Relations, including their current report and instructions on how to read the report.

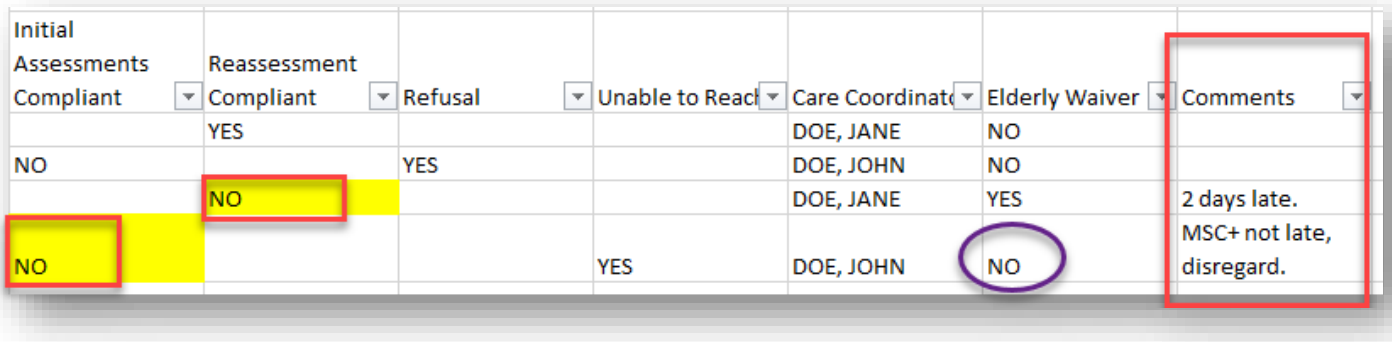
The top of the report includes overall # of assessments completed for both products including data on initials, re-assessments, refusals, and Unable to Reach.



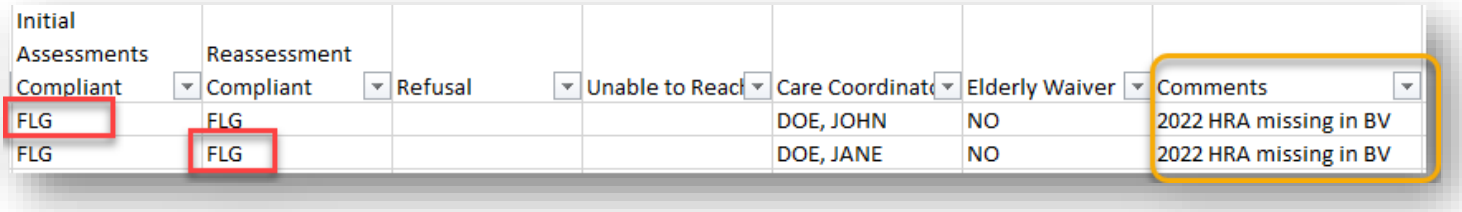
		Total of required Assessments			Completed HRA's				Refusals			Unable to Reach (UTR)		Totals for HRA and Refusals	Compliant all
Delegate Name	Product Name	Total # of Assessments (Includes all HRA completed and Refusals and UTR	Total # of Completed HRA Assessments	Total # of Completed HRA Assessments Compliant	Total # of non compliant Completed HRA Assessments (missing or not timely)	Total % of Completed HRA Assessments Compliant	Total number of Refusals	Total # of Refusals timely compliant	Total number of Refusals not timely Compliant	Total number of UTR	Total # of timely Compliant UTR	Total number of UTR not timely Compliant	Total # of Compliant HRA-Refusals-UTR	Total % of Compliant completed HRA-UTR and Refusals
ABC AGENCY															
	Combined	24	16	14	2	87.5	5	5	0	3	3	0	22	91.66
	MSHO	16	12	10	2	83.33	3	3	0	1	1	0	14	87.5
	MSC+	8	4	4	0	100	2	2	0	2	2	0	8	100

Member ID	Last Name	First Name	Product	Date of First Enrollment	Date of Disenrollment	Date of Previous Assessment	Date of Current Assessment	Initial Assessments Compliant	Reassessment Compliant	Refusal	Unable to Reac	Care Coordinat	Elderly Waiver	Comments
801234567	SPICE	PUMPKIN	MSC+	10/1/2010	99/99/9999	7/6/2021	7/5/2022		YES			DOE, JANE	NO	
801234567	LEAVES	AUTUMN	MSC+	7/1/2022	99/99/9999		7/7/2022	NO		YES		DOE, JOHN	NO	
801234567	CIDER	APPLE	MSHO	7/1/2019	99/99/9999	7/13/2021	7/14/2022		NO			DOE, JANE	YES	2 days late.
801234567	PATCH	PUMPKIN	MSC+	7/1/2022	99/99/9999		7/18/2022	NO			YES	DOE, JOHN	NO	MSC+ not late, disregard.

The lower portion of the report provides detail at a member level of HRAs that have been entered or are missing in Bridgeview. Delegate should review the report, including any comments, and correct the following for compliance:



Initial Assessments Compliant	Reassessment Compliant	Refusal	Unable to Reac	Care Coordinat	Elderly Waiver	Comments
	YES			DOE, JANE	NO	
NO		YES		DOE, JOHN	NO	
	NO			DOE, JANE	YES	2 days late.
NO			YES	DOE, JOHN	NO	MSC+ not late, disregard.



Initial Assessments Compliant	Reassessment Compliant	Refusal	Unable to Reac	Care Coordinat	Elderly Waiver	Comments
FLG	FLG			DOE, JOHN	NO	2022 HRA missing in BV
FLG	FLG			DOE, JANE	NO	2022 HRA missing in BV

- If the Care Coordinator fields are blank, log into Bridgeview and assign members to individual Care Coordinators.
- If assessment dates are missing:
    - Log into Bridgeview and enter the HRA completion dates and required fields.
    - If the assessment has not been completed, it should be scheduled as soon as

possible.

- If the assessment dates are greater than 365 days from the previous assessment, follow up with the Care Coordinator and determine if additional training is needed on required health risk assessment timelines.
- Review fields with a *FLG*. This means this member was reported to you in previous performance report(s) and has still not been resolved.
- Review fields with NO including comments and resolve accordingly.

Important reminders:

- Any health risk assessments reported as 'Refusals' or 'Unable to Reach' will be flagged as a *NO* in the compliance portion of this report. CMS does not allow us to count a refusal as a completed assessment.
- If the Elderly Waiver column is incorrect, you must review this discrepancy and correct as soon as possible. You can disregard if you know the member is on a waiver other than EW.
    - Reminder: member's on MSC+ who are open to EW must be assessed within 30 days of enrollment.

There is no requirement to report back to Partner Relations on the action you take on these reports unless you have questions or are reporting a discrepancy or another issue.

Care Planning Options & Requirements

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 must 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 Provider.
- 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.
- 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.

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 new 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:

1. Complete all sections of the appropriate care plan.
2. Include Care Coordination and Case Aide on the Budget Worksheet for all Community Well members
3. Sign the care plan.
4. Must obtain the member's signature. Document all attempts to get member signature.
5. Provide a complete copy of the care plan to the member and any care team members chosen by the member.
6. Mail the following:
    - 8.25 (SB) or 8.25.01 (MSC+) Care Plan Cover Letter

      And

    - 6.02.03 Medicare-Medicaid Member Rights or
    - 6.02.04 Medicaid-Only Member Rights MSC+
7. Send a copy of the care plan or care plan summary (Care Plan Summary Letter - Intro to Primary Care Provider) to the member's primary care provider. For clinic delegates, notification to primary care provider documented per clinic process.
8. Obtain necessary service provider signatures Service Provider Signature Requirements for sharing support plan information.
9. Create goals that are person-centered.
10. Evaluate and update any changes to the member's condition and corresponding services and supports, at minimum mid-year. Follow process in next section *Updates to the Care Plan*.

Mid-year and reassessment care plan review

Care Coordinators are required to monitor and document progress towards their care plan goals during each mid-year contact and at reassessment. Care Coordinators are required to review the goal(s) progress and document if the goal was achieved, will be discontinued, or continued to the next care plan.

At mid-year and reassessment, Care Coordinator must review with the member the following:

- Are the goals still relevant or do the goals need to be modified?
- Service review:
    - Are the services being provided as authorized?
    - Is the member satisfied with their service provider(s)?
    - Are there any gaps in the service(s) they are receiving?

Care Coordinators must date and document the status of each goal in the applicable monitoring columns (mid-year) and outcome column (end of year) on the care plan.

Updates to the Care Plan

Updates to the Care Plan must 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 service provider, or addition of a new service provider) complete the following.

The Care Coordinator must 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 *Service Provider Signature Requirements for sharing support plan information*. 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:

1. Update the budget worksheet as applicable.
2. Update any other applicable sections of the care plan.
3. Complete the 8.50 Member Service Change Letter.
4. Enclose a copy of the updated budget worksheet or the full care plan per member's choice.
5. Send it to the member for signature.

6. Document this discussion in a case note.
7. 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 service provider signature as outlined in the next section.

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

Service Provider Signature Requirements for sharing support plan information

***Sharing support plan information and obtaining Service 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.

Members can choose to have a copy of their care plan shared with their service provider(s) or just a summary letter. If the service provider is providing more than one service only one letter is required.

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) in the fields provided on the care plan signature page.

If a provider is not yet selected, the Care Coordinator can write "potential provider" on the signature page at the time of assessment. When the provider is selected, the CC must update the care plan accordingly. And then has 30 days from the date the provider is selected to send the first signature attempt to the selected provider.

Care Coordinators can use either letter to share care plan information with each service provider per member decision. Both have a field where the service provider should sign.

- Service Provider Care Plan Cover Ltr for members who agree to send the entire care plan or
- Service Provider Care Plan Summary Ltr which includes support plan information applicable only to that provider.

- If applicable, a member can choose to send the RS tool or ICLS Planning form instead of a copy of the care plan or care plan summary. If so, the CC should document this decision in case notes. And should check "none" on the signature page. The CL provider can sign anywhere on the RS tool. If member chooses to send both care plan and RS Tool, provider does not have to sign both. Send both with the care plan cover letter and have the provider sign the care plan cover letter.

The Care Coordinator must make a minimum of two attempts to obtain the applicable provider signatures:

- Within 30 days of the date the care plan was completed. Sending the first letter is considered the first attempt.
- If no service provider signature received, a second attempt to obtain the service provider(s) signature must be done again within 60 days of the date the plan was completed. Document this follow-up attempt in your case notes.

Member decision to share support plan information with EW Providers and CCs requirement to obtain their signatures is required for:

- Initial assessments
- Annual assessments
- Changes to existing plan and anytime a new EW or PCA (if applicable) service is added throughout the year. (i.e., changes in hours/units, change in service provider, new service). CC must discuss the member's decision to Share Care Plan Information with EW and PCA (if applicable) Providers

  If the member agreed to share this updated care plan information with the EW and/or PCA provider(s) if applicable, follow the same steps for sending the information and obtaining service provider signature as outlined above.

Service 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 service 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.
- Any services already started prior to Health Plan enrollment (such as member already on EW and then enrolls in a health plan) does not require the Care Coordinator to obtain the service provider's signature. However, if there are any new providers, follow the same

steps for sending the information and obtaining service provider signature as outlined above.

- Purchased-item service (formerly tier 3) transportation provided by a commercial or common carrier vendor. Commercial common-carriers include buses, taxicabs and light rails.

Note: Service provider signature is required for members accessing the Housing Stabilization Service program. See *Housing Stabilization Services*.

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

Case Management and Behavioral Health Case Management

Complex Case Management/Disease Management/Behavioral Health Case Management is available when members are identified as needing additional support. Members or their caregivers have access to additional case management to receive consultation, education and support for situations involving:

- Catastrophic illness
- High medical costs
- Substance abuse
- Frequent hospitalizations
- Out-of-state providers
- When additional education or support is requested by a member's caregiver.

Care Coordinators can make a referral at time of assessment, or any time need for additional supports are identified by sending in the Complex-Disease-Behavioral CM Referral Form available on the care coordination website.

Home Health Care Authorization Processes

Medicare skilled home care services and Medical Assistance state plan home care services can be provided by an in-network or out-of-network provider if enrolled with DHS. See processes below.

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 who are Community Well, and 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.

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)

Service Agreement entry

Enter the Service Agreement into Bridgeview per the instructions found in the Bridgeview Care Coordination User Guide.

NOTE: For any existing authorizations made prior to 4/14/22 **that require changes**, fax the Care Coordinator Request for Service Authorization Form to AGP UM Operations. In addition Care Coordinators must update 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.

Care Coordinator Role:

1. 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.
2. Determine if home care agency is in the Blue Plus network by verifying with the home care providers directly or calling Member Services.
    a. If a **current** member is requesting to use a provider out of the Blue Plus network as it has been determined that an out-of-network provider has immediate availability or that the agency is meeting a cultural need that cannot be meet by an in-network provider, the CC can authorize the out-of-network provider when it is confirmed that the provider **is enrolled with DHS**.
    b. If the provider is not enrolled with DHS, the provider cannot be authorized. The CC will need to find an in-network provider or a provider enrolled with DHS. See directions for **new** enrollees requesting OON providers below.
3. Coordinate service needs with the provider including initial authorizations, acute changes in a member's condition requiring additional services, or at re-assessment.
4. Enter the Service Agreement into Bridgeview per the instructions found in the Bridgeview Care Coordination User Guide. CC must note in the Service Description if the provider is out-of-network provider and enrolled with DHS.
    - 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 enter two authorizations in Bridgeview: RN using procedure code T1030 and LPN using T1031.
5. 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.
6. 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 reviewing other Case Managers recommendations and, if in agreement, authorizing state plan home care services.

- Authorization must 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 enter a Service Agreement into Bridgeview following the process outlined in the Bridgeview Care Coordination User Guide, 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

CC must note in the Service Description if the provider is out of network and whether they are enrolled with DHS. (For new enrollees requesting an OON provider see below)

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 must 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" when entering a Service Agreement into Bridgeview following the process outlined in the Bridgeview Care Coordination User Guide 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

CC must note in the Service Description if the provider is out of network and whether they are enrolled with DHS. (For new enrollees requesting an OON provider see below).

Upon receipt of the prior authorization request, UM will:

1. Conduct a medical necessity/clinical review following the guidelines outlined in the Home Care chapter of the CBSM and applicable State Statutes. Per statute, authorization is based upon medical necessity and cost-effectiveness when compared with other options.
2. Request any necessary medical information needed directly from the home care agency. Submitting clinical documentation is the home care agency's responsibility.
3. Contact the Care Coordinator if additional input from the Care Coordinator is required.
4. Make a coverage determination within 10 business days or 14 calendar days.
5. Notify member and home care provider of the decision via letter.
6. The Care Coordinator can view completed authorizations in Member360.

New enrollees with previously approved state plan home care services

If the member is new to Blue Plus with previously approved state plan home care services, for continuity of care, the CC must honor the current authorization until a new assessment is completed. The CC must determine if the home care agency is in the Blue Plus network by verifying with the home care provider directly or calling Member Services.

1. If the agency is not an in-network provider, the CC may continue with authorizing the out-of-network (OON) provider as follows:
2. Confirm with provider that they are enrolled with DHS.
3. Enter the Service Agreement into Bridgeview following the directions outlined in the *Bridgeview Care Coordination User Guide*. CC must enter the dates of the remaining span from the previous authorization.
4. Care Coordinator **must** add in the Service Description that this is for a new member and that the provider is OON and enrolled with DHS *or* indicate if they report they are not enrolled with DHS. Care Coordinator will be contacted by Blue Plus if there are service authorization date parameters that are set for a provider that is not enrolled with DHS.

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)

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 or requesting state plan home care services

Care Coordinators (CC) or other waiver case managers may initiate state plan home care recommendations/communication by completing the *Recommendation for State Plan Home Care Services DHS-5841* and sending supporting documentation. Other waiver case managers may reach out directly to the assigned Care Coordinator for authorization of state plan home care services or by sending the DHS-5841 to the Care Coordinator or to Blue Plus. In the event the notification was by phone the Care Coordinator must request the DHS-5841. As stated on the form, for services to be reviewed and authorized, county case managers must also submit a copy of the most recent PCA or HCN assessment(s) to the assigned Care Coordinator or to Blue Plus. If the form is sent to Blue Plus, we will forward the form and assessment(s), if included, to the assigned Care Coordinator.

Care Coordinators must:

- Review the full DHS-5841. Determine what is the reason for the communication and what are the recommended services. (Initial, increase in services, decrease in services)
- Review assessment(s) and care plans attached or request if not received.
- After their review the CC must send the form with their signature to the other waiver case manager within 10 working days stating if the Care Coordinator: approved, denied, or is requesting additional information. (the other waiver CM is responsible to ensure services remain within waiver budget).
    - If the recommended services from the other waiver case manager is a decrease in service(s) and the CC agrees with this decision the CC must issue a DTR. (Follow DTR Process)

- If the recommended home care services are not approved by the CC they must communicate with the waiver case manager and the member to determine alternative services and the CC must submit a DTR when applicable. If state plan services are modified during this process a new DHS-5841 is required to be sent and approved by the Care Coordinator.
- If the CC is in agreement with services requested, Care Coordinators will then enter the Service Agreement into Bridgeview following the directions outlined in the *Bridgeview Care Coordination User Guide*.

  Authorization dates entered into BV must align with the non-EW waiver span.

- If the waiver CM is the same as the assigned Care Coordinator, no need to complete DHS-5841.

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:

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

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.

Service Authorization Errors

If the Care Coordinator learns of a MA Home Care service authorization error, the error must be modified in Bridgeview following the process outlined in the Bridgeview Care Coordination User Guide.

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 Service Agreement Entry:

Care Coordinators must enter the Service Agreement into Bridgeview per the instructions found in the Bridgeview Care Coordination User Guide.

NOTE: For any existing authorizations made prior to 4/14/22 **that require changes**, fax the Care Coordinator Request for Service Authorization Form to AGP UM Operations. In addition, Care Coordinators must update 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.

PCA Services for members open to non-EW waiver:

Other waiver case managers may reach out directly to the assigned Care Coordinator for authorization of PCA services. Or they may send DHS-5841 Recommendation for State Plan Home Care Services to the Care Coordinator or to Blue Plus. As stated on the form for services to be authorized, county case managers must also submit a copy of the most recent PCA or HCN assessment(s) to the assigned Care Coordinator or to Blue Plus with this service request.

- If the form comes to Blue Plus, we will forward the form and assessment(s) to the assigned Care Coordinator.
- Care Coordinators must review the request and assessment(s).
- If in agreement with the services requested, Care Coordinators will then enter the PCA Service Agreement into Bridgeview following the directions outlined in the Bridgeview Care Coordination User Guide.
    - The PCA authorization dates are determined by the MnCHOICES assessment, not the 3428H assessment date. CC's may complete their 3428H reassessment to align with the other waiver CM's reassessment date not to exceed 365 days.
- If the waiver CM is the same as the assigned Care Coordinator, no need to complete DHS-5841.

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 the PCA agency is not in network the CC may continue with authorizing the out-of-network (OON) provider as follows:

1. Confirm with the provider that they are enrolled with DHS.

2. Enter the Service Agreement into Bridgeview following the directions outlined in the Bridgeview Care Coordination User Guide. CC must enter the dates of the remaining span from the previous authorization.

3. Care Coordinator **must** add in the Service Description that this is for a new member and that the provider is OON and enrolled with DHS *or* indicate if they report they are not enrolled with DHS. Care Coordinator will be contacted by Blue Plus if there are service authorization date parameters that are set for a provider that is *not* enrolled with DHS.

4. 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 must 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 must note in the Service Description the reason for additional PCA units.

    - The authorization requested dates and units must start with the member's enrollment date and must 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:

1. Upon completion of the PCA assessment, the CC is responsible for providing a copy of the completed PCA Assessment and Service Plan to the member and PCA provider within 10 days of the assessment.
2. Determine if the PCA provider is in the Blue Plus network by verifying with the PCA provider directly or calling Member Services.
3. If the member is requesting to use a provider out of the Blue Plus network as it has been determined that an out-of-network provider has immediate availability or that the agency is meeting a cultural need that cannot be meet by an in-network provider, the CC can

authorize the out-of-network provider when it is confirmed that the provider is enrolled with DHS. If the provider is not enrolled with DHS the provider **cannot** be authorized. The CC will need to find an in-network provider or at minimum enrolled with DHS.

4. Prior to starting services, the CC must enter the Service Agreement into Bridgeview following the directions outlined in the Bridgeview Care Coordination User Guide using two six month spans. The Care Coordinator must align the PCA date span with the EW date span, if applicable.
5. If applicable, Care Coordinator must note in the Service Description that provider is OON and enrolled with DHS.

Re-assessment PCA Authorization Requests:

1. Complete the PCA Assessment and Service Plan prior to the end of the authorization period.
2. Provide a copy of the completed PCA Assessment and Service Plan to the member and PCA provider within 10 days of the assessment.
3. At least 10 business days prior to the end of the current authorization, the CC must enter the Service Agreements into Bridgeview following the directions outlined in the Bridgeview Care Coordination User Guide using two six month spans. The Care Coordinator must align the PCA date span with the EW date span, if applicable.

Change in PCA Provider:

1. If member has a current PCA but wishes to change PCA providers, the CC must determine if the new PCA provider is in network by verifying with the PCA provider directly or calling Member Services.
2. If the member is requesting to use a provider out of the Blue Plus network as it has been determined that an out-of-network provider has immediate availability or that the agency is meeting a cultural need that cannot be meet by an in-network provider, the CC can authorize the out-of-network provider when it is confirmed that the provider is enrolled with DHS. If the provider is not enrolled with DHS the provider cannot be authorized.
3. The CC must update the Service Agreement into Bridgeview following the directions outlined in the Bridgeview Care Coordination User Guide. Care Coordinator must add in the Service Description if the provider is OON and enrolled with DHS.

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 following the guidance outlined in DHS PCA Manual.

1. CC must conduct a telephone assessment to determine the increased service needs using the provider, member/responsible party, and/or other health care providers as sources of information.
2. CC must review the PCA agency's documentation substantiating the need for the temporary start/increase in service. This may include reports, notes, and admission or discharge histories.
3. CC must review and utilize the DHS PCA Change of condition or health status guidance to determine additional time.
4. The increase cannot exceed 45 days. If the member requires an increase for more than 45 days, the Care Coordinator must complete a new DHS 3428 LTCC and PCA assessment.
5. CC must enter the Service Agreement into Bridgeview using appropriate procedure code from the DHS 3945.
6. When the temporary need for increased PCA is reduced, a DTR is needed. See DTRs—Coordination of Potential Denials, Terminations, and Reduction of Services.

Extended PCA Requests for Members on EW:

For Blue Plus members open to EW, extended PCA hours may be authorized by the Care Coordinator. This authorization will be entered in Bridgeview. Care Coordinators must use a DHS EW enrolled provider. 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 must 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 10 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.

Member's open to EW who have PCA with the enhanced rate may make a request to exceed their case mix cap, if applicable. Care Coordinators should refer to the Requests to Exceed Case Mix Budget Cap section for more information.

Service Authorization Errors

If the Care Coordinator learns of a PCA service authorization error, the errors must be corrected to the Service Agreement in Bridgeview following the directions outlined in the Bridgeview Care Coordination User Guide.

Elderly Waiver Authorizations

When authorizing EW services, the Care Coordinator is expected to be compliant with all EW program rules. Care Coordinators must 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 Coordination 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 service 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 must 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 (Pass through billing)

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). 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. To confirm if your county/agency has a pass-through billing contract or would like information on becoming a contracted pass-through entity, contact your Partner Relations Consultant.

Refer to the *Bridgeview Care Coordination User Guide* for details on how to enter service agreements as a pass through for Approval Options Services in Bridgeview. Contracted pass-through counties/agencies are required to choose vendors to deliver approval-option services following DHS requirements including completion of a vendor tracking log (DHS-7044A). See the DHS CBSM – Lead agency oversight of waiver/AC approval-option service vendors for more information on the requirements for lead agency oversight.

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 Coordination 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 service provider the waiver obligation was applied to 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/MnCHOICES (reviewed within the previous 60 days)
- Current Care Plan
- A copy of Residential Services tool, if applicable. Customized Living rate must be within CL rate limits except for EW Conversion rate requests.
- PCA assessment, if applicable.
- 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.
- Reauthorizations must include the previous EW RS Tool and/or PCA Assessment, if applicable.

The EW Review Team will:

1. Review the request within 10 business days/14 calendar days, whichever is sooner, of the receipt of all the required information/documents
2. Confer with the Care Coordinator if the documentation provided does not support the requested level of service
3. Consult with the submitting Care Coordinator to ask for clarification or request further documentation as needed
4. Consult with the Medical Management Medical Director as needed
5. Approve, deny, or recommend a change in the budget rate request
6. If request is approved, Review Team will determine the length of time for the approval. Requests to exceed the case mix cap approval period will be determined based on the member needs and reason for exception, not to exceed a twelve-month period.

If approved, the EW Review Team will:

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

The Care Coordinator must:

Place the full CAP amount (rather than the approved amount that exceeds case mix cap) in the Case Mix/DRG Amount field on the LTC screening document.

If not approved, the EW Review Team will:

1. Advise the Care Coordinator to assist the member to explore other options which may include adjusting the level of service to more appropriately reflect the documented need and/or explore other provider options.
2. Request a DTR
    - UM will issue a Denial, Termination, or Reduction (DTR) letter to the member and Care Coordinator within 10 calendar days, whichever is sooner, of the receipt of all the required information/documents.

      ** Refer to DTR section for additional information

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

Withdrawal of a request to exceed case mix cap

If at any time the Care Coordinator decides to withdraw the Request to Exceed Case Mix Budget Cap prior to the authorized end date, the Care Coordinator must:

1. Communicate the withdrawal request in writing to Partner.Relations@bluecrossmn.com

   Be sure to include:

   - Member Name
   - Member ID number
   - Date of initial request
   - Request to Exceed Case Mix Cap Z end date
   - Reason for withdrawal (Examples: no changes in services but due to DHS Annual COLA increase the member no longer exceeds their case mix cap; member initiated a reduction in current services; member expired and no longer needs request to exceed case mix cap, etc.)
2. Update the member's service agreement(s) and MA plan service amount in Bridgeview for the remainder of the EW span date after the withdrawal effective date.

EW Conversion Requests

A monthly EW conversion rate for a budget limit is an exception to the monthly case mix budget cap for EW participant(s) leaving a nursing facility to return to a qualifying community setting after 30 days, this includes EW CDCS. EW conversion definition includes conversion service rates for customized living, including 24 customized living and adult foster care for EW participants meeting the conversion eligibility criteria.

Note: For EW service rate limit conversion requests, the service rate must be based on service plans documented on the Elderly Waiver Residential Services Tool. Submission requirements of the EW RS Tool remain the same using the MnCHOICES application to access the MnCHOICES Support Plan (MnSP).

- First-time conversion requests must take place prior to the service initiation.
- Select and complete the appropriate form (with or without CDCS), including associated documents and return to Blue Plus.
- 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 a 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/MnCHOICES
- Current Care Plan/support 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). Customized Living rate must be within the CL rate limits except for EW conversation rate requests.
- PCA Assessment (if applicable)
- Any other supporting documents deemed appropriate
- Other documents requested by the EW Review Team
- Reauthorizations must include the previous EW RS Tool and/or PCA assessment, if applicable.

The EW Review Team will:

1. Review the request within 10 business days/14 calendar days, whichever is sooner, of the receipt of all the required information/documents
2. Confer with the Care Coordinator if the documentation provided does not support the requested level of service
3. Consult with the submitting Care Coordinator to ask for clarification or request further documentation as needed
4. Consult with the Medical Management Medical Director as needed
5. Approve, deny, or recommend a change in the budget rate request
6. If request is approved, EW Review Team will determine the length of time for the approval.
    - **Initial Conversion Rate** for members transitioning out of a nursing facility, authorization will be given for a six-month period. This will allow the Care Coordinator and the EW Review team time to determine if the member is stable in their new community environment and if services and rates need to be adjusted to meet any changes in the identified needs of the member

- **Reauthorization without Change in Level of Service:** If the EW Review team agrees with the level of services authorized for members who have previously transitioned to the community using an approved EW conversion budget, Blue Plus will reauthorize the budget for a twelve-month period. This applies to current and newly enrolled MSC+ /MSHO members
- **Reauthorization with Change in Level of Service:** If the EW Review Team assesses the member to need a different level service than what was previously authorized for a member who has transitioned to the community using an approved EW conversion budget, the authorization period will be for six months. This will allow the Care Coordinator and the EW Review Ream time to determine if the member is stable with the new service levels and if services and rates need to be adjusted to meet any changes in the identified needs of the member

If approved, the EW Review Team will:

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

The Care Coordinator must:

1. Place the full CAP amount (rather than the higher conversion rate) in the Case Mix/DRG Amount field on the LTC screening document.
2. For approved Conversion Requests when a member will/does reside in Customized Living, the Care Coordinator must complete the "Conversion Limit" tab in the CL workbook.

If the request is <u>not</u> approved, the EW Review Team will:

1. Advise the Care Coordinator to assist the member to explore other service/transitional service options.
2. Request a DTR
   - UM will then issue a Denial, Termination, or Reduction (DTR) letter to the member and Care Coordinator within 10 calendar days, whichever is sooner, **of the receipt of all the required information/documents.**

     ** Refer to *DTR section* for additional information.

3. 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:

1. Communicate the withdrawal request in writing to Partner.Relations@bluecrossmn.com. Be sure to include:
    - Member Name
    - Member ID number
    - Date of initial request
    - Reason for withdrawal (Examples: no changes in services but due to DHS Annual COLA increase the member no longer exceeds their case mix cap; member initiated a reduction in current services; member expired and no longer needs request to exceed case mix cap, etc.)
2. Update the member's service agreement(s) and MA plan service amount in Bridgeview for the remainder of the EW span date after the withdrawal effective date.
3. 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/MnCHOICES
- 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 Care Coordination 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 must 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:

1. 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.
2. 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).
3. There must 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) must be separate service agreements from the CDCS service agreement in Bridgeview and are not included in the member's CDCS budget.
4. 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.

5. 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.
6. 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
7. 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 must 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: An optional, 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.

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 must 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 and include either of the following options:
   A. Completed DME Payor Determination Checklist indicating that all applicable resources have been researched.
      OR
   B. Member specific information to include:
      - Member Name
      - Member ID number
      - MSHO or MSC+
      - HCPC code for item being requested
      - Cost of item
      - Item Description
      - Comment/justification for coverage and alternative items 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:

1. Submit a claim to the member's medical benefit

2. If the cost of the lift mechanism is greater than $400, the DME provider must request prior authorization following the authorization process as outlined in the BluePlus Provider Policy and Procedure Manual.
3. If prior authorization is needed, UM will review the request and make a coverage determination within 10 business days and notify the appropriate parties of the approval or denial determination as follows:

   If approved under the Medicare benefit:

   - Notification will be sent to:
     - The member
     - Durable Medical Equipment Provider
     - Care Coordinator
   - UM will enter an authorization into the claims payment system.

   If denied under Medicare benefit:

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

4. If the DME provider determines the member <u>does NOT meet Medicare/Medicaid criteria*</u> for coverage of the lift mechanism portion of the chair, the DME provider must:

- Provide the Care Coordinator detailed reason for not meeting criteria. CCs may refer to the Medical Supply Coverage guide for the coverage criteria if needed.
- Care Coordinator must enter the service agreement for the lift portion 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 and entering a service agreement in Bridgeview. A note in the service description indicating the case was reviewed and approved by the Supervisor and/or Partner Relations Consultant is required.

- 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 Service 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.

Outpatient Procedures

Because the Care Coordinator is responsible for coordination of the provision of all Medicaid health and long-term care services and Medicare (if applicable) among different health and social service professionals and across settings of care, Blue Plus will keep the Care Coordinator informed of any authorized outpatient procedures through our daily Inpatient/Outpatient notification reports. At a minimum, the Care Coordinator must 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. Care Coordinators must document their outreach in the case notes. A Transitions of Care (TOC) log is not required for outpatient procedures.

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 must communicate applicable information about the transition(s) with them. This communication at a minimum should include the member has been admitted and updates at discharge.

The Care Coordinator is responsible for completing all required tasks related to the transition(s) of care.

Definitions:

- **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.
- **Outpatient procedures:** See *Outpatient Procedures* section.
- **Planned transition:** Planned transitions include scheduled elective procedures performed in a hospital; 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.

- **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.
- **Unplanned transition:** Unplanned transitions are most often urgent or emergent hospitalizations.
- **Usual Care Setting/New Usual Care setting:** Usual care setting is defined as the place where the member lives (own home, CL, resident of a nursing home). New usual care setting means the member will not be discharging back to their usual care setting following transitions. This often happens when a member enters the nursing home for rehab following a hospitalization and it is determined that they will stay in the nursing home permanently. The nursing home is now their "new usual care setting" and final TOC activities outlined in #9 below should be completed.

Care Coordination TOC Documentation Responsibilities:

1. Complete Blue Plus Transitions of Care Log (up to 3 transitions or up to 6 transitions) (PDF) for all planned or unplanned admission transitions.
2. Use tool tips located on each field of the Blue Plus Transitions of Care Log for instructions on required tasks and for detailed information on the completion of the log. In order to see the tooltip instructions on the updated TOC logs, you will need to download/save the PDF by clicking on the download arrow.
3. TOC logs are required if the CC learns of a transition while the member is in any phase of the transition process. See tooltips for how to document each transition if discharge from a care setting occurred prior to notification.
4. If the CC begins TOC interventions/log, they must 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.
5. **Planned Transitions:** The Care Coordinator must 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.
6. **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. Hover over the field titled "Shared CC contact info, care plan/services with receiving setting Date completed" for instructions.

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.

7. Notify the Primary Care Provider and/or Specialty Care Physician of all transitions including the transition to home, within 1 business day of learning of the transition. Hover over tooltip in the field "Notified PCP of transitions – Date Completed" for instructions.

   Optional form can be used to notify PCP: 6.22.02 Fax Notification of Care Transition.

8. **Member Returns to Usual or New Usual Care Setting:** Care Coordinator should be working with the discharge planner/Social worker to assist in discharge planning. 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. The hover-over tool tips in each field of the final page of the TOC log titled "Return to usual or new usual care setting required tasks" for detailed instructions and timelines on each of the following required tasks:

   - Care transition process including sharing Care Coordinator contact information for additional support. Hover over the checkbox next to this task for detailed instructions and timelines.
   - Changes to the member's health status and updates to the member's care plan as applicable. If the member's usual care setting is a nursing facility, the Care Coordinator must confirm that necessary changes were applied to the care plan and offer input, if applicable, and provide support/reinforcement of the updated care plan. Hover over the checkbox next to this task for detailed instructions and timelines.
   - Education about transitions and how to prevent unplanned transitions/readmissions. Discuss and update any changes to plan of care. Hover over the checkbox next to this task for detailed instructions and timelines.
   - The Care Coordinator shall address the "Four Pillars for Optimal Transition: Care Coordinators should refer to tool tips in each yes/no field for information and instructions on the four pillars:

     1. Timely follow up appointment. Hover over the "yes" and "no" checkboxes next to this task for detailed instructions.
     2. Can the member manage their medications? Hover over the "yes" and "no" checkboxes next to this task for detailed instructions.

3. Can the member verbalize warning signs and symptoms to watch for and how to respond. Hover over the "yes" and "no" checkboxes next to this task for detailed instructions.
4. Does the member use a Personal Health Record. Hover over the "yes" and "no" checkboxes next to this task for detailed instructions.

Note: Communication with the Customized Living or Nursing Facility staff does not replace the requirement to contact the member/member's representative. Members in nursing facility or CL facility can benefit from CC opportunity to reinforce or develop what is in their NF or CL plan of care.

- For MSHO members offer post discharge resources. See TOC log final page for details and links. Hover over the checkboxes for instructional details. Refer, also, to Post Discharge Resources for SecureBlue Members.

- **Assessment due for members that are inpatient:** Care Coordinator must attempt to reach the member/responsible party. If the member and/or responsible party refuses the assessment while inpatient, document a refusal. Inform the member/responsible party of Care Coordinator's role in assisting with the transition to include completing an assessment and discharge planning for necessary services prior to the members discharge.

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 admitting to a nursing home for any length of time must be made 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 mental illness and/or developmental disability. For members with 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.

Continuity of Care when there's a change in Care Coordinator: Best Practices

The preference of DHS and Blue Plus is the Care Coordinator (CC) remain the same person across all living arrangements and settings of care. All CC transitions are required to be member centric, and the process should not be transactional only. When there are instances resulting in a change in Care Coordinator, both parties must work together to ensure a smooth transition including clear communication with the member and sharing of member needs and transitioning of Care Coordination tasks.

To ensure continuity of care during Care Coordination transitions either within the same agency or to another Blue Plus Delegate, Care Coordinators must complete the transfer tasks outlined in the next section and both Care Coordinators should consider the following best practices:

- Both Care Coordinators should call the member to explain the change in Care Coordination, which would include a review of transfer paperwork sent or received.
- Both Care Coordinators should collaborate to confirm and review receipt of all member documents, give verbal report on member's status, and ensure all LTSS services and needs are being addressed, as applicable.
- The current Care Coordinator should remain involved until there is confirmation of a new Care Coordinator assigned and an introduction to the member has been completed.
- When possible, both Care Coordinators should be present during member's next face to face visit or care conference, as applicable. Dual billing for Care Coordination time is allowed if needed to ensure a smooth transition.

For member's transitioning from a long-term nursing home stay back to the community, the following best practices are recommended:

The new community Care Coordinator must complete the assessment and coordinate with the previous Care Coordinator. Both parties should work closely together to ensure a smooth discharge home for the member with the following considerations being addressed during transition planning:

- Sharing of all historical information.
- Sharing of member's needs and wishes.
- Assurance that the member understands who the assigned Care Coordinator will be post-discharge including contact information.
- Nursing Home CC should be a part of the assessment process either in person or by phone.
- The discharge planning process should not be transactional only. There should be regular communication and coordination between both parties with the member/family or authorized rep.

Transfers

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

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

Transfers of Care Coordination to Another Blue Plus Delegate

When a Care Coordinator becomes aware that a member is moving from their service area or the member chooses a PCC that impacts care coordination, the CC must:

1. Confirm the new Care Coordination Delegate by referring to 9.07 Care Coordination Delegate Listing and Contact Table or contact your Partner Relations Consultant.
9. 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
10. Update the member's address, county of residence and/or PCC in Bridgeview.
11. Notify the member's financial worker by completing the DHS 5181.
12. 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 via 6.08 Transfer in Care Coordination form. For exceptions to this, either Delegate must email secureblue.enrollment@bluecrossmn.com for coordination.

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 must continue to follow the member until the member's coverage terminates.

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

1. Confirm the current and/or new PCC with the member, authorized rep, or customized living/nursing facility. This is especially important if the change in PCC triggers a change in care coordination delegation. For example, the following PCCs also provide care coordination to our members:

- Bluestone Physicians (also responsible for: Fairview Partners and select metro M Health Fairview Clinics formerly HealthEast locations only)
- Essentia Health
- Genevive (MSHO only in select nursing facilities)
- Genevive (MSHO & MSC+ in Hennepin County with Allina PCC)

13. 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.
14. If the PCC needs to be changed, follow the PCC change process as outlined in the *Primary Care Clinic (PCC) Change* section.

Responsibilities of the transferring Care Coordination Delegate:

1. Send form 6.08 Transfer in Care Coordination Delegation and all transfer documents (HRA, care plan, etc.) directly to the new Delegate. **Optional:** complete DHS-6037 HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form
15. 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 service provider signature documentation
    - A copy of the Residential Services tool and DHS 7176H HCBS Rights Modification Support Plan
    - My Move Plan Summary
    - Housing and Stabilization Service (HSS) documents and service plan, if applicable
    - The **transferring** Care Coordinator must communicate the following to the member's financial worker:
        a. Address change
        b. EW eligibility
16. If the member is open to EW, the **transferring** Care Coordinator must:
    - 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.

17. 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 must proceed with the transfer process outlined here and change the PCC (if applicable).
18. 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 staff or the transferring Delegate. The transferring Delegate must send 6.08 Transfer in Care Coordination Delegation form to the receiving Delegate. Receipt of this form and supporting documents is official notification of the transfer.

The receiving Delegate must not wait for the member to show on the enrollment report before initiating Care Coordination activities.

1. Assign a Care Coordinator and notify the member by the 10th of the month the change is effective. The 8.30 CM Change Intro letter may be used to notify the member of a change in Care Coordinator.
19. Enter the name of the assigned Care Coordinator in Bridgeview following the process outlined in the *Bridgeview Care Coordination User Guide*.
20. Update the Screening Document to reflect the change in Care Coordinator
21. Notify the financial worker of the assigned Care Coordinator's name.
22. Notify the primary care provider using Intro to Primary Care Provider letter. For clinic delegates, notification to primary care provider 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.
23. 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.
24. 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.
25. 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. 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.

Transfers of Care Coordination within your agency (change in CC)

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 primary care provider using Intro to Primary Care Provider letter. For clinic delegates, notification to primary care provider documented per clinic process. See *Primary Care Provider Contact Requirements*.

My Move Plan Summary

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

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

The My Move Plan Summary must be offered in the following scenarios:

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

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

- EW members who are permanently moving into a nursing facility

- CW members who are moving residences
- NH members who are moving residences and not going on EW

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

The Care Coordinator is responsible to:

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

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

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

If the My Move Plan Summary was not completed, the Care Coordinator must 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 must 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. After entering DOD into Bridgeview, all EW service agreements will be auto closed as of the date of death including the LTCC/Case Mix waiver span. CC must verify the SA's were closed.
4. Close member to EW in MMIS (EW only)

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

1. Notify Financial Worker via DHS 5181
    a. Care Coordination activities must continue until member officially terms off enrollment
2. Once officially termed on enrollment, Care Coordinator must:
    a. Close member to EW in MMIS (EW only)
    b. Close service agreements in Bridgeview (EW only).

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)	Service 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.

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)	Service Provider notification via phone	Other tasks
	MSC+	No	Yes	N/A	N/A	Yes	
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 must:

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 must 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 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:

- Contact the member and the provider to discuss denial, termination, or reduction of the service, explaining that the 10 calendar days given on the letter they will receive from Blue Plus is the appeal window. If they choose to continue services during this appeal window and they do not appeal or the DTR is upheld, any paid claims will be adjusted, and any payment paid will be recouped.
- EW services agreements: Do not update any service agreements until you receive an email confirmation from UM with the DTR effective date(s) which are typically 10 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 (see DTR Reference Guide for Hospital and Nursing Home Stays below)

Situation	Care Coordination Notification of DTR
Member's Medical Assistance eligibility ends for any reason	Not required
Member moves out of the state or out of the country	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
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
When reducing a temporary service increase (i.e. with Activity Type 10, or Temporary PCA 45 day)	Required

DTR Reference Guide for Hospital or Nursing Home Stays or vacation/temporarily out of service area

*Notification to any home care or EW services providers is required as soon as the Care Coordinator is notified of any inpatient or skilled nursing facility admission.

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	EW: close service agreements in BV back to admission date. State plan home care: Nothing required.	Not required

Member admits to a hospital for >30 days.	EW: Close the waiver in MMIS and service agreements in BV back to the date of hospital admission. 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 stay will exceed 30 consecutive days.
Member admits to a nursing facility for >30 days.	EW: Close the waiver in MMIS and service agreements in BV back to the date of the nursing facility admission. 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 nursing facility stay will exceed 30 consecutive days.
Member is admitted to the hospital and transitions to a nursing facility. Member is in the nursing facility for >30 days.	EW: Close the waiver in MMIS and service agreements in BV back to the nursing facility 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 nursing facility stay will exceed 30 consecutive dates.
Member's EW/State Plan services authorized by the Care Coordinator are on hold for >30 consecutive days due to member vacation/temporarily out of the service area	EW: modify service agreements in BV as appropriate. State plan home care: Nothing required.	Not required

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 explaining that the 10 calendar days given on the letter they will receive from Blue Plus is the appeal window. If the provider chooses to continue services during this appeal window and they do not appeal or the DTR is upheld, any paid claims will be adjusted and any payment paid will be recouped.
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 explaining that the date given on the letter they will receive from Blue Plus is the appeal window. If the provider chooses to continue services during this appeal window and they do not appeal or the DTR is upheld, any paid claims will be adjusted and any payment paid will be recouped.
2. Send DHS 5181 to the Member's Financial Worker.
3. Enter a screening document to exit elderly waiver into MMIS.
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.).

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 must use the most cost-effective means. Care Coordinators are encouraged to use over-the-phone interpretation as a first option when possible. A Care Coordinator and interpreter may set a time before the assessment to:

- Discuss how to translate assessment concepts across cultures
- Communicate the assessment process to review service options
- Identify challenging concepts that might take longer to discuss. In some cultures, certain words, behaviors or particular feelings have no literal word translation. It may take extra time to describe the meanings of these words.

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:

Provider	Geographic Coverage (By County)
Claro Interpreting Services **Phone: (651) 705-8890** **Monday – Friday: 7:00 am - 6:00 pm**	Metro, Southern MN, Western MN
Bridge World Language Center Inc **Phone: (320) 259-9239** **Monday – Friday: 8:00 am - 5:00 pm** **Online: www.bridgelanguage.com** **After hours and weekends:** **(320) 656-8119** **Fax: (320) 654-1698**	North Metro, St. Cloud, and surrounding counties
INGCO International **Monday – Friday 8:00am – 6:00pm** **Phone: 612-605-8006** **Online: ingcointernational.com**	7 County Metro, Stearns, Wright & Olmstead Counties

Provider	Geographic Coverage (By County)
Intercultural Mutual Assistance Association (IMAA) **Phone: (507) 289-5960** **Fax: (507) 289-6199** **Online: imaa.net**	Southeast MN
Itasca Interpretation Services **Phone: 651-457-7400** **Fax: 651-457-7700** **Online: itascainterpreter.biz** **24 hours, 7 days a week**	Metro
Language Incorporated **Monday – Sunday 8:00am – 5:00pm** **Phone: 507-573-1427** **Online: www.languageincorporated.com**	Steele, Rice, Waseca, Ramsey, Mower, Freeborn & Blue Earth In-Person & Phone Services
The Language Banc **Phone: (612) 588-9410** **Online: thelanguagebanc.com**	Metro, Stearns, and surrounding Counties
Project FINE **Phone: (507) 452-4100** **Online: www.projectfine.org**	Winona County Only
3H Interpreter & Translation Services **Phone: 701-540-3347** **Fax: 701-425-0357** **Online: 3H Interpreter & Translation Services**	Cass, Clay Counties
Vida Interpreting **Monday - Sunday 8:00am - 6:00pm** **Phone: 320-339-1131** **Online:www.vidainterpreting.com**	Todd, Stearns, Morrison, Wadena, Douglas, and Pope Counties

Provider	Geographic Coverage (By County)
Open End Communications **Phone: 320-204-4493** **Online: www.openendcommunication.com**	Stearns and Sherburne Counties
Dialog One **Phone: 651-379-8600** **Toll Free: 1-877-300-5326** **Online: www.dialog-one.com** **24 hours, 7 days a week**	State-wide Over the phone and virtual services only
Minnesota Interpreters and Translators **Phone: 651-353-7179** **Online: mintlanguages.com**	State-Wide In-Person & Phone Services
LinguaOne **Phone: 507-351-8787** **Online: www.linguaone.com**	Blue Earth, Brown, Le Sueur, Faribault, Nicollet & Watonwan Counties

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.

Pharmacy

SecureBlue MSHO members have prescription coverage through their MSHO Part D benefits. See the *Provider & Pharmacy Directory/MSHO Formulary* page on our website for access to:

- Pharmacy Directory
- SecureBlue MSHO Formulary (PDF and online search option)
- Medicare Part D Claims Reimbursement Form:

Self-administration of medications and vaccine coverage

MSHO members may be billed for some Medicare Part D vaccinations received in a clinic setting or over the counter medications self-administered in a hospital or emergency room 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 since they are not a pharmacy, clinics cannot bill Part D benefits for the vaccine itself.
- 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 over-the-counter medications normally taken 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.).

MSHO members and/or Care Coordinators can submit these to their drug coverage under their SecureBlue MSHO plan for potential coverage by Blue Plus by completing the Medicare Part D Claims Reimbursement Form found on the Care Coordinator website

- Members receiving bills can do one of the following:
    - Pay the bill and submit for 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.

Ask your PR Consultant if you have any questions.

Pharmacy programs for members

Program	Who qualifies	What to expect	Care Coordinator Role
MRP: Medication Reconciliation Post Discharge (Medication Review if no discharge paperwork is provided) *Provided by Tabula Rasa/Essentia*	**MSHO** members only post-discharge from hospital or SNF	• 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.	• 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*

in home or telephonic		• Pharmacist sends action plan to member's PCP	
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 meeting the following criteria are eligible for the MTM program at the beginning of the year and are scheduled to receive a CMR: **Criteria A:** Meeting the CMS criteria for MTM services. Completing a CMR for these members improves our Star measure • 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). **Criteria B:** Any **MSHO** can elect to have their	• 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. • 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 • MTM pharmacist will follow up with members if there were any	• Educate member on benefits of having CMR if contacted. • Care Coordinators should complete the Medication Therapy Management (MTM) Referral form and email to: Medicaid.MTM@bluecrossmn.com

	medications reviewed by a pharmacist. These members can be referred by a care coordinator for MTM services. Examples of MTM referral criteria include: • Drug side effect/adverse drug event • Polypharmacy (4 or more meds) • Adherence issues • Medication interaction or dosing concerns • Chronic conditions • Frequent ER/hospital visits	medication-therapy problems identified during the CMR to ensure recommendations made to the member and/or provider were accepted.	

Relocation Service Coordination (RSC)

As part of your role, Care Coordinators provide relocation services coordination to members planning to return to the community from a Nursing Facility. Do not initiate formal relocation targeted case management services (RSC- TCM) for existing Blue Plus members. For newly enrolled Blue Plus member(s) previously receiving formal relocation targeted case management services, prior to Blue Plus enrollment, the member must be given the choice to continue to work with their current Relocation Targeted Case Manager. The Care Coordinator would document this in the member's file. If the member chooses to continue to work with their Relocation Targeted Case Manager, the Care Coordinator is expected to collaborate with the Relocation Targeted Case Manager on the member's plan of care and ensure there is no duplication in services.

It remains the Care Coordinator's responsibility to ensure all activities included in the Care Coordination Guidelines are completed within the required timelines. If a member does not wish to continue to work with their Relocation Targeted Case Manager, the Care Coordinator will

provide all necessary relocation services coordination. For more information refer to the following resources: *At a Glance – Relocation Resources (*see *Care Coordinator Resources) and* Relocation Service Coordination -Targeted Case Management section of the MHCP Provider Manual.

Housing Stabilization Services

Housing Stabilization Services (HSS) is a benefit to help people with disabilities and seniors find and sustain housing services if they meet the required needs-based criteria. This benefit is available to Medicaid enrollees as a state plan Home and Community-Based Service (HCBS) under their Medical Assistance (MA). No prior authorization or service agreement is needed from the Care Coordinator. For more information refer to the following resources: *At a Glance – Relocation Resources (*see Care Coordinator Resources*)*, DHS 7347 Housing Stabilization Services Person-Served Workflow, HSS section of the MHCP Provider Manual, DHS HSS policy page.

DHS will notify Blue Plus of any eligibility approvals and authorized HSS provider changes. Upon receipt of notification, the Partner Relations Team will notify the Care Coordinator of service approvals via a secure email.

Goal:

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

Eligibility:

- Enrolled on Medical Assistance; and
- Have a disability or disabling condition or are 65 years or older; and
- Housing instability (one of the risk factors below); and
    - Homeless; or
    - Currently transitioning or recently transitioned from institution or licensed/registered setting; or
    - At risk of homelessness when
        - circumstance will likely cause a person to become homeless.
        - person previously homeless discharging from correctional/medical/mental health or substance use disorder treatment center lacking resources to pay for housing and does not have permanent housing; would be at risk of homelessness if housing services were removed.
- Assessed need for services with at least one of the following areas due to limitations resulting from a person's disability/long-term or indefinite condition:
    - Communication; or
    - Mobility; or
    - Decision-making; or
    - Managing challenging behaviors

Service options under the HSS benefit:

Consultation Services (Care Coordinator or HSS Provider*)
Formal Housing Stabilization Consultation Services provides a person-centered plan for persons not actively receiving case management/care coordination. For our MSHO and MSC+ members, this service under the HSS benefit is ***provided by the Care Coordinator*** as part of the assessment and care planning process. For members on another HCBS waiver, their waiver case manager will provide the comprehensive assessment and care planning/support plan to the HSS provider.

HSS consultation services benefit is ***provided by the Care Coordinator*** as part of the current assessment and care planning process. HSS must be documented on the member's collaborative care plan/support plan. Member(s) refusing to engage in their Care Coordination benefits, by way of declining the LTCC/Comprehensive Health Risk Assessment, may choose to receive housing consultation services through a formal Housing Consultation Services Provider following the appropriate steps:

- The Housing Consultation Services Provider must reach out to Blue Plus or the Care Coordinator to verify this information prior to initiating services.
- HSS Consultation Services Provider must have and/or provide documentation of this verification upon request.
- Valid eligibility approval notification from DHS for formal HSS Consultation Services

Blue Plus reserves the right to deny claims without proper documentation verifying this information prior to the start of services. Care Coordinators must reach out to their Partner Relations Consultant if they learn their member is working with a formal HSS Consultation Services Provider.

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

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.

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 must complete the required care planning components and referral to a DHS approved HSS provider. The care plan must include documentation on this assessed need for HSS. The Provider is responsible for completing all DHS requirements including making the referral to DHS. 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.

It is important to note, not all members are eligible for elderly waiver transitional services. Upon review, if the member is not eligible for elderly waiver transitional services and the HSS provider insists the Care Coordinator provides a service agreement, reach out to Partner.Relations@bluecrossmn.com to consult with the Partner Relations Subject Matter Expert (SME).

***HSS Providers:**
Providers must be a DHS enrolled HSS Provider and have all HSS services approved prior to billing Blue Plus. Approval for HSS must be obtained by following the requirements published by DHS. Once services are approved, a notification will be forwarded to Blue Plus for claims processing purposes.

Moving Home Minnesota

Moving Home Minnesota (MHM) is a federal demonstration project. The goal of this program is to promote transitions for people residing in qualifying institutions living with chronic conditions and disabilities an opportunity to return to an integrated community setting. 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 community residence. Care Coordinator must consult with the Partner Relations Team Subject Matter Expert (SME) prior to making a MHM referral to DHS. If the member meets the MHM eligibility criteria and is experiencing housing instability, refer to the *Housing Stabilization Services* section. Medical Assistance (MA) services and waivered services must be used first when the same service is available under the MHM program. For more information refer to the following resources *At a Glance – Relocation Resources (*see Care Coordinator Resources*)*, Moving Home Minnesota Demonstration and Supplemental Services Table, MHM section of the MHCP Provider Manual and MHM Lead Agency Responsibilities.

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 or other HCBS waiver. To be eligible for MHM, upon discharge, members must enroll in the elderly waiver or enroll in a disability waiver program (refer to exception of unforeseen circumstances prior to discharge). Select transition planning and transition coordination services may be allowable prior to the 60-day qualified institutional stay and up to 180 days prior to discharge. Ideally, members will require a comprehensive assessment (i.e., LTCC) within 60 days of discharge. This assessment will be used to determine their elderly waiver eligibility, if the services under the medical benefit and elderly waiver can meet the member's identified transitional needs and open the elderly waiver upon discharge. If the assessed needs can be met, 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 social worker, family member, etc.). When this occurs, a member of the Partner Relations Team will reach out to the Care Coordinator for more information. Referrals from a Care Coordinator should be sent using secure email to Partner.Relations@bluecrossmn.com for consultation and next steps.

MHM eligibility criteria:

1. Member resides for a minimum of 60 consecutive days (may include 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
2. Member is enrolled in MA prior discharge and throughout partcipation; **and**
3. Member will open to the elderly waiver unless the member is eligible to enroll in a disability waiver program at the time of discharge; **and**

4. 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 lockable entrance and exit doors; or
    - 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: As part of the authorization process, the member's MMIS screening document must indicate "Y" in the MHM indicator field. Do not enter service agreements into Bridgeview. Upon discharging from the qualifying institution, MHM transition coordination 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).

MHM services do not count towards the member's monthly elderly waiver case mix budget. For MHM services not available on MA or elderly waiver or other home community-based service waiver, those select MHM services may continue up to 365 days on one span. Upon the Care Coordinator notifying the Partner Relation Team SME of the member's discharge and services, the SME will work with the Care Coordinator and Bridgeview to enter MHM related service agreements.

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**.
5. 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

6. Americans with Disabilities Act (ADA)--Please contact your Partner Relations Consultant if you need assistance with addressing member ADA needs.

Compliance and Fraud Waste and Abuse (FWA)

Compliance and FWA training is required for anyone who supports our Blue Plus Medicare or Medicaid products including Care Coordinators, Case Aides, and Supervisors. It is required within 90 days of hire/contracting for new staff and yearly thereafter.

Compliance and FWA training can be completed in two ways:

- Complete the Blue Plus training created for all provider types, which includes Care Coordination at: Provider/FDR Medicare Training
- Complete equivalent Compliance and FWA training provided from another source (ie. counties, agencies, CMS).

Retain attestation at your agency.

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 must 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 (*see exception below). Members do not have coverage for services received from a provider who is not in our network unless it is emergency or urgently needed care. Members and Care Coordinators can refer to the Provider Directories located on our website keeping in mind the directory is not continuously updated throughout the year. For the most current network information, go to the Find A Doctor tool at bluecrossmn.com/public programs or call member services.

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. Refer to the member handbooks on our website.

Members should contact member services with coverage questions. Providers should contact provider services. See *Contact Information* section.

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 new enrollees/ existing members who want to use out of network PCA and State Plan Home Care providers, the Care Coordinator must follow the process outlined in the *Home Care Authorization* and *PCA Authorization Process* sections.

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 UTR Member Support Plan 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.