2024 BLUE PLUS
CARE COORDINATOR FALL TRAINING

Government Markets Partner Relations Team

October/November 2024

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AGENDA

- ❑ CMS Audit Overview
  - Lessons Learned About the Audit Process
  - Lessons Learned About File Reviews
    - Letters
    - Transitional Health Risk Assessments (THRA)
    - Nursing Home Care Plan
    - Transitions of Care
    - Addressing Assessment Results
    - Case Notes
- ❑ Review of Intro Letters
- ❑ Transitional Health Risk Assessment (THRA)
- ❑ CDCS Audits
- ❑ MnCHOICES Educational Audit Findings
- ❑ Model of Care
- ❑ Community First Support & Supports (CFSS)
- ❑ Determining last in-person assessment for EW Members in MMIS

Appendix:

- ❑Guidelines Updates
- ❑ 2025 Supplemental Benefits

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CMS AUDIT OVERVIEW

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THANK YOU

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LESSONS LEARNED ABOUT THE AUDIT PROCESS

Review audit protocol for potential additional work and universes that can/could be requested.

CMS Auditors can ask Blue Plus for an impact analysis into any area of the audit that they deem us to be non-compliant.

We need to communicate a more accurate timeline for our document requests. This timeline should reflect the time it may take us to review the selected members and create the emails.

We need to fully describe what it means for those who agree to be a "point of contact" for the audit. We need to be clear on the time commitment as we will have further questions/requests after the initial file request. We also need to be clear that other Delegates with no files selected may be needed during the audit to respond to requests for file information on transferred members.

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LESSONS LEARNED ABOUT THE AUDIT PROCESS

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If a selected member's Care Coordinator is Merit Certified, we will need to ask for proof of their related 4-year degree. This should be retained in each Care Coordinator's file at the Delegate agency.

We will ask for case notes in date order; it is a challenge if notes are sorted in different ways.

Delegates should review the member files they send for any concerns with documentation and alert auditors if found. This decreases the back and forth between us and the delegate, asking for additional documentation that may not exist, and allows us to be transparent with CMS.

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LESSONS LEARNED ABOUT FILE REVIEWS

Results	• Final audit results due at the end of October or early November. Information shared is based on CMS file reviews.
Letters	• Accurate support plan letters for refusals and UTR must be used • Ensure that at a minimum all selected on the ICT team are sent a support plan letter or select not requested
THRAs	• Do not use if the member is transferring from delegate to delegate or Blue Plus CC to Blue Plus CC
ursing Home Care Plans	• Facility plans that are reviewed need to have goals and interventions clearly defined.
TOCs	• When applicable, must update the Support Plan • Must contact member after discharge to new/usual care setting
Addressing Assessment Results	• If diagnosis/health concerns are included/noted on assessment, must be addressed
Case Notes	• To be used as a source of evidence, case notes must be thorough

LETTERS

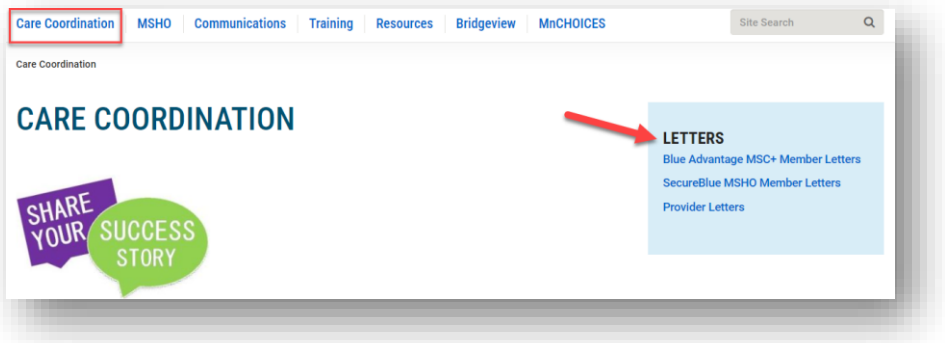
UTILIZING CORRECT BLUE PLUS LETTERS

Refer to Care Coordination Guidelines or checklists to ensure understanding/compliance with member/provider letter requirements.

- Example: Members who are UTR or refuse must receive the applicable Support Plan letter. PCPs must also receive the UTR-Refusal Support Plan Summary – Intro to PCP letter following timelines noted within guidelines/checklists.

Never use and save copies of Blue Plus letters on your computer.

- Always download and use letters from our Care Coordination website.



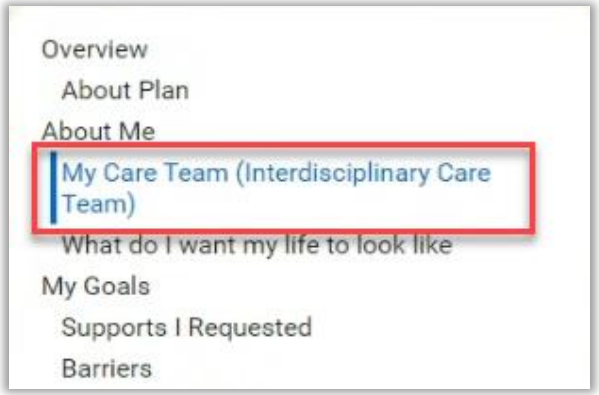
LETTERS/SHARING SUPPORT PLAN WITH ICT

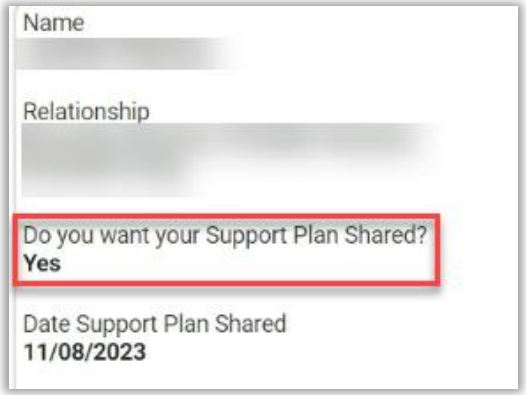
If a member chooses to share a copy of their Support Plan with an EW/PCA service provider, please refer to CC Guidelines under the heading *Service Provider Signature Requirements for sharing support plan information*.

- Send the EW/PCA Service Provider the Service Provider Support Plan Cover or Summary Letter for signature, following the timelines outlined in guidelines.

Additional Reminder: When a person or entity is listed within MnCHOICES as being part of member's ICT, it must be noted if member wants them to receive a copy of their Support Plan.

- **For any marked yes, please indicate date Support Plan shared & document in case notes.**





THRAS - CMS

THRAs **should not** be used when a member has a Blue Plus to Blue Plus Change in Care Coordinator or Change in Delegate (transfers) situations.

THRAs **can** be used:

- When a member is new to a Blue Plus product and has a current assessment **OR**
- An existing Blue Plus member has a current assessment (within 365 days) and has a product change.

NURSING HOME CARE PLAN

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The Nursing Home's Care Plan should demonstrate (at a minimum) :	• Goals • Interventions
What if this is not clear or on the Facility's Nursing Home Care Plan?	• CC **must** inquire about the above **and** ask NH to include/update Care Plan • **OR** discuss with NH and add missing elements to Blue Plus's 6.15 NH-ICF Assessment & Support Plan

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NURSING HOME CARE PLAN

Problem	Goal	Approach
Problem Start Date: 03/19/2024 ADL dependencies: Requires assistance with ADL's r/t weakness with severe COPD with chronic O2 use, chronic respiratory failure and SOB with exertion, at rest, and while lying flat. Edited: 05/24/2024	Goal Target Date: 07/11/2024 1. BED MOBILITY: Resident will be assisted as needed in bed mobility and will be free of avoidable skin breakdown through the review date. Edited: 05/24/2024	Approach Start Date: 03/19/2024 Has pressure redistributing mattress on bed. Resident spends majority of day in bed. Edited: 03/26/2024 Approach Start Date: 03/19/2024 Monitor for presence of pain/intolerance during bed mobility. Edited: 03/26/2024

Facility's Plan of Care:

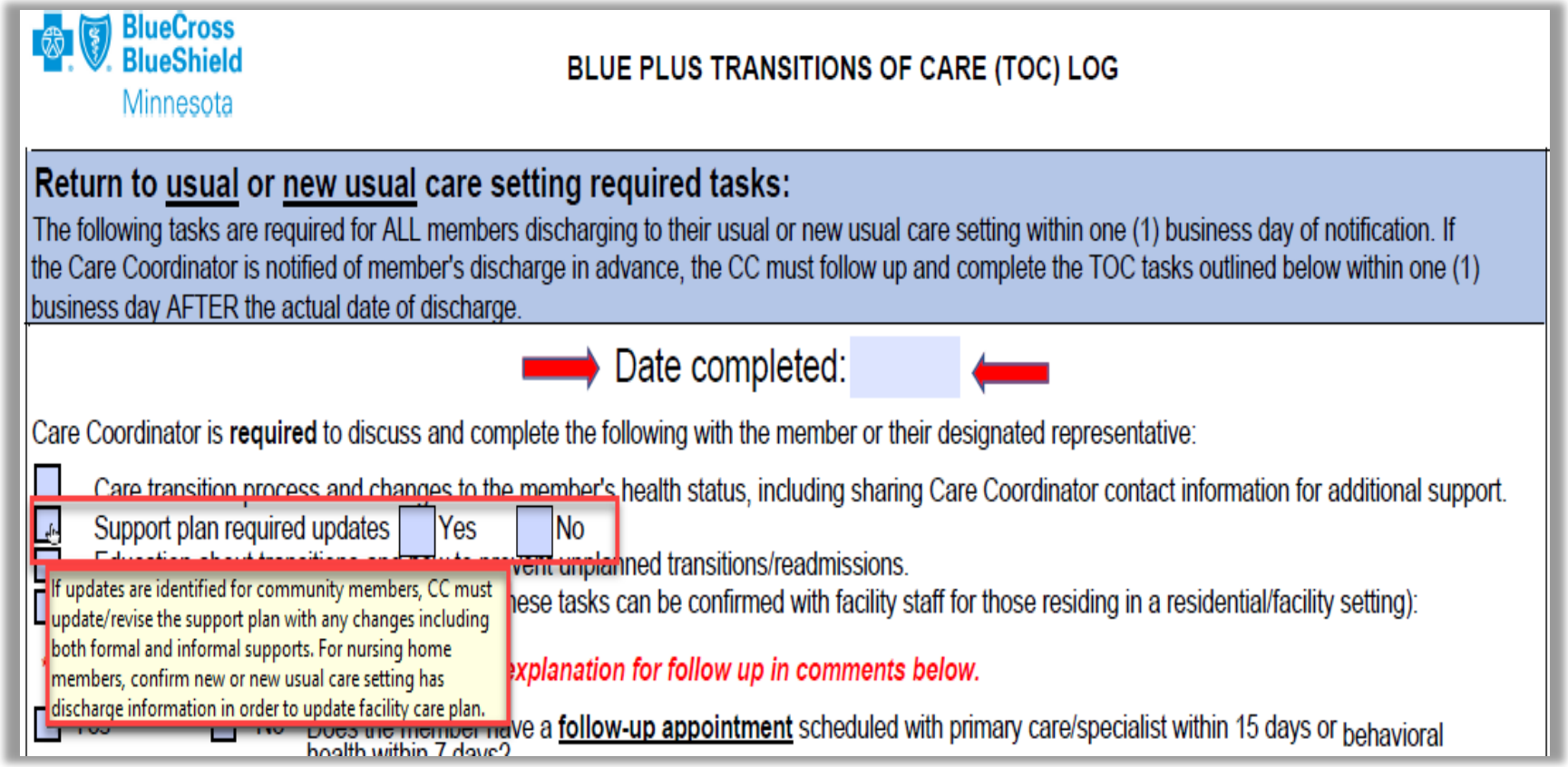
☐ I have reviewed the facility Plan of Care and Goals.

Comments:

Section to elaborate on Nursing Home Care Plan regarding Goals and interventions if applicable

TRANSITIONS OF CARE

Guidelines state the following about updating a member's support plan:



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BLUE PLUS TRANSITIONS OF CARE (TOC) LOG

Return to usual or new usual care setting required tasks:

The following tasks are required for ALL members discharging to their usual or new usual care setting within one (1) business day of notification. If the Care Coordinator is notified of member's discharge in advance, the CC must follow up and complete the TOC tasks outlined below within one (1) business day AFTER the actual date of discharge.

Date completed:

Care Coordinator is **required** to discuss and complete the following with the member or their designated representative:

Care transition process and changes to the member's health status, including sharing Care Coordinator contact information for additional support.

Support plan required updates Yes No

If updates are identified for community members, CC must update/revise the support plan with any changes including both formal and informal supports. For nursing home members, confirm new or new usual care setting has discharge information in order to update facility care plan.

transitions/readmissions.

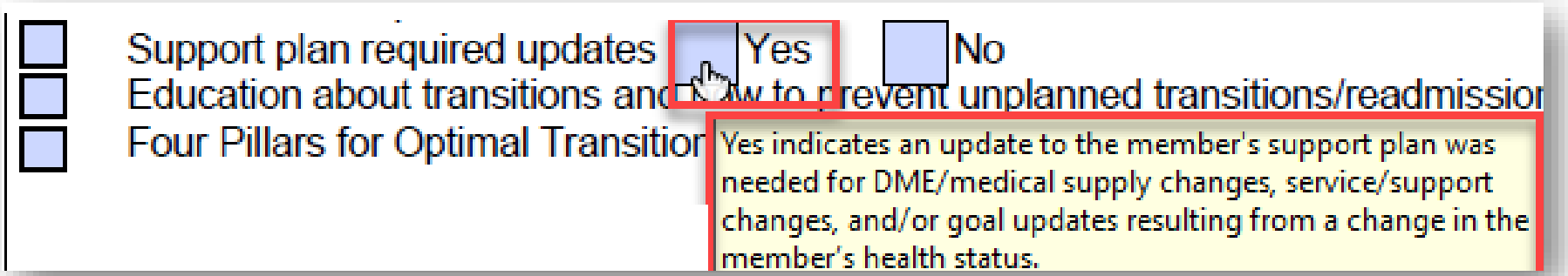
tasks can be confirmed with facility staff for those residing in a residential/facility setting):

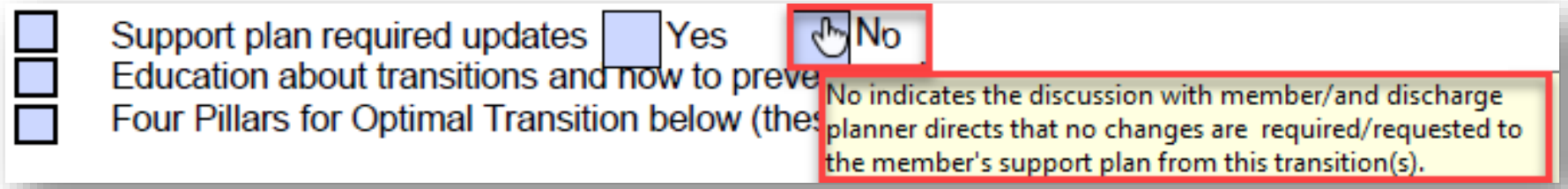
explanation for follow up in comments below.

ve a **follow-up appointment** scheduled with primary care/specialist within 15 days or behavioral

Please review in full the TOC section of Blue Plus's Care Coordination Guidelines.

TRANSITIONS OF CARE





ASSESSED NEEDS MUST BE CARRIED OVER TO SUPPORT PLAN/ASSESSMENT

CMS sent the intent for issuing Blue Plus a m*andatory improvement or a CAP* for this element. They documented that 10/30 members had support plans that did not address *ALL* diagnosis codes or health issues identified on the assessments.

Our response was that we believed the support plans did address issues identified in the health risk assessment based on:

- Each assessment is designed to identify the support, services and or programs to meet the individual member's needs. For LTCCs reviewed, the assessment gathers all diagnoses, past and present.
  - CMS expected to see support planning around all noted diagnoses.
- Each diagnosis alone may not impact the member's daily life and abilities or connect directly to a needed service or a goal.
- The Care Coordinator formulates the goals in collaboration with the member and the member's caregiver(s). Support plans are based on the needs identified in the assessment, which are then discussed to ascertain the member's preferences and desired outcomes.

ADDRESSING ASSESSMENT RESULTS

Our Model of Care states:

The contents of the Support Plan are based on the needs identified in the assessment and the member's preferences. Whichever HRA is used, the Care Coordinator is responsible for ensuring that any needs for supports and services – social services, elderly waiver services, specialty care, case or disease management programs, therapy programs, and self-management programs – identified through the HRA are addressed by the Support Plan.

The Care Coordinator is responsible for ensuring that any needs for supports and services – social services, elderly waiver services, specialty care, case or disease management programs, therapy programs, and self-management programs – identified through the LTCC/MHRA are addressed by the Support Plan. The Support Plan therefore reflects not only the primary, acute, and long-term care needs of the member, but their mental health, cognitive, and social service needs.

The Care Coordinator works with the member on medical and social issues (i.e. social, emotional, mental health, preventive care) and ensures each is accounted for on the member's support plan.

HOW TO ENSURE RESULTS OF ASSESSMENT ARE ADDRESSED

Care Coordinators must be vigilant!

An assessment that documents a health concern/diagnosis or an assessed need or risk must have them addressed in the Support Plan or in the assessment. This includes the documents that are reviewed by the Care Coordinator when completing a THRA.

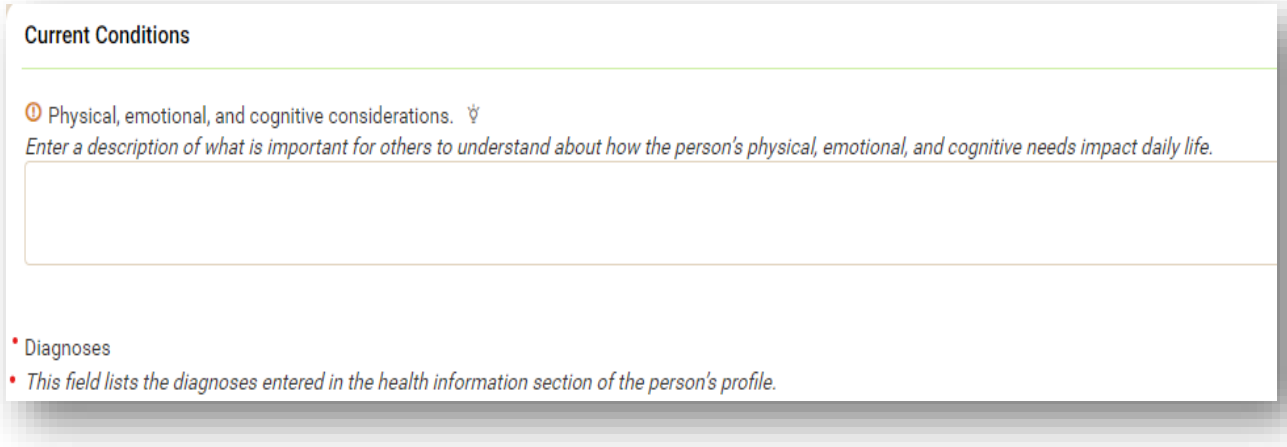
Document how it is addressed or not addressed by:

- Statement on how it is addressed in the plan with formal or informal support/service
- Adding as a goal
- Stating on support plan that it no longer requires support
- Stating it is being addressed by primary physician /specialist
- Stating member does not want to address in their support plan

For THRAs: When areas are not addressed on reviewed support plan/assessment, the above needs to be added to THRA /or the reviewed support plan. Reminder: this is now your support plan.

EXAMPLE CASE OF A NON-COMPLIANT SUPPORT PLAN

The member's assessment has Diabetes Mellitus and Major Depressive disorder pulled over from Health Information>Diagnoses into the assessment and is listed under Current Conditions. The assessment also states the member had psychosocial and emotional health needs and wanted a diabetic eye exam.



- The support plan did address managing their diabetes with a written goal and was listed as support needed for PCA service.
- The plan did not address other Major Depressive Disorder, responses to mental health questions in the assessment, or the diabetic eye exam. There was no mention of how these elements were being managed.

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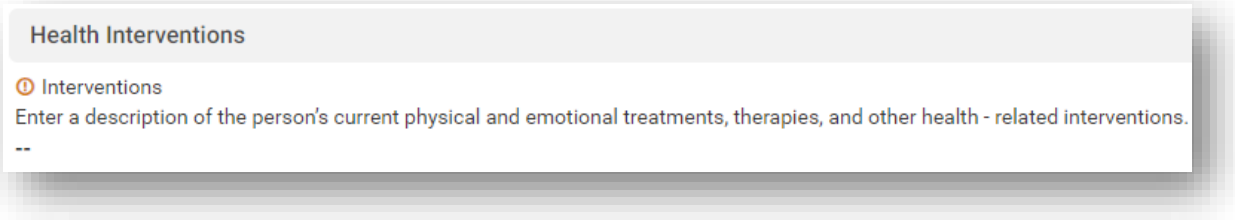
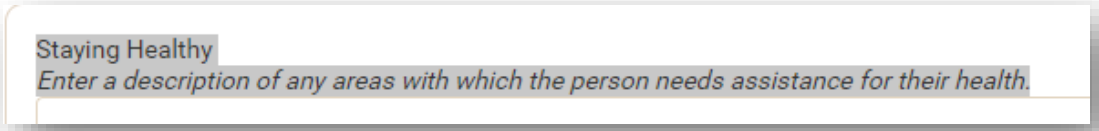
LOCATIONS TO DOCUMENT IN THE SUPPORT PLAN/ASSESSMENT

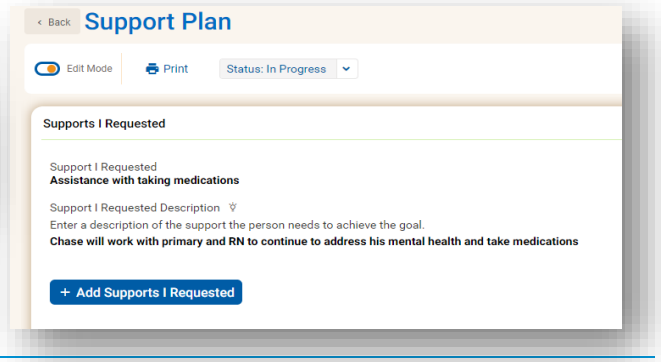
- There is an area under health interventions in the assessment that can have a statement about any of the areas of health and how they are being addressed (primary/medications/continued support of family)



- Care Coordinator could list, under case management support, that they were assisting the member with scheduling a Diabetes eye exam and add it as a goal.

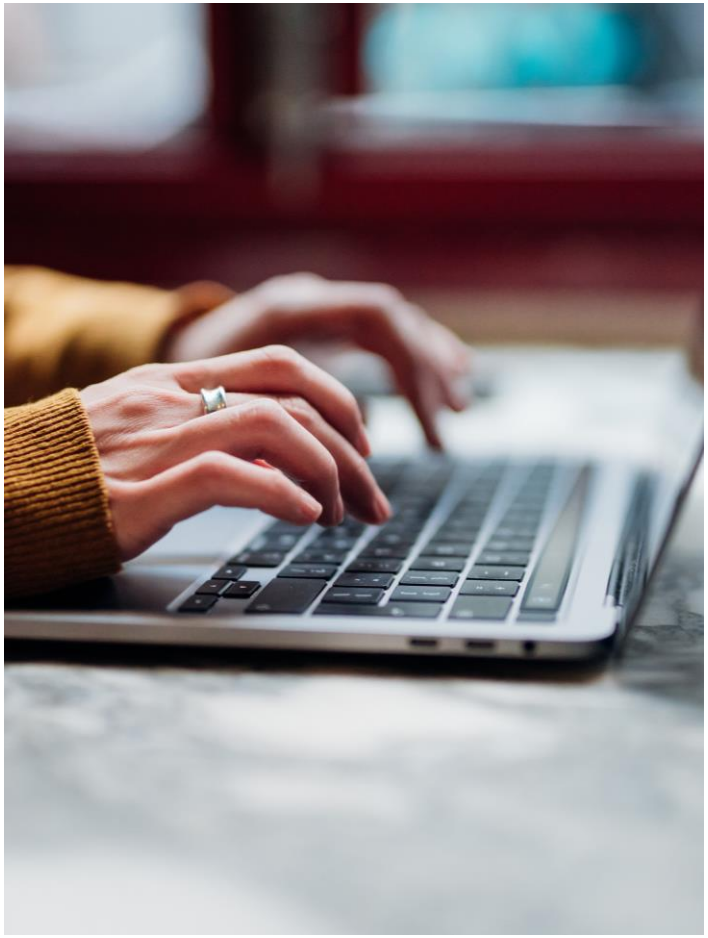
- CC can list any concerns, with the description of support, under "Staying Healthy" in the support plan or under “Supports/Requested.”





CASE NOTE EXPECTATIONS

- Who, what, where, when, why
- If it is not documented, it did not happen
- Be descriptive. Remember those who are reading it were not there. Must “paint a picture”.
- Source of truth: subjective vs. objective and stated vs. supported
- Make sure to clarify your actions i.e.
  - Writer sent the “Welcome Letter” to the member on 8-1-2024.



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BEST PRACTICE - EMAILS IN CASE NOTES

Summarize	Save	Reference	Highlight Key Information	Maintain Confidentiality
• Start by summarizing the key points of the email. • Include the sender, date, and main content. This helps to keep the case notes concise and focused.	• Save the email directly to a separate email folder. • This ensures that the full email is available for reference if needed.	• In your case notes, reference the email by noting that a detailed email is attached. • For example, “See saved email from [Sender] dated [Date] for detailed information.”	• Extract and highlight any critical information from the email that is relevant to the case. • This could include decisions made, actions required, or important updates.	• Ensure that any sensitive information in the email is handled according to your organization’s confidentiality policies.

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CASE NOTES EXAMPLES

Talked to NH Social Worker and requested needed documentation.

- CC talked to Good Samaritan NH Social Worker, Sara Miller, at 612.XXX.XXXX and requested a copy of the Nursing Home Care Plan by the end of this week.

CC contacted the DME provider to order incontinence products

- CC called APA and talked to Cate (last name unknown) and placed an order for 4 packages a month of chucks. CC called member to make them aware and asked them to contact this CC if they do not receive them within 10 business days.

Called around trying to find ICLS providers. Caremate noted they would call the client to schedule intake.

- CC called Best Care (talked to Bobbi Jo Ness) regarding ICLS who reported they have no staff. CC called Independent Living and left VM regarding ILCS services referral. CC called and talked to Caremate (Stormy Church) who noted they do have ICLS staff available. CC completed the ICLS referral and emailed it to Stormy at Caremate. Stormy at Caremate called CC and reported they would contact the member to set up an intake meeting next week. CC called member to provide them with this information and asked them to reach out if they do not hear from Caremate next week they let this CC know. CC completed the ICLS Planning summary and emailed it securely to Stormy at Caremate. CC updated the Support Plan to reflect ICLS services and sent an updated Support Plan to member.

CC received the FMS spending summary

- CC received and reviewed the FMS spending summary from PICs dated September 2024. Neither over or under spending is occurring at this time.

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REVIEW OF INTRO LETTERS

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INTRO TO PCP LETTERS

Change in Care Coordinator- Intro to PCP letter is for CC change purposes only.

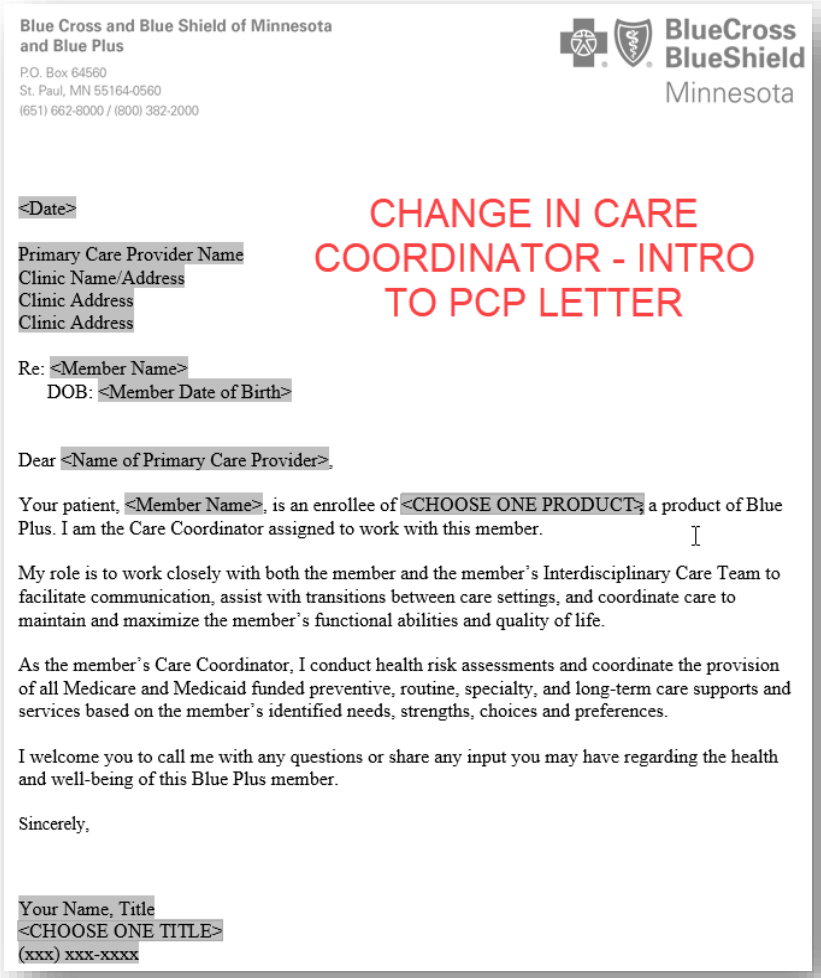
- Does not meet compliance requirements for sharing support plan summary info.

Change in Care Coordinator- Intro to PCP *letter* is only required in the following scenario:

- Change in Care Coordination
  - Internal transfers from one CC to another within the same delegate.
  - Case transfers from one delegate to a new delegate, when a member's product has **not** changed.

For DD/CADI/CAC/BI members, initially and if assigned CC changes, the ***8.39 Intro Letter to Other Waiver CM*** should be sent to the waiver CM.

INTRO LETTERS



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CHANGE IN CARE COORDINATOR - INTRO TO PCP LETTER

<Date>

Primary Care Provider Name
Clinic Name/Address
Clinic Address
Clinic Address

Re: <Member Name>
DOB: <Member Date of Birth>

Dear <Name of Primary Care Provider>,

Your patient, <Member Name>, is an enrollee of <CHOOSE ONE PRODUCT>, a product of Blue Plus. I am the Care Coordinator assigned to work with this member.

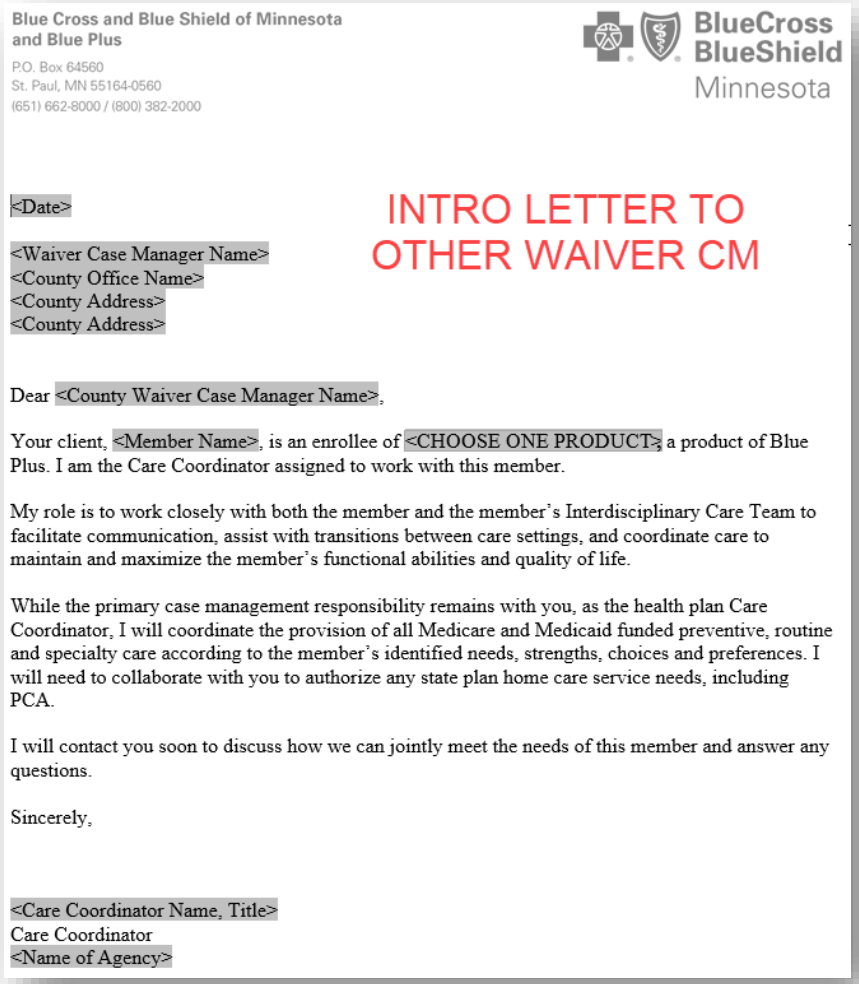
My role is to work closely with both the member and the member's Interdisciplinary Care Team to facilitate communication, assist with transitions between care settings, and coordinate care to maintain and maximize the member's functional abilities and quality of life.

As the member's Care Coordinator, I conduct health risk assessments and coordinate the provision of all Medicare and Medicaid funded preventive, routine, specialty, and long-term care supports and services based on the member's identified needs, strengths, choices and preferences.

I welcome you to call me with any questions or share any input you may have regarding the health and well-being of this Blue Plus member.

Sincerely,

Your Name, Title
<CHOOSE ONE TITLE>
(xxx) xxx-xxxx



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INTRO LETTER TO OTHER WAIVER CM

<Date>

<Waiver Case Manager Name>
<County Office Name>
<County Address>
<County Address>

Dear <County Waiver Case Manager Name>,

Your client, <Member Name>, is an enrollee of <CHOOSE ONE PRODUCT>, a product of Blue Plus. I am the Care Coordinator assigned to work with this member.

My role is to work closely with both the member and the member's Interdisciplinary Care Team to facilitate communication, assist with transitions between care settings, and coordinate care to maintain and maximize the member's functional abilities and quality of life.

While the primary case management responsibility remains with you, as the health plan Care Coordinator, I will coordinate the provision of all Medicare and Medicaid funded preventive, routine and specialty care according to the member's identified needs, strengths, choices and preferences. I will need to collaborate with you to authorize any state plan home care service needs, including PCA.

I will contact you soon to discuss how we can jointly meet the needs of this member and answer any questions.

Sincerely,

<Care Coordinator Name, Title>
Care Coordinator
<Name of Agency>

PCP SUMMARY LETTERS

The following letters combine the requirement to share a summary of a member's support plan and provide CC introduction to PCP:

Support Plan Summary Letter – Intro to Primary Care Provider

UTR-Refusal Support Plan Summary– Intro to Primary Care Provider

NH-ICF Post-Visit Summary Letter– Intro to Primary Care Provider

- Letters must be sent initially within 90 days of notification of enrollment AND after support plan/THRA completion.
- For reassessments, must be sent within 90 days of support plan completion.
- For use in the following scenarios:
  - New enrollment/Initials
  - Product changes
  - Annual Reassessments

❖ *IMPORTANT: Standalone Change in Care Coordinator - Intro to PCP letter is NOT required if one of the above combination letters is sent within the noted timelines.*

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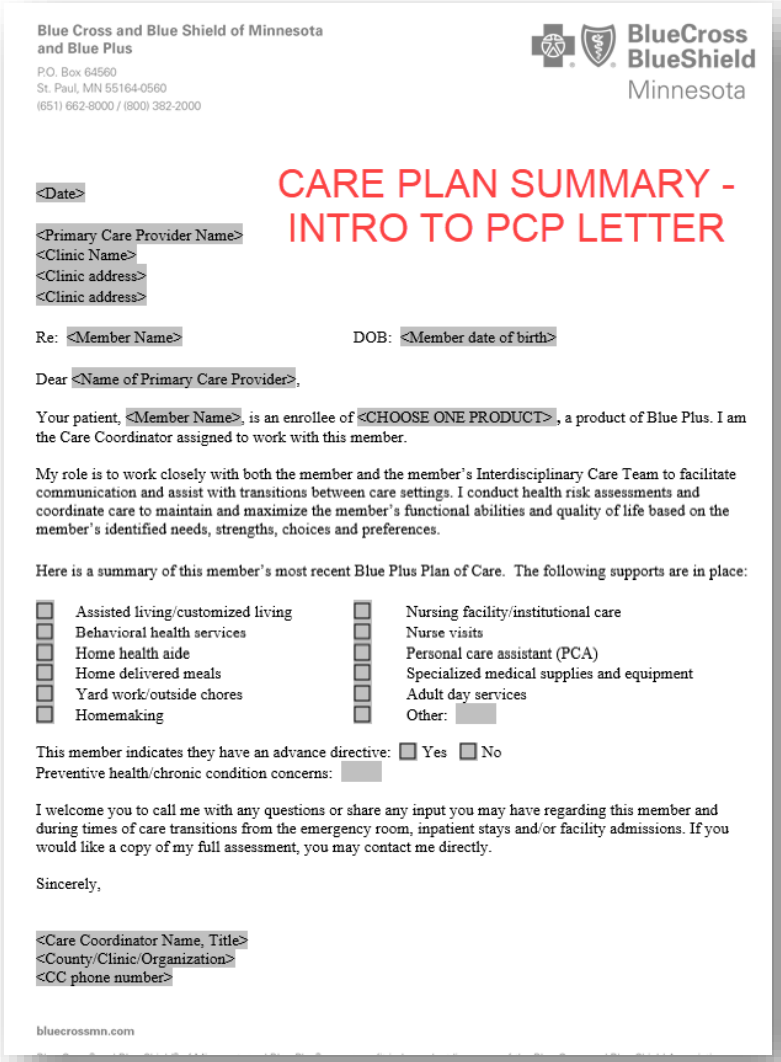
SUMMARY – INTRO TO PCP LETTERS



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CARE PLAN SUMMARY - INTRO TO PCP LETTER

<Date>

<Primary Care Provider Name>
<Clinic Name>
<Clinic address>
<Clinic address>

Re: <Member Name> DOB: <Member date of birth>

Dear <Name of Primary Care Provider>,

Your patient, <Member Name>, is an enrollee of <CHOOSE ONE PRODUCT>, a product of Blue Plus. I am the Care Coordinator assigned to work with this member.

My role is to work closely with both the member and the member's Interdisciplinary Care Team to facilitate communication and assist with transitions between care settings. I conduct health risk assessments and coordinate care to maintain and maximize the member's functional abilities and quality of life based on the member's identified needs, strengths, choices and preferences.

Here is a summary of this member's most recent Blue Plus Plan of Care. The following supports are in place:

- ☐ Assisted living/customized living
- ☐ Behavioral health services
- ☐ Home health aide
- ☐ Home delivered meals
- ☐ Yard work/outside chores
- ☐ Homemaking
- ☐ Nursing facility/institutional care
- ☐ Nurse visits
- ☐ Personal care assistant (PCA)
- ☐ Specialized medical supplies and equipment
- ☐ Adult day services
- ☐ Other:

This member indicates they have an advance directive: ☐ Yes ☐ No
Preventive health/chronic condition concerns:

I welcome you to call me with any questions or share any input you may have regarding this member and during times of care transitions from the emergency room, inpatient stays and/or facility admissions. If you would like a copy of my full assessment, you may contact me directly.

Sincerely,

<Care Coordinator Name, Title>
<County/Clinic/Organization>
<CC phone number>

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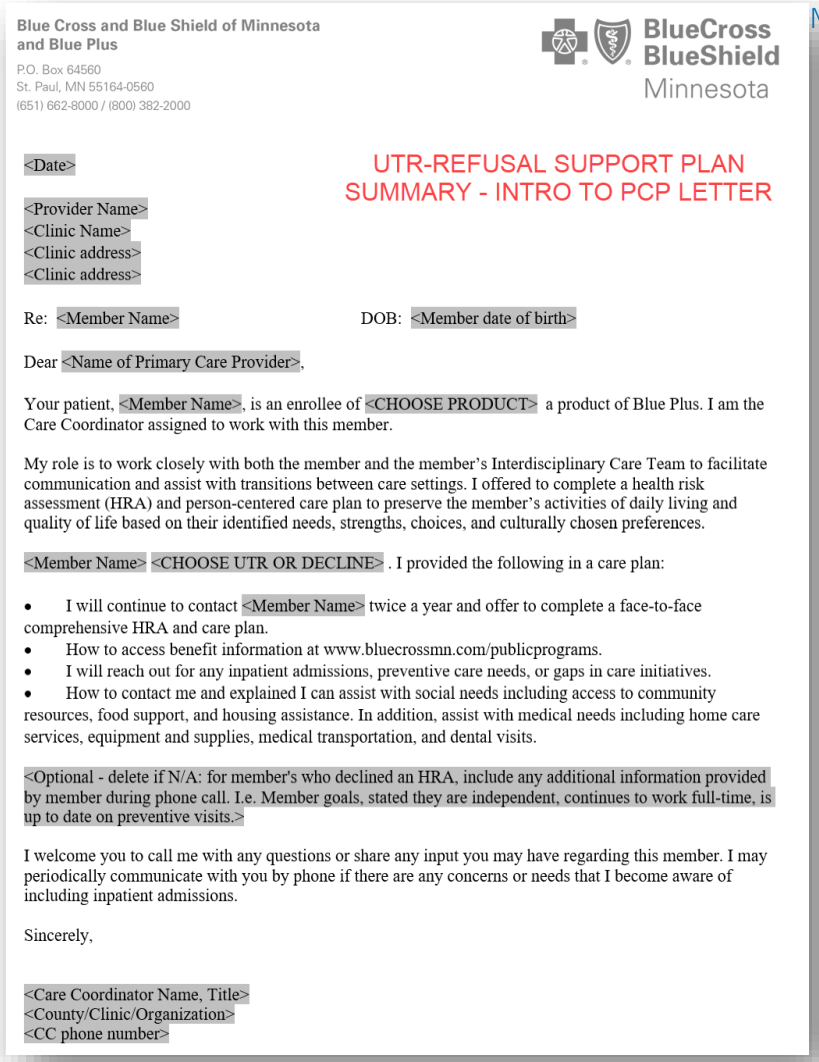

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UTR-REFUSAL SUPPORT PLAN SUMMARY - INTRO TO PCP LETTER

<Date>

<Provider Name>
<Clinic Name>
<Clinic address>
<Clinic address>

Re: <Member Name> DOB: <Member date of birth>

Dear <Name of Primary Care Provider>,

Your patient, <Member Name>, is an enrollee of <CHOOSE PRODUCT> a product of Blue Plus. I am the Care Coordinator assigned to work with this member.

My role is to work closely with both the member and the member's Interdisciplinary Care Team to facilitate communication and assist with transitions between care settings. I offered to complete a health risk assessment (HRA) and person-centered care plan to preserve the member's activities of daily living and quality of life based on their identified needs, strengths, choices, and culturally chosen preferences.

<Member Name> <CHOOSE UTR OR DECLINE> . I provided the following in a care plan:

- I will continue to contact <Member Name> twice a year and offer to complete a face-to-face comprehensive HRA and care plan.
- How to access benefit information at www.bluecrossmn.com/publicprograms.
- I will reach out for any inpatient admissions, preventive care needs, or gaps in care initiatives.
- How to contact me and explained I can assist with social needs including access to community resources, food support, and housing assistance. In addition, assist with medical needs including home care services, equipment and supplies, medical transportation, and dental visits.

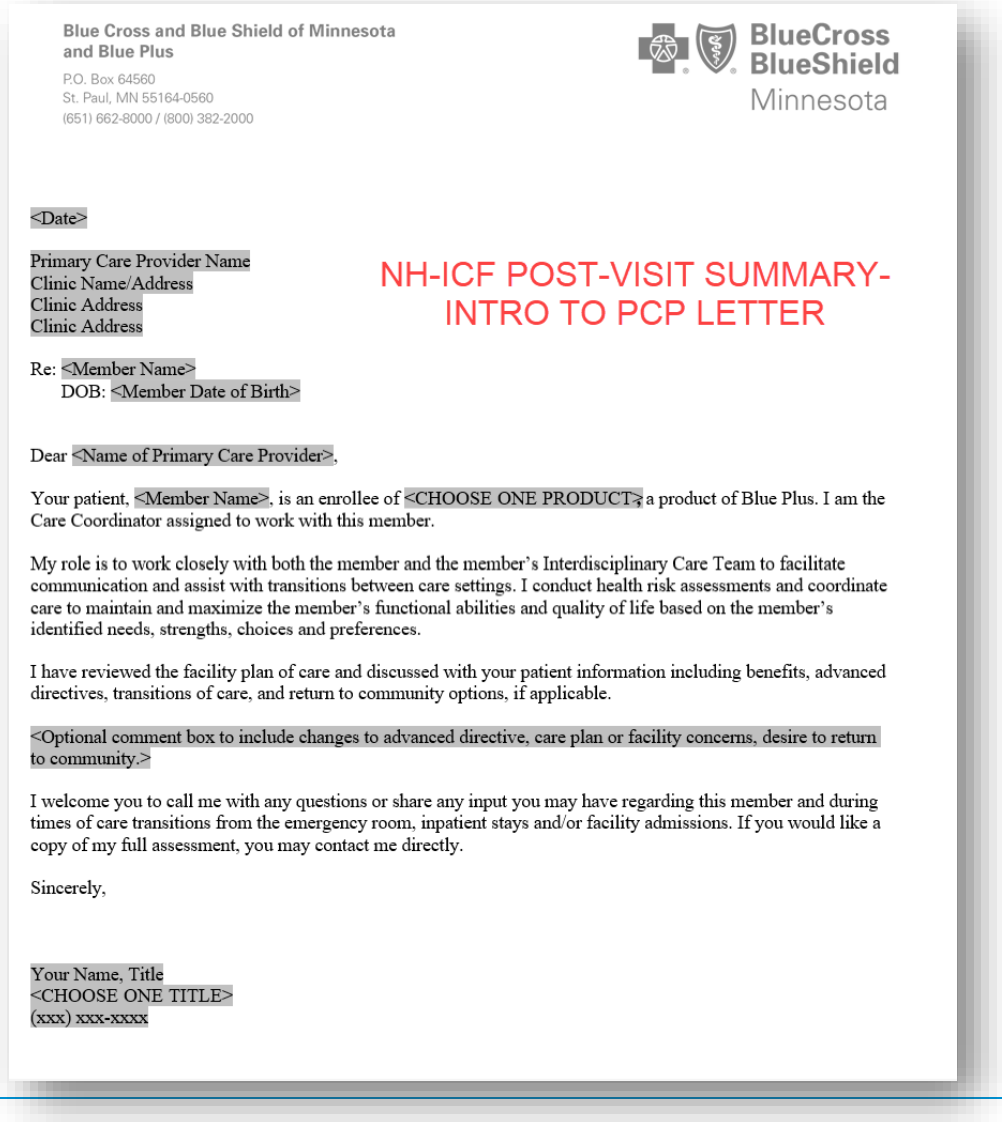
<Optional - delete if N/A: for member's who declined an HRA, include any additional information provided by member during phone call. I.e. Member goals, stated they are independent, continues to work full-time, is up to date on preventive visits.>

I welcome you to call me with any questions or share any input you may have regarding this member. I may periodically communicate with you by phone if there are any concerns or needs that I become aware of including inpatient admissions.

Sincerely,

<Care Coordinator Name, Title>
<County/Clinic/Organization>
<CC phone number>

SUMMARY – INTRO TO PCP LETTERS



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BlueCross BlueShield Minnesota

<Date>

Primary Care Provider Name
Clinic Name/Address
Clinic Address
Clinic Address

NH-ICF POST-VISIT SUMMARY-
INTRO TO PCP LETTER

Re: <Member Name>
DOB: <Member Date of Birth>

Dear <Name of Primary Care Provider>,

Your patient, <Member Name>, is an enrollee of <CHOOSE ONE PRODUCT> a product of Blue Plus. I am the Care Coordinator assigned to work with this member.

My role is to work closely with both the member and the member's Interdisciplinary Care Team to facilitate communication and assist with transitions between care settings. I conduct health risk assessments and coordinate care to maintain and maximize the member's functional abilities and quality of life based on the member's identified needs, strengths, choices and preferences.

I have reviewed the facility plan of care and discussed with your patient information including benefits, advanced directives, transitions of care, and return to community options, if applicable.

<Optional comment box to include changes to advanced directive, care plan or facility concerns, desire to return to community.>

I welcome you to call me with any questions or share any input you may have regarding this member and during times of care transitions from the emergency room, inpatient stays and/or facility admissions. If you would like a copy of my full assessment, you may contact me directly.

Sincerely,

Your Name, Title
<CHOOSE ONE TITLE>
(xxx) xxx-xxxx

TRANSITIONAL HRA (THRA)

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6.28 TRANSITIONAL HRA - BACKGROUND

Conduct a 6.28 Transitional HRA (THRA)* within 30 days of enrollment for MSHO or MSC+ EW or within 60 days of enrollment for MSC+ not open to EW when:

- New enrollees who have had an LTCC/3428H/MnCHOICES assessment (done either in the 1.0 or Revised MnCHOICES applications) within the previous 365 calendar days.
- New enrollees due to a Product Change (MSHO to MSC+ or MSC+ to MSHO) and had an LTCC/3428H/MnChoices assessment (done either in the 1.0 or Revised MnChoices applications) within the previous 365 calendar days.

*As always—if a significant health change is identified during the THRA, do not complete a THRA, must complete a full MnCHOICES or HRA-MCO.

THRA - WHAT YOU MUST DO

1. Complete 6.28 Transitional HRA form reviewing the current LTCC/3428H/MnChoices assessment and plan (done either in the 1.0 or Revised MnChoices applications.

2. Goal review requirements with THRA:

No Support Plan in MnCHOICES:

- CC must complete a new Support Plan in MnCHOICES using the existing assessment information.

Current Support Plan in MnCHOICES:

- Review each goal with the member and use the “revise” function.
- Comment that each goal was reviewed including the date.
- Add any new goals requested by the member.
- CC must document on the 6.28 Transitional HRA form in the goals section “See plan revision”.

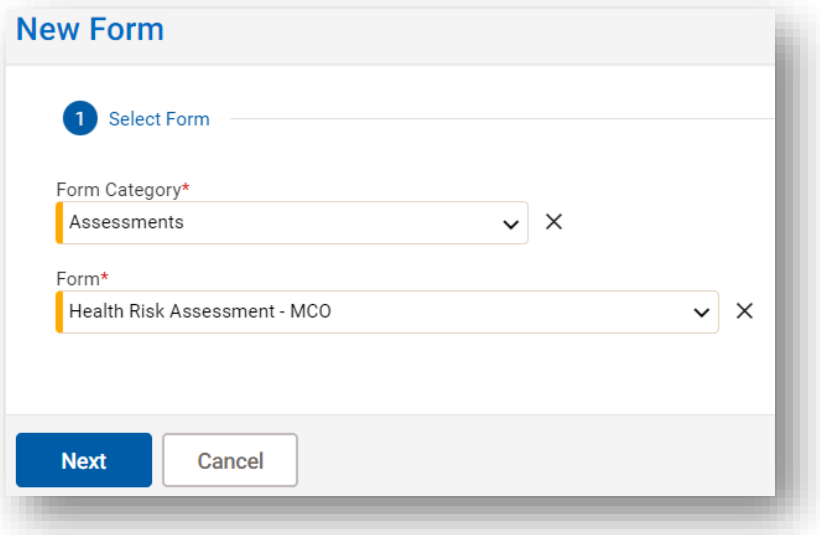
Confidential and proprietary.

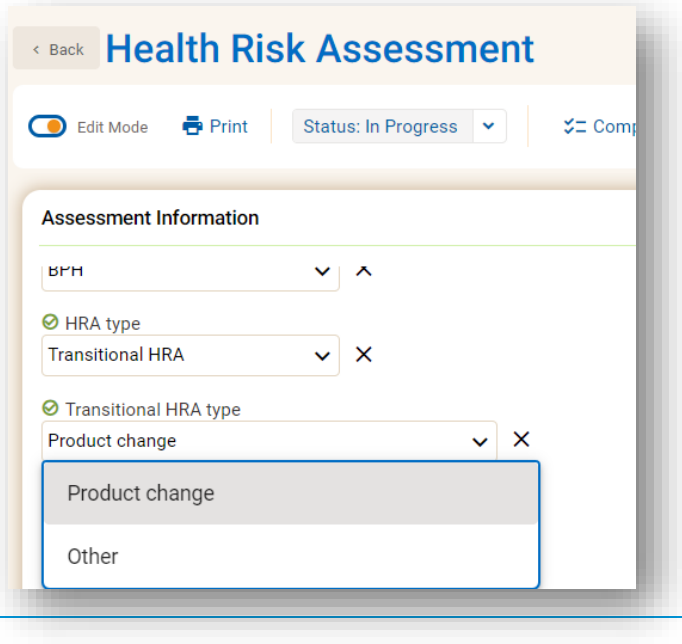
THRA - WHAT YOU MUST DO

BlueCross BlueShield Minnesota

3. Enter the Transitional HRA as a form type into MnCHOICES.

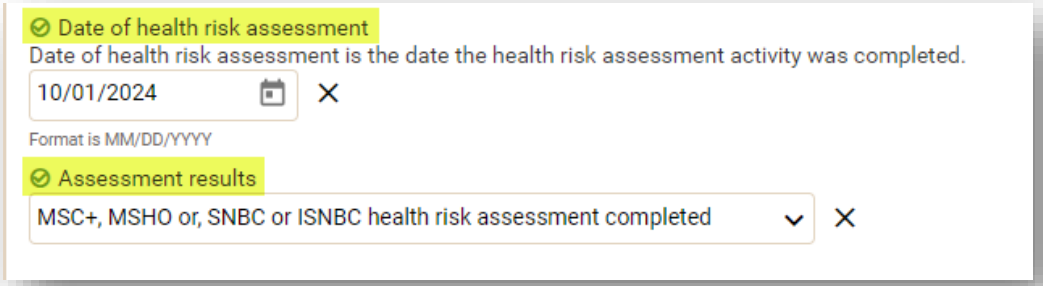
- Select “Health Risk Assessment – MCO
- HRA type “Transitional HRA”
- Transitional HRA type – choose “Product Change” or “Other”
  - Product Change = existing member MSHO to MSC+ or MSC+ to MSHO
  - Other = new enrollee from Fee for Service or another MCO





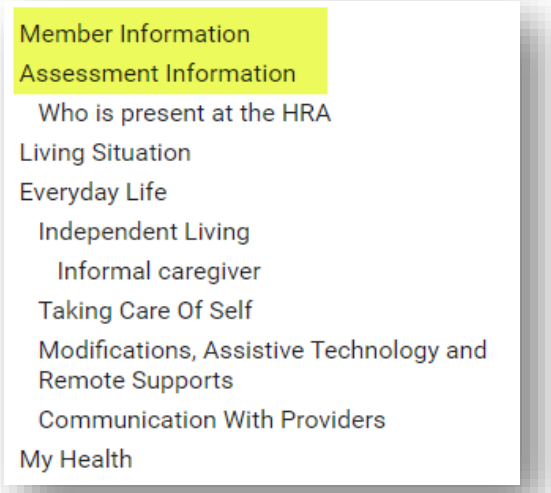
THRA - WHAT YOU MUST DO

- Enter the date of your review with the member/auth rep as the THRA assessment date.
- Select “MSC+, MSHO or SNBC or ISNBC health risk assessment completed” under Assessment results.



Complete these sections:

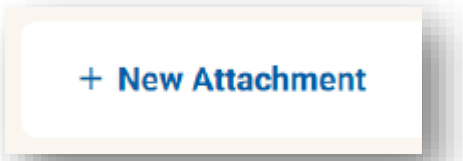
- Member Information
- Assessment Information

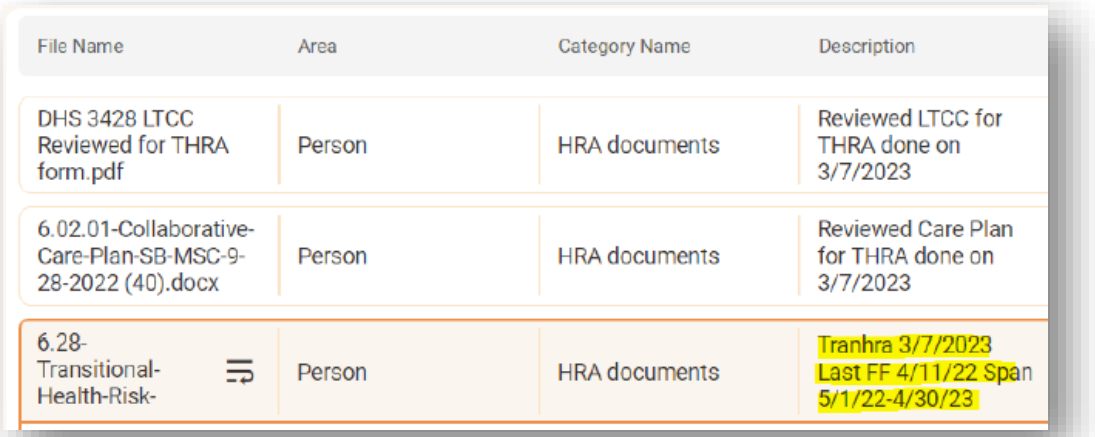


THRA - WHAT YOU MUST DO

4. Must attach the following into R-MnCHOICES with a clear Description of what the document is:

- A copy of the completed and signed 6.28 Transitional HRA form.
- And attach either:
  - a copy of the MnCHOICES assessment summary and CSSP if the previous assessment was completed in MnCHOICES 1.0. **Or,**
  - a copy of the previous LTCC/3428H and corresponding Care Plan, as applicable.
  - No need to attach these if they are already available in MnCHOICES.





File Name	Area	Category Name	Description
DHS 3428 LTCC Reviewed for THRA form.pdf	Person	HRA documents	Reviewed LTCC for THRA done on 3/7/2023
6.02.01-Collaborative-Care-Plan-SB-MSC-9-28-2022 (40).docx	Person	HRA documents	Reviewed Care Plan for THRA done on 3/7/2023
6.28-Transitional-Health-Risk-	Person	HRA documents	Tranhra 3/7/2023 Last FF 4/11/22 Span 5/1/22-4/30/23

THRA - WHAT YOU MUST DO

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5. Bridgeview entry:

- Enter both the date of the Transitional HRA and the date of the other assessment reviewed into Bridgeview following the process outlined in the Bridgeview Care Coordination User guide section titled *LTCC/MnCHOICES completed prior to enrollment*
- **OR**
- If Product change, enter the Transitional HRA assessment date following the process outlined in Bridgeview CC User Guide section titled *Transitional HRA for Product Changes for Community*
  - Remember: Select 6.28 TRANS HRA as the HRA Form used.

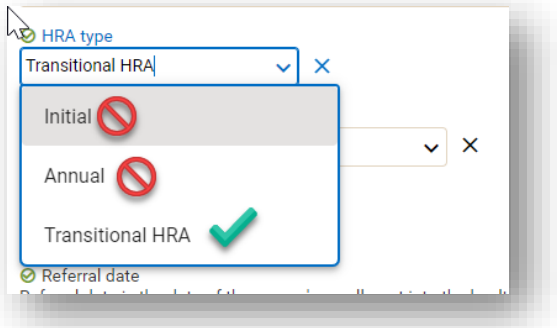
6. Schedule your reassessment within 365 days of previous assessment or if on EW, before the end of the waiver span and before EW cut off date.

(Do not schedule based on date of the 6.28 Transitional HRA)

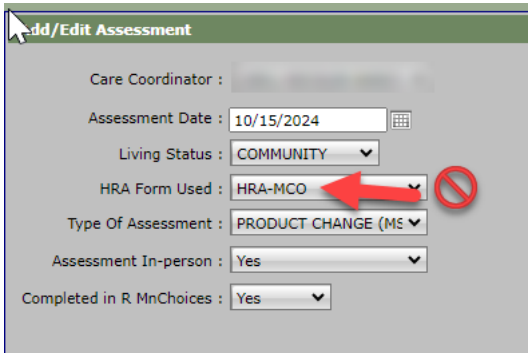
7. Follow normal process for authorizing services.

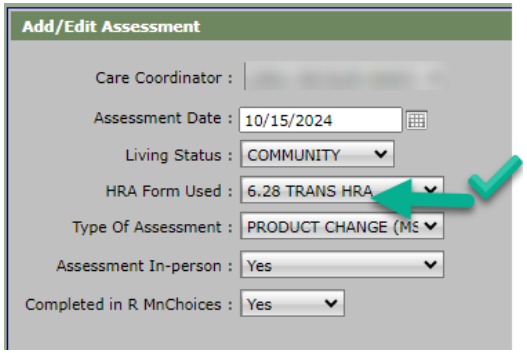
THRA - WHAT YOU MUST NOT DO

- Do not select “Initial or Annual” for HRA type when entering a THRA in R-MnCHOICES



- Do not conduct an HRA-MCO if your intention is to do a Transitional HRA.
- Do not do make two assessment entries in R MnCHOICES application to document THRA
- Do not record a THRA as HRA-MCO as the HRA Form Used in Bridgeview.





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THRA - WHAT YOU SHOULD NOT DO

Do not complete a Functional Needs Update—this is not considered an assessment and should not be used in lieu of our Trans HRA (until further notice).

Do not enter 6.28.01 Nursing Home Transitional HRA into MnCHOICES.

*As always, if you do not receive the previous assessment and care plan (completed within the last 365 days) to pair with it, you cannot complete a THRA.

THRA - NO SUPPORT PLAN COMPLETED

Can I complete a 6.28 THRA when I receive a new enrollee from Fee For Service (FFS) with an R MnCHOICES/MnCHOICES/HRA-MCO assessment completed within the last 365 days with no completed Support Plan?

Yes, only if you can review the completed assessment with the member and/or auth representative to ensure there are no significant health changes and create a support plan using the information from the reviewed assessment.

- Create an applicable support plan based on assessed needs with the member/auth rep
- Obtain and document support plan signature from member/auth rep and/or Providers, as applicable.
- Follow the normal process for conducting Transitional HRAs as previously outlined.

THRA - REFUSAL

If my new or existing member declines the 6.28 THRA for their initial/product change assessment, can we continue to authorize their existing MA or EW services?

- **Yes,** if the member has a current assessment, services are appropriate, no significant health changes, and is within their assessed case mix budget.
- Follow process for conducting Transitional HRA's as previously outlined. Only mbr or auth rep can decline. Send Member Refusal Support Plan letter within 30 days. Date assessment declined is assessment date for THRA entry. ***Note: Member cannot refuse reassessment and continue EW and other services. Follow DTR process.**

In Bridgeview	In R MnCHOICES Application
HRA Form Used: Select No Form	Form: Select HRA-MCO
	HRA Type: Select Transitional HRA
Type of Assessment: Select Refusal	THRA Type: Select Product Change or Other (Other = Initial)
	Assessment results: Person declines health risk assessment
IMPORTANT: Do NOT use this date to calculate the reassessment date.	

THRA - UNABLE TO REACH

If my new or existing member is unable to reach for their initial/product change (total of 4 attempts), can we continue to authorize their existing MA or EW services?

- **Yes,** if the member has a current assessment, services are appropriate and within their assessed case mix budget.
- Best practice is to contact existing service providers to assist in locating member.
- Should also send UTR Support Plan Letter. Date of letter (4th attempt) is assessment date. ***Note: Member cannot be UTR for their reassessment and continue EW and other services. Follow DTR process.**

In Bridgeview	In R MnCHOICES Application
*Must have total of 4 documented attempts. Only member or auth rep can decline assessment	Form: Select HRA-MCO
	HRA Type: Select Transitional HRA
HRA Form Used: Select No Form	THRA Type: Select Product Change/Other
Type of Assessment: Select Unable to Reach	Assessment results: Person not located for health risk assessment
Assessment in Person: Select No	
IMPORTANT: Do NOT use this date to calculate the reassessment due date.	

CDCS AUDITS

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CDCS REMINDERS

6532 CDCS CSP Must be signed by Member and/or Responsible Party before CDCS services start.

CC and/or supervisor must also sign.

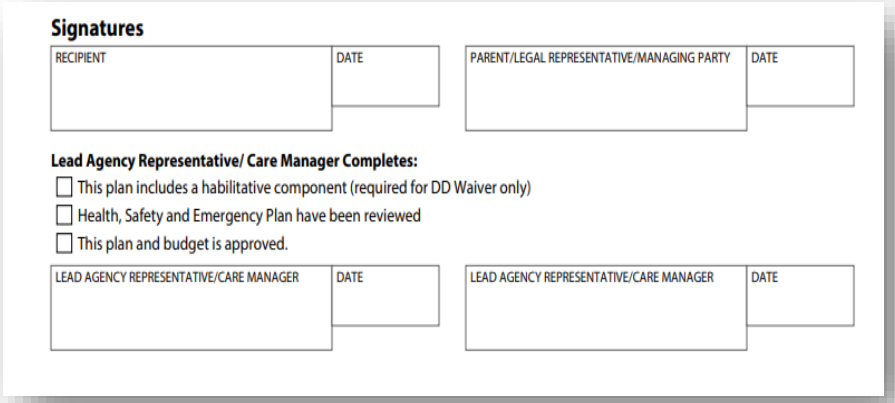
CC must provide the member with the legislative rate increase timely

Review FMS Expense summaries

- Frequency- review resource document
- Case Note that it was done

Sending a copy of the decision to SP, FMS, and member

- Case Note it was completed



Signatures

RECIPIENT	DATE	PARENT/LEGAL REPRESENTATIVE/MANAGING PARTY	DATE

Lead Agency Representative/ Care Manager Completes:

- ☐ This plan includes a habilitative component (required for DD Waiver only)
- ☐ Health, Safety and Emergency Plan have been reviewed
- ☐ This plan and budget is approved.

LEAD AGENCY REPRESENTATIVE/CARE MANAGER	DATE	LEAD AGENCY REPRESENTATIVE/CARE MANAGER	DATE

CDCS REMINDERS

Authorization of CDCS:

Not based on CDCS max, but on what is requested and approved.

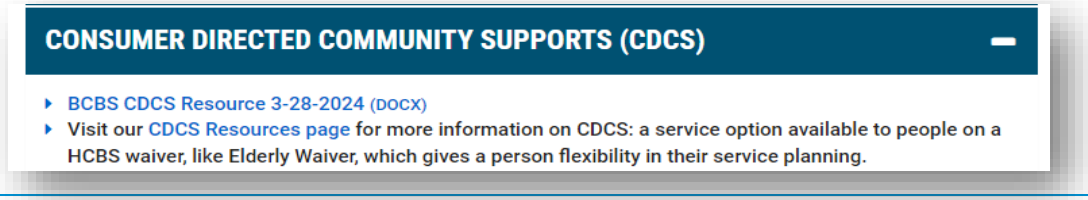
Separate Lines for:

- CDCS/FMS
- CDCS Background check
- Case Mgt
- Formal MA homecare services i.e., PCA, HHA, etc.(as applicable)

No other lines such as T2029 should be authorized

Keep copies of addendum/changes throughout span.

Refer to the CDCS Resource Guide on the Care Coordination website.



MNCHOICES EDUCATIONAL AUDIT FINDINGS

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MNCHOICES EDUCATIONAL AUDIT

94 files reviewed, 5 had no misses.

Observations:

- Missing Caregiver questionnaire attachment
- No documentation of CC on support plan under either Services and Supports for CW or People and Organizations that Support Me for EW
- No documentation of Safe disposal of medications
- No documentation of MSHO Program/Supplemental Benefits Discussion
- All service needs were not listed or addressed in Support Plan
- Missing documentation for date letter sent to PCP
- Lack of signature attachments
- Support Plans and/or assessments not in closed/completed status

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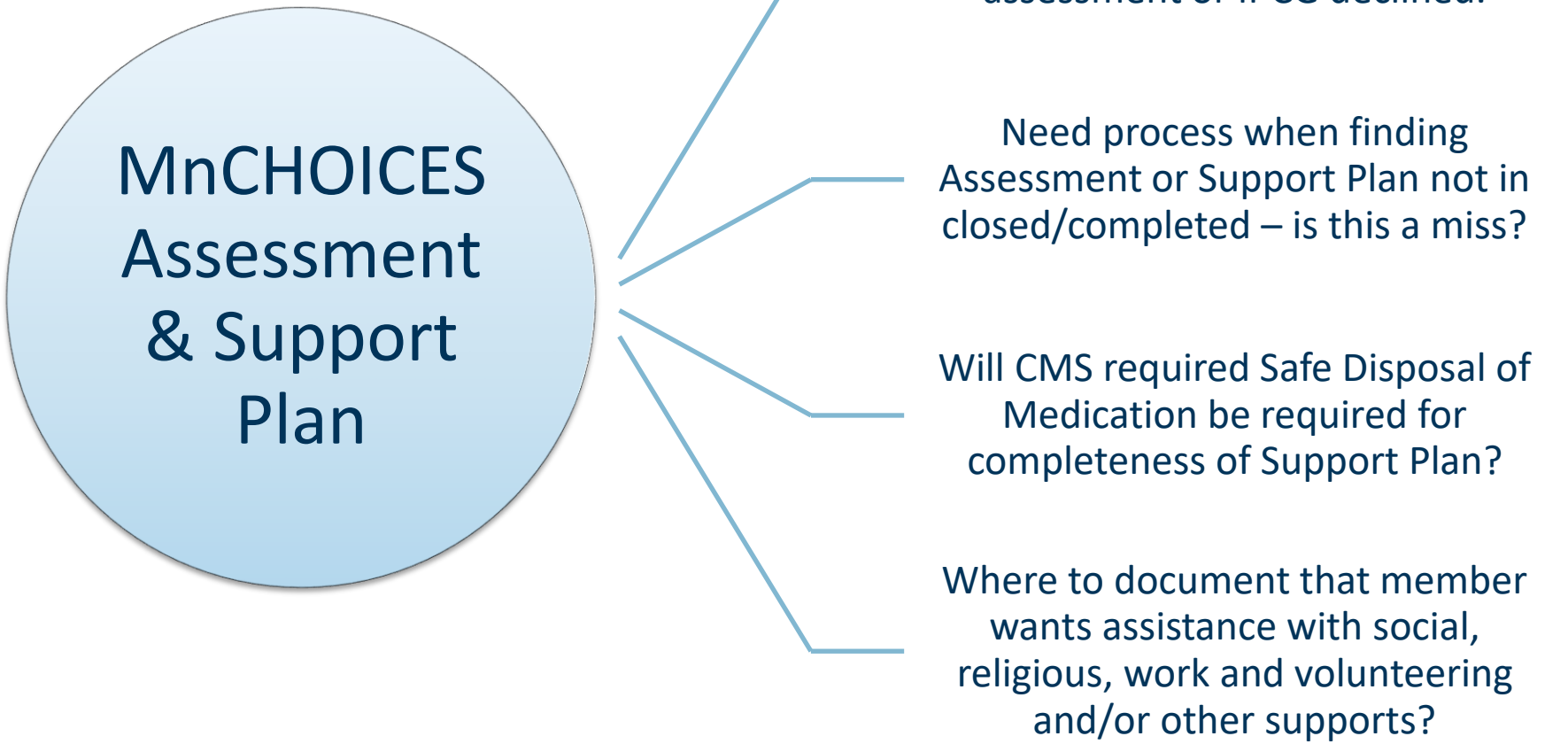
RECOMMENDATIONS SHARED W/DHS



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RECOMMENDATIONS SHARED W/DHS

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- Clarification on how CC enter risk when not pulled from assessment, and how to document no risk plan is needed.
- Required Support Plan print for CW looks different from EW. CW support plan lists Primary Doctor on page 2 with "Date Support Plan Shared with the Primary Doctor" noted, EW does not.
- How to know if member did not want support plan sent? What if it is blank, is that ok for audit purposes?
- When there is a revised support plan is there a way to pull out what has changed? (ie. could there be a date field added?)

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RECOMMENDATIONS SHARED W/DHS CONT.

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Health Risk Assessment and Support Plan

- As with EW, no area in the support plan to document plan for managing risks or state no risk planning needed. Only "My Plan to Address Safety Needs". If a requirement, we need to instruct where to document.

- Choice of Individuals to receive support plan: how do we know if member did not want support plan sent, has to be pulled over, what if it is blank - is that ok for audit purposes?

MODEL OF CARE

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association.

2025 MODEL OF CARE

The Model of Care is a CMS required quality improvement tool that ensures the unique needs of each of our members are identified and addressed. Your role is to follow our Model of Care to address and fill any gaps in care our members may have. It is the shell for the work you do.

All health plans are required to have a Model of Care, but how each health plan meet those needs may differ slightly.

Anytime there is a suggested change to be made to a process, we must determine if/how it impacts our Model of Care and address it with CMS and DHS as needed.

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2025 MODEL OF CARE

Goals of the MOC:

- Ensure access to affordable healthcare services
- Ensure coordination of care across payers and care settings
- Improve health outcomes
- Reduce avoidable hospitalizations
- Facilitate appropriate use of services

Submitted to CMS (and DHS) at least every 3 years

Annual required MOC training ensures that care coordinators are educated, aware and will adhere to the MOC to deliver care and services to SecureBlue MSHO members.

2025 MODEL OF CARE

CMS requires that all Special Needs Plans have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA).

SecureBlue MSHO is a Special Needs Plan (SNP) for members dually eligible for both Medicare and Medicaid (D-SNP)

The SecureBlue MOC:

- provides the framework for how Blue Cross identifies and addresses the unique needs of our members
- promotes quality, care management, and care coordination processes
- includes MN DHS elements related to MN's Managed Long-Term Care Services and Supports requirements

2025 MODEL OF CARE

BlueCross BlueShield Minnesota

The Model of Care describes our **SecureBlue population**:

Frail and vulnerable:

Average age 78 yrs, many members live alone, approx. 80% of members live in the community

High need for social supports:

40% are eligible for Home and Community Based Services

Poor socioeconomic status:

34.5% income level less than $10,000 per year

Low health literacy:

23% did not complete high school

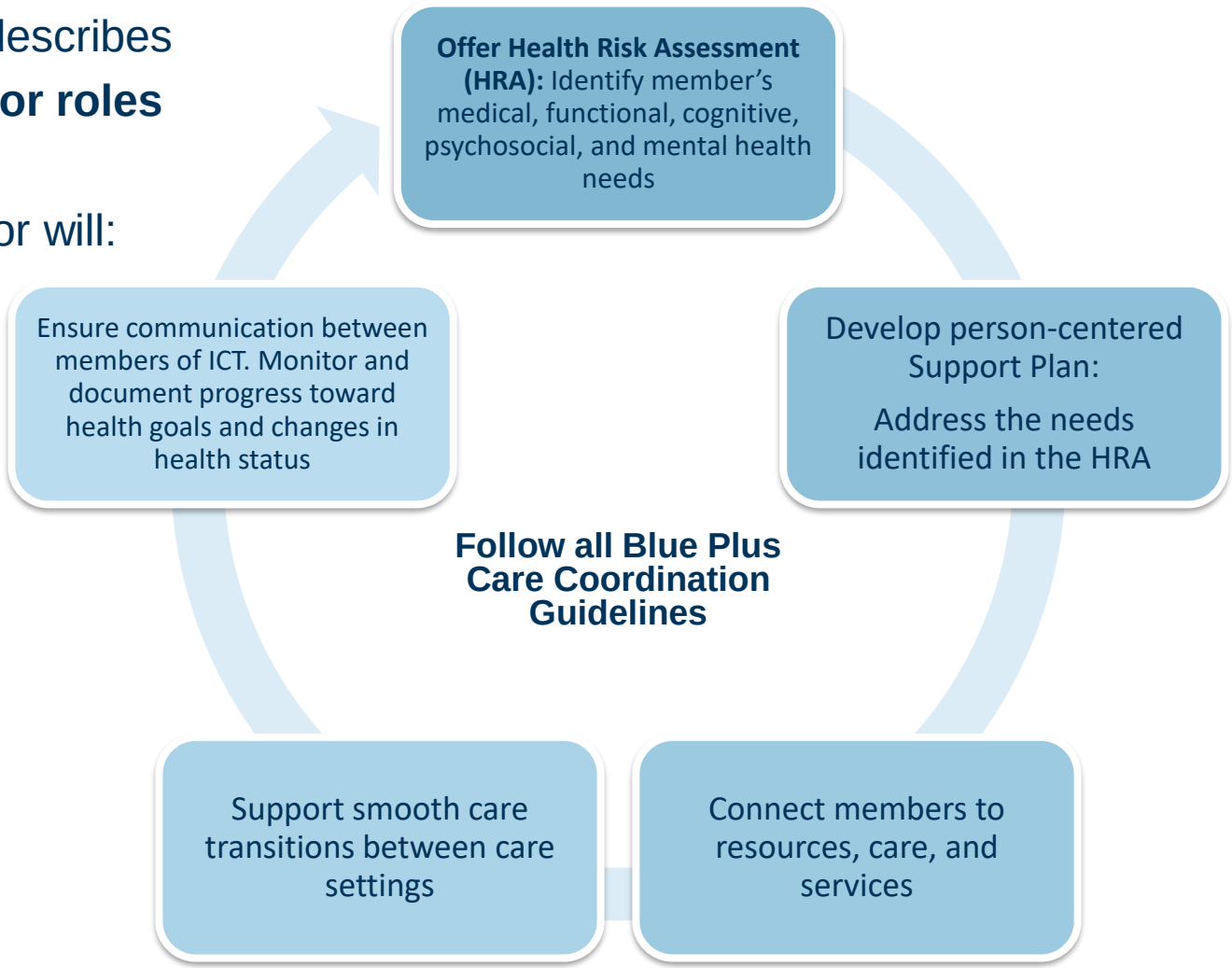
Complex medical needs and chronic condition management

Cognitive and sensory impairments

2025 MODEL OF CARE

The Model of Care describes our **Care Coordinator roles and processes.**

The Care Coordinator will:



2025 MODEL OF CARE

The Model of Care describes our **Quality Measures and Goals** including:

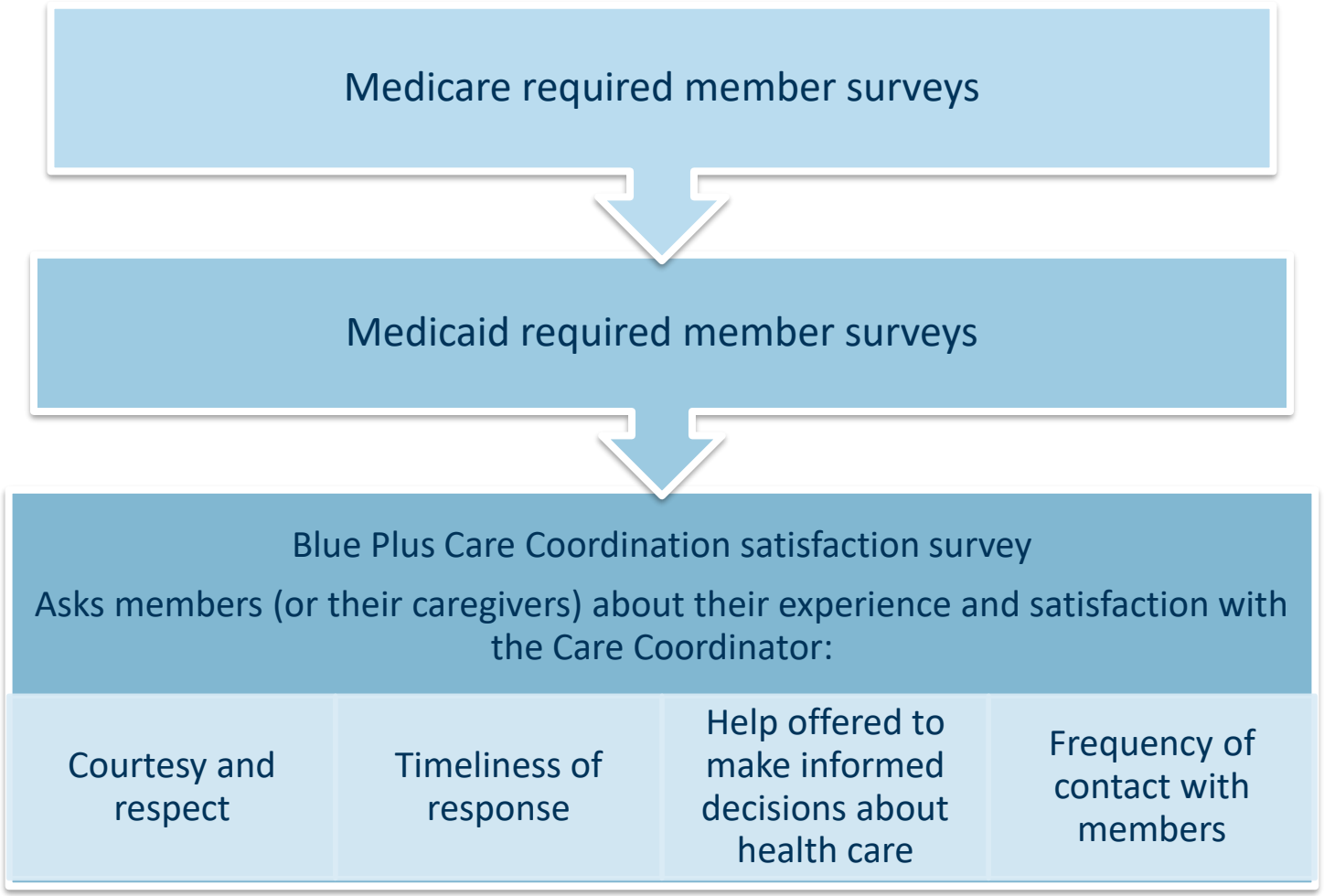
- Improving member and community health across the continuum of care by removing barriers to preventive and chronic condition care
- Improving social factors that contribute to health

- Enhancing the member experience by ensuring ease and understanding throughout the member journey by intentionally building a member journey that makes health care easy to understand
- Eliminating health inequities in health outcomes by building an enterprise culture of equity and inclusion

Confidential and proprietary.

2025 MODEL OF CARE

The Model of Care describes our **Member satisfaction surveys** including:



2025 MODEL OF CARE

CMS requires all staff working with our MSHO members complete SNP-MOC training upon hire and annually thereafter:

- Newly hired CC's review the most recent fall training slides.
- Each Delegate should maintain all records of attendance. Do not send to Blue Plus.

COMMUNITY FIRST SERVICES AND SUPPORTS (CFSS)

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CFSS DEFINITION | TIMELINE

Definition	Timeline
Community First Services and Supports (CFSS) is a Minnesota health care program that offers flexible options to meet the unique needs of people.	CFSS has replaced PCA services on Oct 1, 2024.
CFSS allows people greater independence in their homes and communities.	MCO's will transition current PCA members at the time of their reassessment. There will be a 3-month transition period for current PCA members.
CFSS will replace personal care assistance (PCA) and the Consumer Support Grant (CSG).	Bridgeview is working to add all CFSS services codes. Currently the only service available for entry in BV is Consultation Services.

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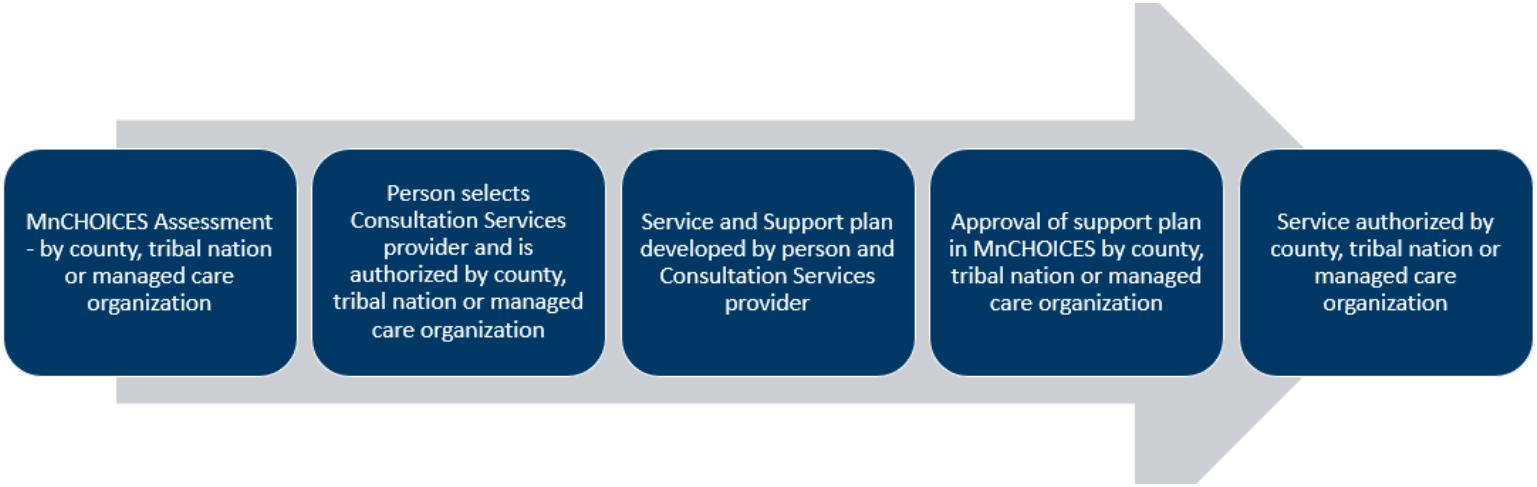
CFSS PROCESS

CFSS will cover services previously provided under PCA and CSG and add additional services, for example:

- Consultation Services
- Worker Training and Development
- Goods/Services
- Personal Emergency Response System (PERS)

The program offers more flexible options to better meet individual needs and helps people maintain greater independence in their homes and communities.



CFSS SERVICE MODELS | ELIGIBILITY

Service Models

Agency Provider Model:

- Member selects agency that serves as their worker's employer. Agencies will recruit, hire, train, supervise and pay support workers.

Budget Model:

- Member is the employer of their support workers.

Eligibility

Members eligible for PCA are eligible for CFSS.

- Live in the community and not a facility such as a SNF.
- Be able to direct care or have a representative who can direct care on their behalf.
- Be enrolled in one of Minnesota's health care programs.
- Have an assessment that determines eligibility.
- Not on the Family Support Grant.

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CFSS RESOURCES

Lead agency staff should complete Community First Services and Supports (CFSS) for Lead Agencies in Trainlink

- Search for “CFSS_LA.”

Community First Services and Supports | Policy Manual

CFSS

Tip Sheet coming soon…

TIMELY EW REASSESSMENTS

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TIMELY EW REASSESSMENTS

Timely RAs means that **all** the following elements have been met (whichever one comes first):

- Assessment is completed within 365 days of the previous assessment, **AND**
- before the waiver span end date, **AND**
- is entered into MMIS on or before the applicable month's cut-off date.

What MMIS Screening Document Activity Types should be used to calculate reassessment due dates?

- 02 – Person to Person Assessment
- 04 – Relocation/Transition Assessment
- 06 – Reassessment
- 08 – BI/CAC/CADI Reassess 65th Birthday

The above activity types **may** indicate an in-person assessment – validate in-person status through other means if member chooses to complete RA remotely.

- For detailed info on remote assessments, refer to Blue Plus Care Coordination Guidelines.

TIMELY EW REASSESSMENTS

Activity Types that **should not** be used when calculating EW reassessment dates:

- 05 – DOC CHG
- 09 – ELIGIBILITY UPDATE
- 07 – ADMIN ACT
- 01 – TEL SCREEN
- 39 – REFUSAL (FOR EW, WOULD ONLY SEE FOR A THRA)
- 50 – UTR (FOR EW, WOULD ONLY SEE UTR FOR A THRA)
- 10 – SERVICE CHANGE

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TIMELY EW REASSESSMENTS

Assessment entry for all members on EW

Elderly Waiver re-assessments must be completed by and entered into MMIS prior to the cut-off dates listed below in addition to being timely within 365 days of the previous assessment.

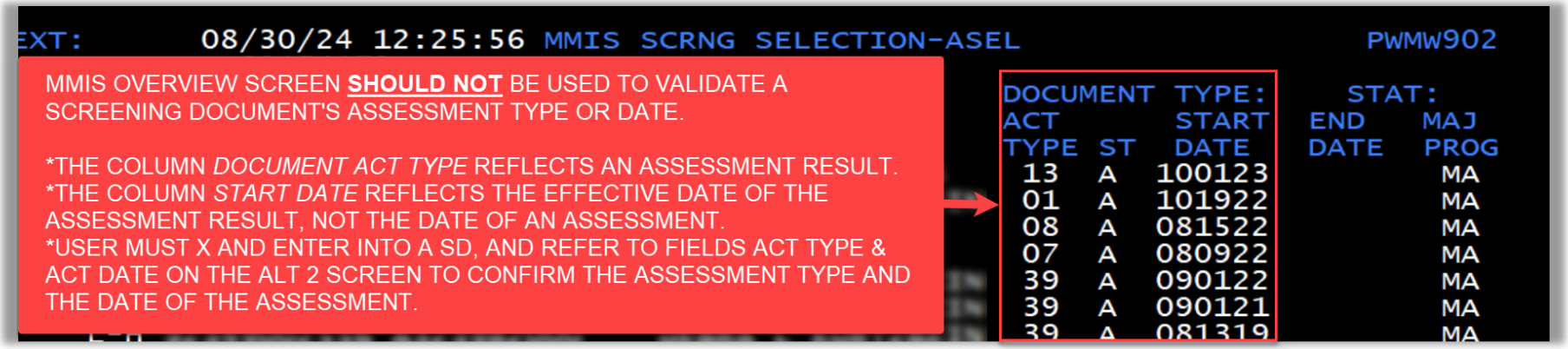
When MMIS entry is late and results in EW closure, the member reverts to rate cell A (community well) status. It may also impact their medical spenddown/elderly waiver obligation, if applicable. When the waiver span lapses, Blue Plus continues to pay out EW claims for these members without the correct reimbursement from DHS.

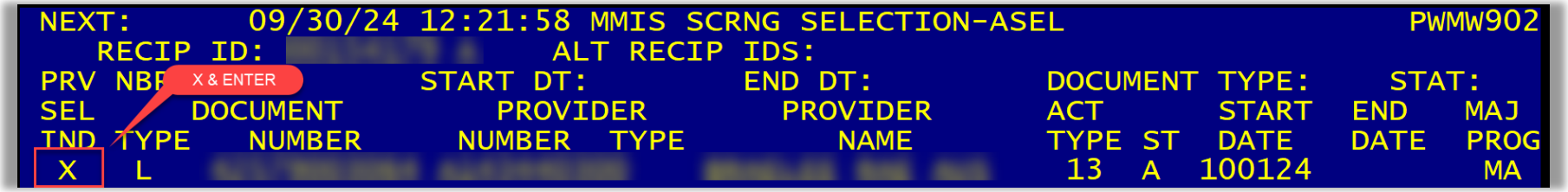
(These dates are one day earlier than DHS capitation dates):

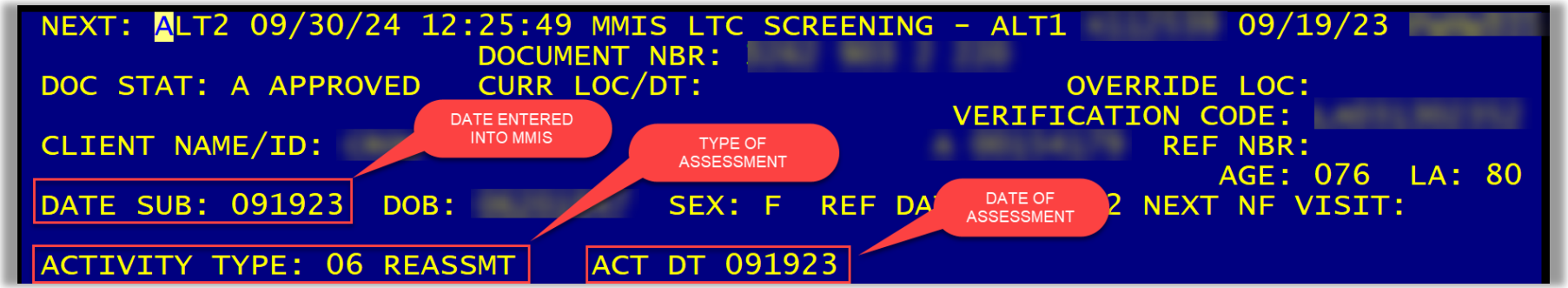
When the first month of the waiver eligibility span is:	Last Day to enter timely screening document into MMIS is:
January 2024	12/20/2023
February 2024	1/23/2024
March 2024	2/21/2024
April 2024	3/21/2024
May 2024	4/22/2024
June 2024	5/22/2024
July 2024	6/20/2024
August 2024	7/23/2024
September 2024	8/22/2024
October 2024	9/20/2024
November 2024	10/23/2024
December 2024	11/19/2024
January 2025	12/20/2024

TIMELY EW REASSESSMENTS

BlueCross BlueShield Minnesota

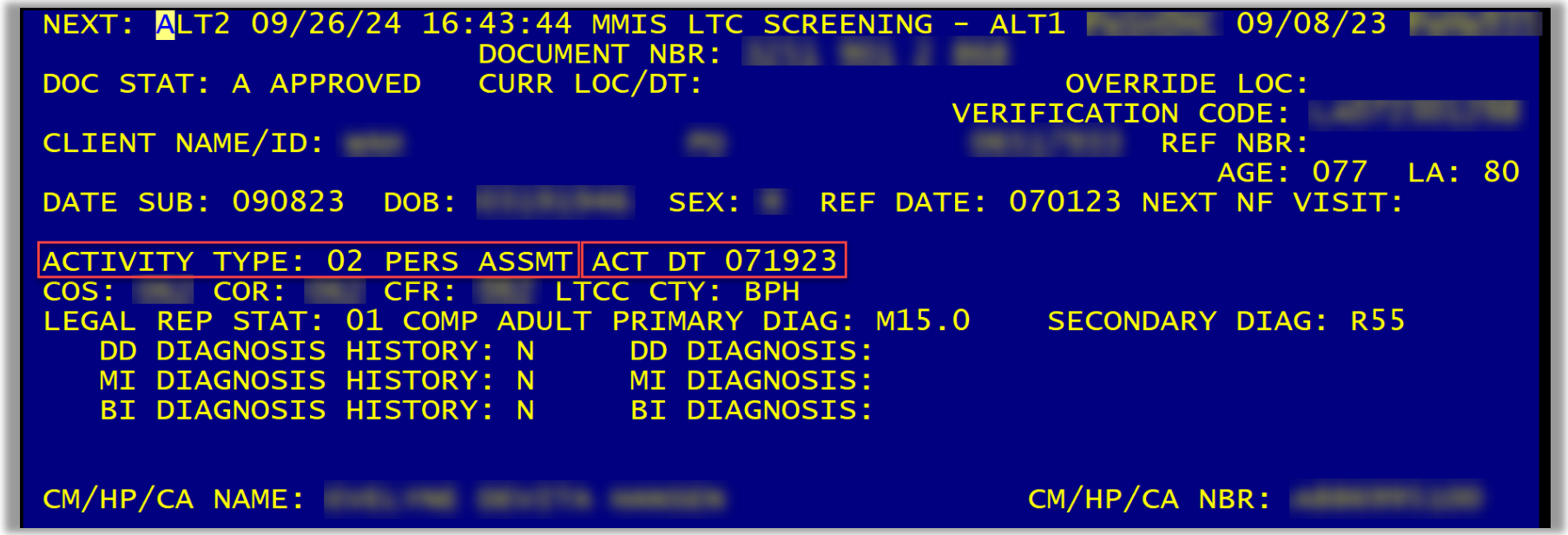


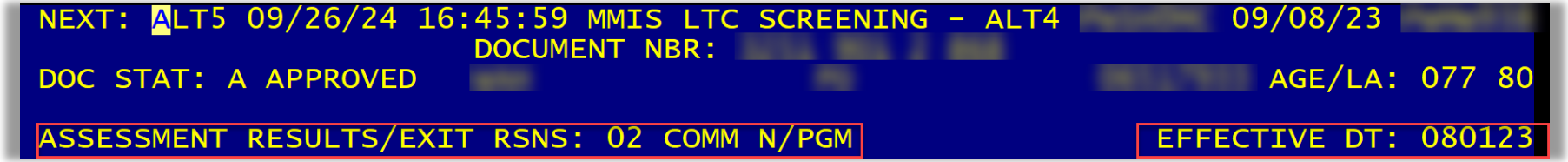




TIMELY EW REASSESSMENTS

BlueCross BlueShield Minnesota



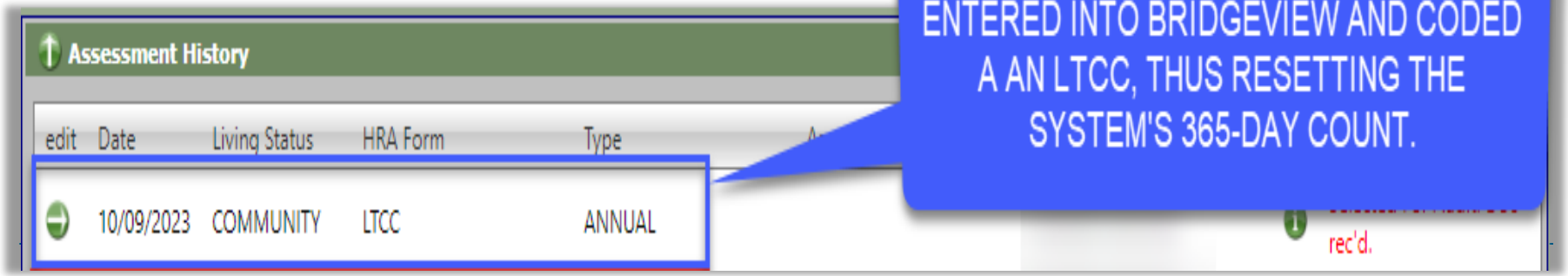


TIMELY EW REASSESSMENTS

BlueCross BlueShield Minnesota

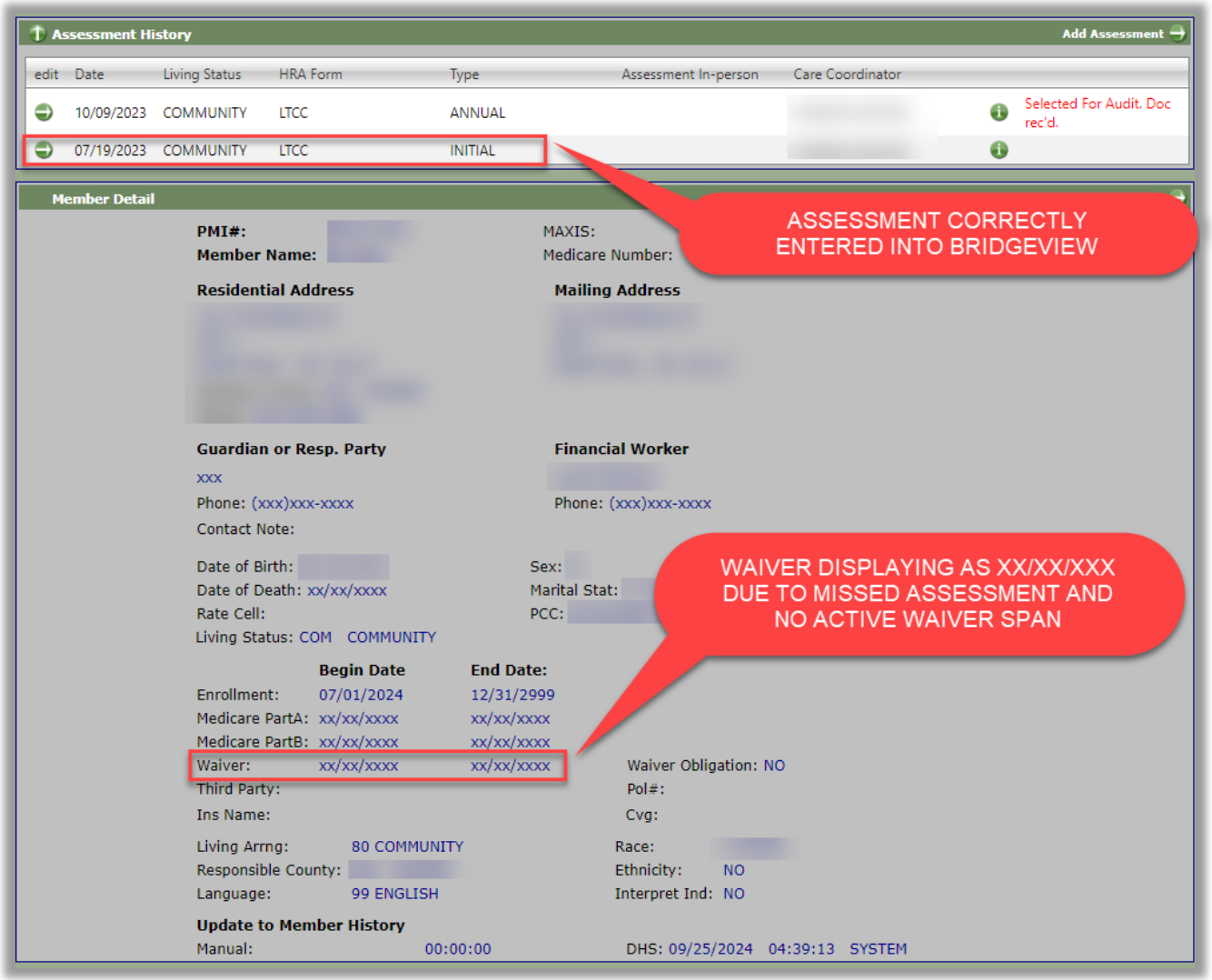
```
NEXT: ALT2 09/26/24 16:47:30 MMIS LTC SCREENING - ALT1 [redacted] 10/13/23 [redacted]
                      DOCUMENT NBR
DOC STAT: A APPROVED   CURR LOC/                          E LOC:
                                                          ODE:
CLIENT NAME/ID: [redacted]                                NBR:
                                                    AGE: 077  LA: 80
DATE SUB: 101323  DOB: [redacted]                   XT NF VISIT:

ACTIVITY TYPE: 09 ELIG UPDTE ACT DT 100923
COS: [redacted]  COR: [redacted]  CFR: [redacted]  LTCC CTY: BPH
LEGAL REP STAT: 01 COMP ADULT PRIMARY DIAG: M15.0    SECONDARY DIAG: R55
   DD DIAGNOSIS HISTORY: N      DD DIAGNOSIS:
   MI DIAGNOSIS HISTORY: N      MI DIAGNOSIS:
   BI DIAGNOSIS HISTORY: N      BI DIAGNOSIS:


CM/HP/CA NAME: [redacted]                          CM/HP/CA NBR: [redacted]
```

* 09 - ELIGIBILITY UPDATE WAS DONE ON 10/9/2023, OPENING MEMBER TO EW.
* ELIGIBILITY UPDATES DO NOT IMPACT WHEN A MEMBER'S REASSESSMENT IS DUE AND SHOULD NEVER BE LOGGED IN BRIDGEVIEW.
* MEMBER'S EW WAIVER SPAN WAS 10/9/2023 THRU 6/30/2024.



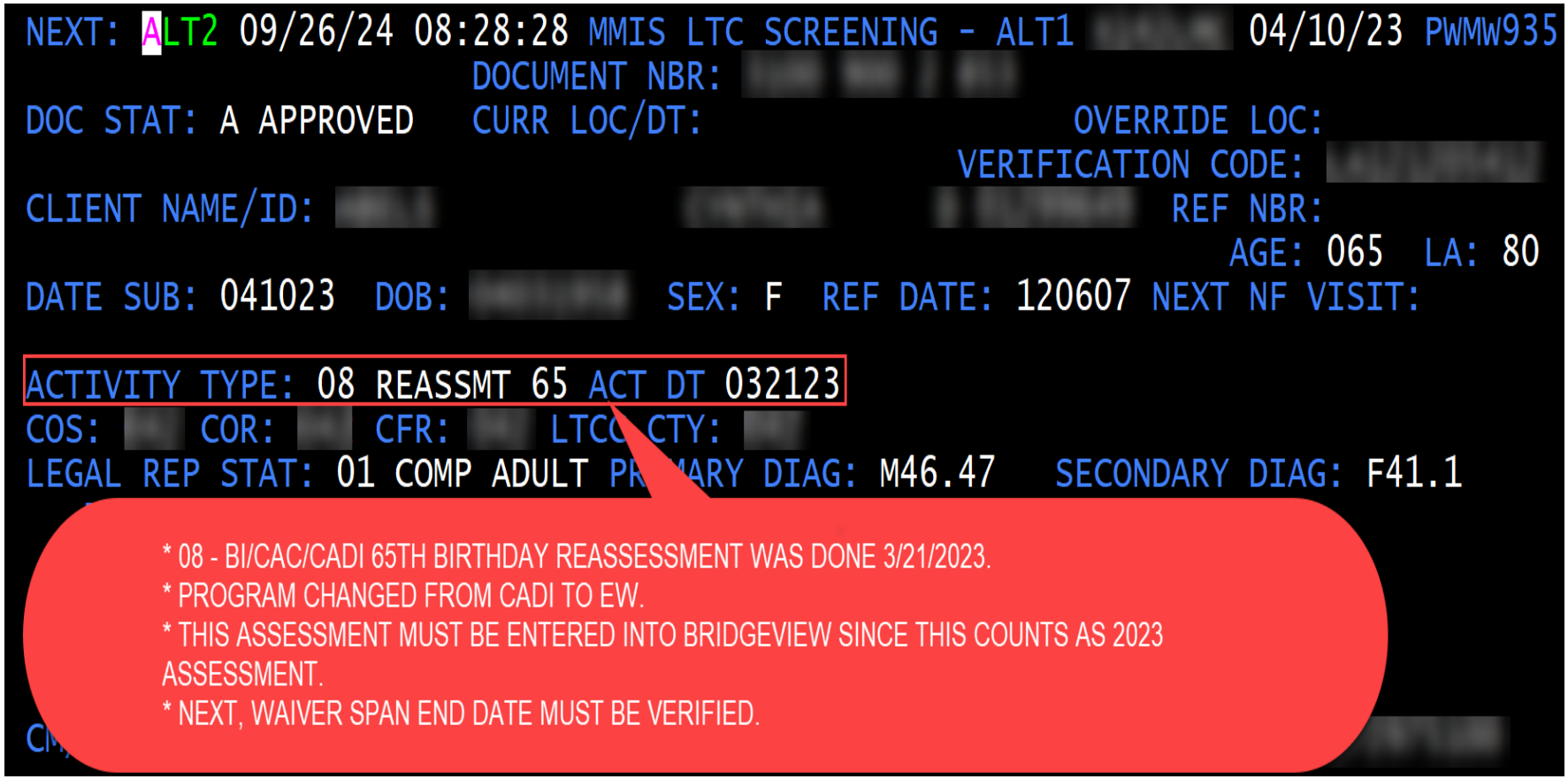
09 - ELIGIBILITY UPDATE INCORRECTLY ENTERED INTO BRIDGEVIEW AND CODED A AN LTCC, THUS RESETTING THE SYSTEM'S 365-DAY COUNT.

TIMELY EW REASSESSMENTS

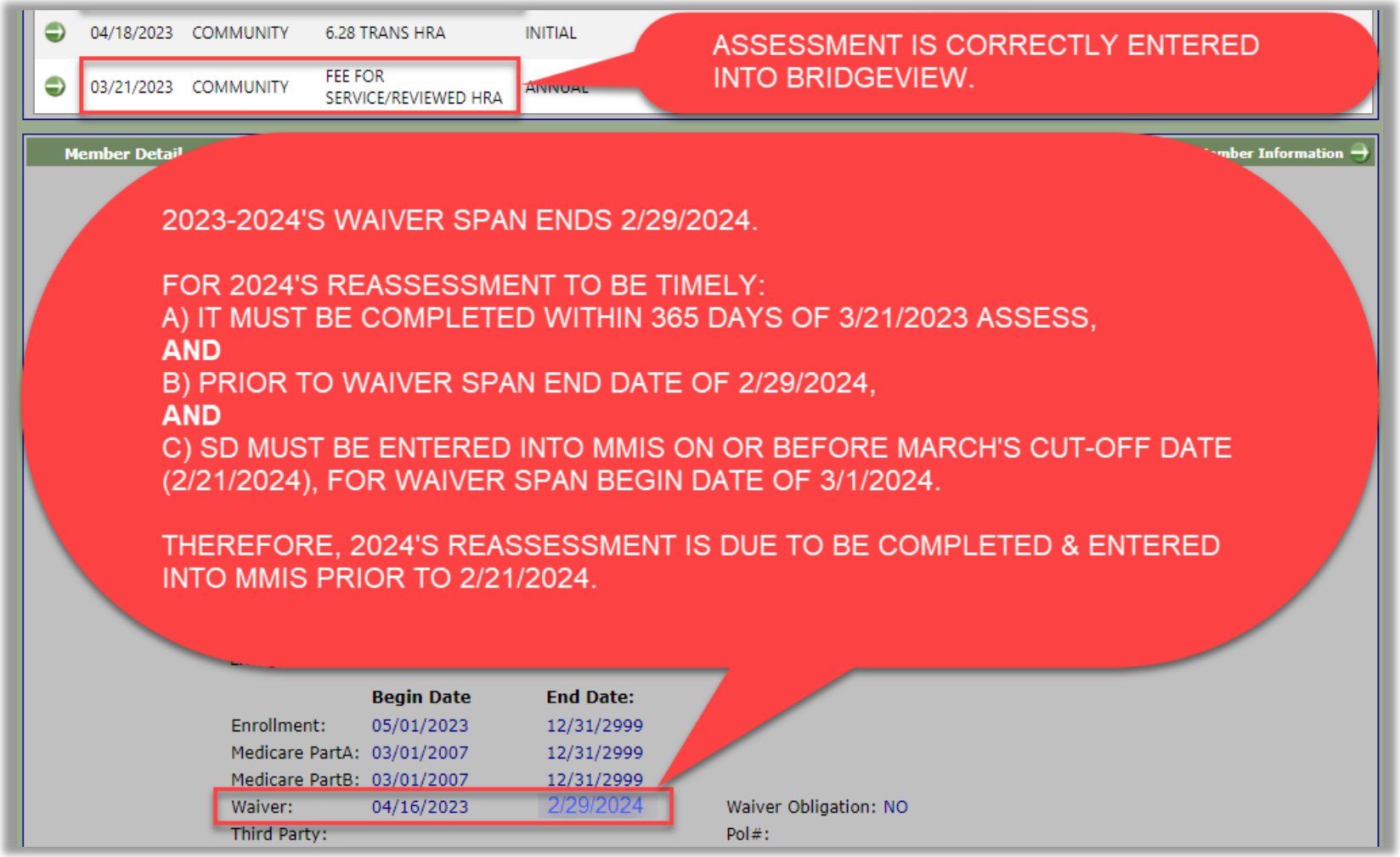


TIMELY EW REASSESSMENTS

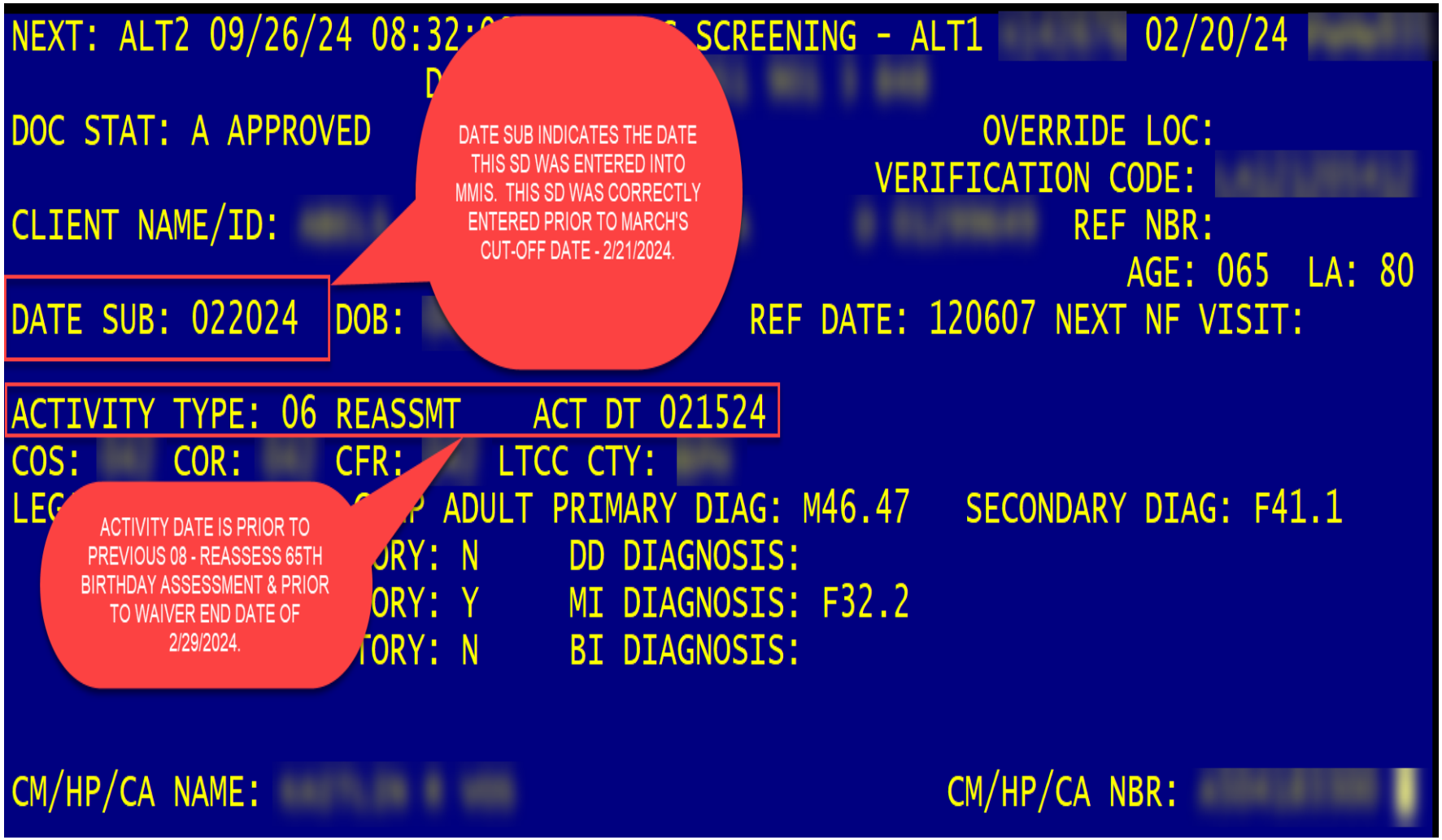
EXAMPLE OF TIMELY EW REASSESSMENT FOR 08 – BI/CAC/CADI REASS 65TH BIRTHDAY



TIMELY EW REASSESSMENTS

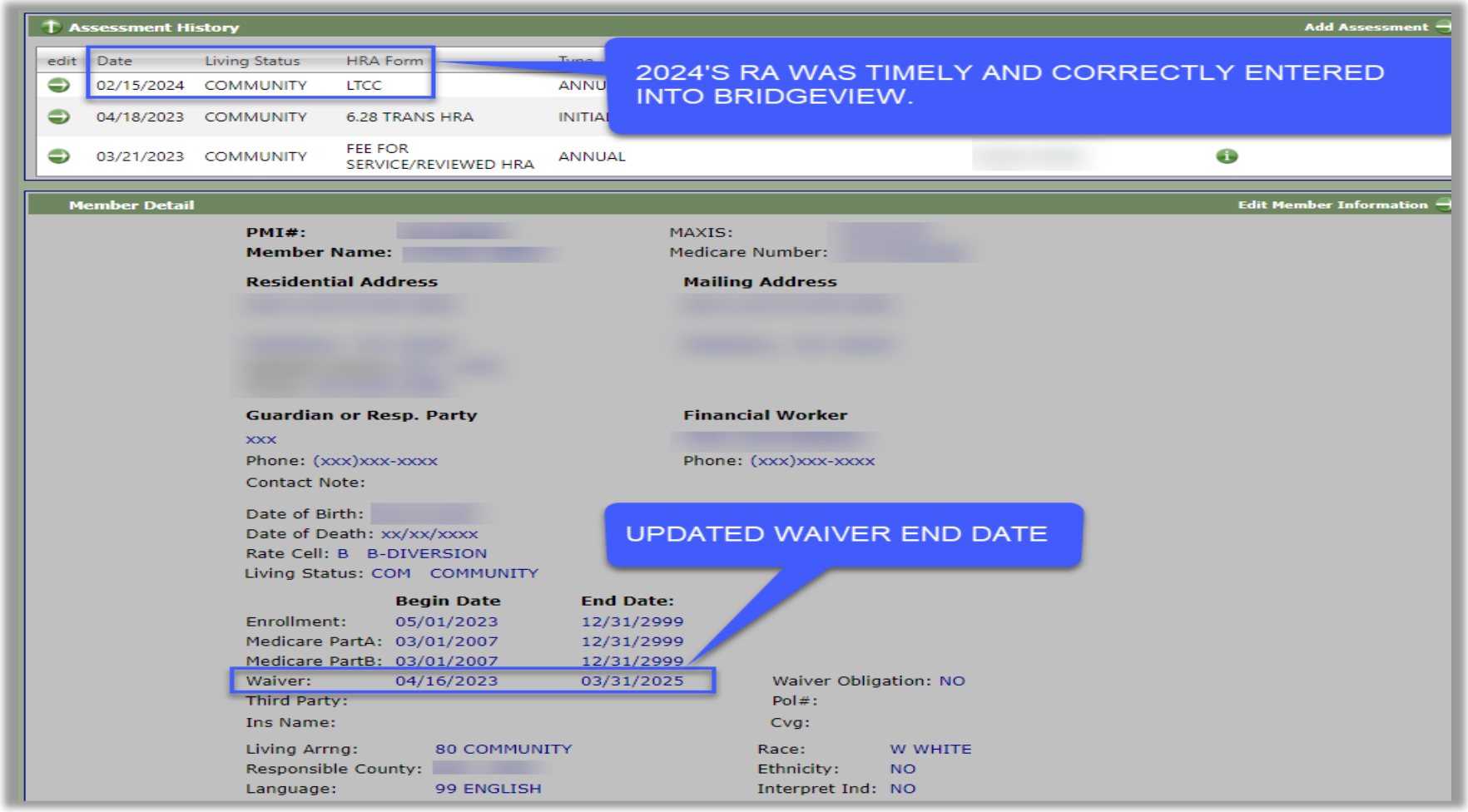


TIMELY EW REASSESSMENTS



TIMELY EW REASSESSMENTS

BlueCross BlueShield Minnesota



FALL TRAINING ATTENDANCE SHEETS

BlueCross BlueShield Minnesota

- Please send your signed and dated attendance sheets via email to me at the conclusion of this training. This can be electronic signatures.

- If there are staff in your office not in attendance, they are required to review the slides. Please have them review and send an attendance sheet.

- Thank you very much for your time today and for all you do for our members.

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QUESTIONS?
THANK YOU.

Government Markets Partner Relations

Partner.Relations@bluecrossmn.com

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APPENDIX

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association.

GUIDELINES UPDATES

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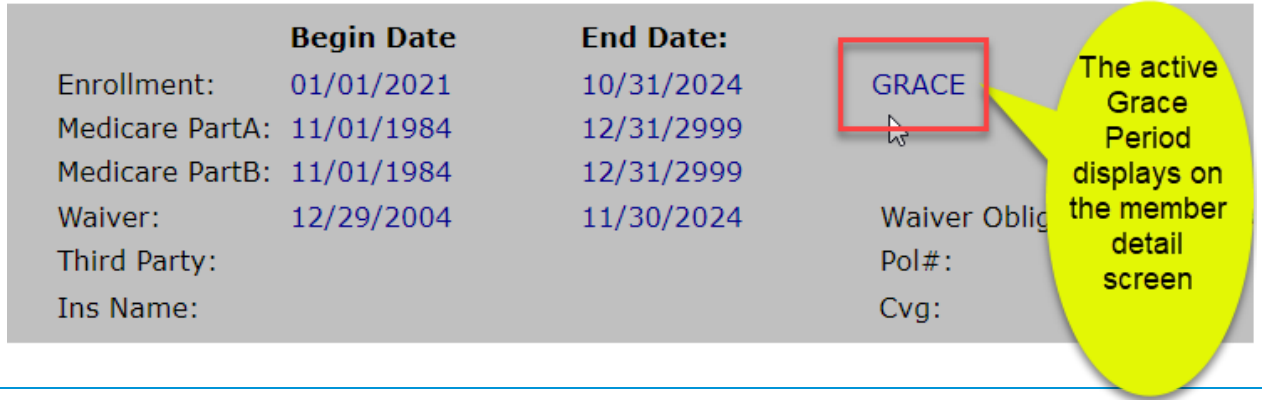
GUIDELINES UPDATES - NON-MNCHOICES

SecureBlue MSHO 90-Day Grace Period

Includes only Medicare, Part D, Care Coordination, and Supp Benefits

- Medicaid, including state plan, and EW services are not covered.

New enrollment flags:



GUIDELINES UPDATES - NON-MNCHOICES

If the member is reinstated or renews their Medicaid eligibility, this GRACE indicator will no longer be displayed, and the end date will show as 12/31/2999:

If the member terms before the 10/31/2024 end date, this GRACE indicator will no longer be displayed, and the new term date will display instead.

In this example, member signed up for another Part D policy and CMS updated our enrollment file to term the member on 9/30/2024.

Delegate will also be notified of the change in term date by receiving a DAILY report in Bridgeview in addition to notification on the following month's Full Detail report:

	Begin Date	End Date:
Enrollment:	10/01/2021	12/31/2999
Medicare PartA:	06/01/1998	12/31/2999
Medicare PartB:	06/01/1998	12/31/2999
Waiver:	xx/xx/xxxx	xx/xx/xxxx
Third Party:	01/01/2021	12/31/2999

The updated term date now displays as 9/30/2024

	Begin Date	End Date:	
Enrollment:	07/02/2023	09/30/2024	
Medicare PartA:	12/01/2022	12/31/2999	
Medicare PartB:	12/01/2022	12/31/2999	
Waiver:	xx/xx/xxxx	xx/xx/xxxx	Waiver Obligation: NO
Third Party:			Pol#:
Ins Name:			Cvg:

MESSAGE	MESSAGE2
TERMED DATE CHANGED: 09-30-2024	PRIOR TERM DATE: 10-31-2024

GUIDELINES UPDATES - NON-MNCHOICES

Term due to lapse in MA coverage for Elderly Waiver Members

- CC required to complete re-assessments for EW members who lose MA eligibility for up to 90 days when it's expected MA will be reinstated
  - MSHO members get 90-day grace period
  - MSC+ members do not

If determined member will reinstate within 90 days:

- Keep case open & work with member/financial worker to reinstate MA asap
- Keep waiver span open in MMIS and SA's open in Bridgeview
- Notify providers
- Send DHS 6037 to County of Residence (COR) by day 60 if MA is not reinstated and member set to term on day 90

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GUIDELINES UPDATES - NON-MNCHOICES

MCO Responsibilities

COR Responsibilities

DHS-6037A-ENG 4-23

Transitions needed due to loss of Medical Assistance (MA) eligibility

Type of change	Days 1-90 from loss of MA eligibility	Day 90 and beyond from loss of MA eligibility
10) Person is enrolled in MSHO/MSC+, on EW and loses Medical Assistance (MA) eligibility. In most cases, if MA eligibility is re-established within 90 days, the person continues on their MCO with no break in MCO enrollment.	The MCO tracks the status of the person and completes any necessary reassessments[4]. The MCO cannot enter a LTC SDOC in MMIS when the person is not eligible for MA. The MCO sends DHS-6037 to the county of residence (COR) by Day 60 if MA has not been re-established by this date. *This is for communication purposes only.* It is not a transfer of HCBS case management responsibility. The document should be filled out in its entirety with all attachments, including any assessments completed. This form alerts the COR that the person has lost MA eligibility and that the MCO will stop following the person at Day 90 if MA eligibility is not re-established by Day 90. NOTE: If a required reassessment is completed by the MCO after the DHS-6037 is sent to the COR and before Day 90, the MCO must also send the reassessment to the COR.	The COR tracks whether the person's MA eligibility was re-established by Day 90. If not, the COR contacts the person to determine the person's status. The COR helps the person to access services and supports as needed. NOTE: 1. If the COR was provided with a reassessment completed by the MCO during Days 1-90, the county may enter the MCO's reassessment in MMIS to establish EW eligibility. Please note that assessments must be entered within 70 days of the assessment date. 2. If the COR is not able to use a reassessment completed by the MCO, due to timelines, the COR completes any necessary assessments needed to reestablish eligibility for EW. The COR may need to communicate with the MCO to request the MCO close the EW span to the date the person lost MA eligibility, in order to enter a new assessment. The COR can open the person to AC if level of care criteria is met, but MA financial eligibility no longer is met or established. For a person who no longer meets either MA financial or level of care criteria, the COR can open the person to ECS.

GUIDELINES UPDATES - NON-MNCHOICES

Transitions of Care

- What if I am unable to reach my member/responsible party?
  - CC must attempt to reach by phone and document the date of first attempt on the TOC log with a note.
  - Best practice: mail the General Unable to Reach letter so member knows CC was attempting to reach to assist post discharge.
- TOC log instructions: created instructional grid using the log tooltips
- Reminder: If the Care Coordinator is notified of member's discharge in advance, the CC must follow up and complete the TOC tasks within one (1) business day AFTER the actual date of discharge.

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GUIDELINES UPDATES - NON-MNCHOICES

Merit hiring: each delegate must maintain documentation to support merit eligibility including a copy of the related 4-year degree and documented experience.

Transfers: added a reminder that THRA does not need to be completed for on a transferred member. CC's to follow same HRA/Mid-year due dates.

New enrollees with previously approved state plan home care services: If agency is out of network, the CC may continue to authorize following process in guidelines, but the provider **must be enrolled with DHS**.

Nursing Home Face-to-Face Contact: Even if the member is not able to actively participate in the assessment, the Care Coordinator must attempt to initiate contact and visually assess the well-being of the member. This face-to-face contact with the member should be clearly documented in section IV. Care Coordinator Tasks.

Nursing Home Care Plan: CCs to retain a copy of the care plan reviewed. Added "be sure the copy of the care plan is dated and includes the member goals, interventions, and target dates."

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GUIDELINES UPDATES - NON-MNCHOICES

BlueCross BlueShield Minnesota

Member is open to EW and is a no show or is refusing timely re-assessment:

- Enter the refusal date in Bridgeview & MnCHOICES and send a Refusal Support Plan letter. Document in case notes.
- Explain to the member an assessment is required to continue receiving services under Elderly Waiver by the waiver span end date. If the member indicates they do not want to continue receiving EW services, CC must notify the member and provider(s) about services ending and submit a DTR request.

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GUIDELINES UPDATES - MNCHOICES

All references to legacy documents (LTCC/DHS 3428H, care plans) were removed and updated to reflect MnCHOICES requirements.

Many of the questions from R-MnCHOICES Blue Plus FAQ have been moved to the Guidelines. The FAQ has been posted with non-guideline related Frequently Asked Questions.

R-MNCHOICES BLUE PLUS FAQ +

Frequently requested guidelines updates included:

- Attachments
- Where to document the following for all assessment types:
  - Safe Disposal of Meds
  - MSHO Supplemental Benefits discussion
  - MSC+ enrollment into MSHO discussion
  - Offering of DHS 6914 Caregiver Assessment

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GUIDELINES UPDATES - MNCHOICES

BlueCross BlueShield Minnesota

Frequently requested updates including:

- Guidance on use of Transitional HRA in MnCHOICES
- Support planning requirements
  - Mid-year support plan review
  - End-of-year support plan review
- Blue Plus expectations for member signature
- Where to enter Care Coordinator/Case Aide for both EW and CW
- How to document services authorized by other waiver CM

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SUPPORT PLAN SERVICES

Services that Support Me	People & Community organizations that support me
All Elderly Waiver services	MSHO Supplemental Benefits
State Plan Services: PCA/CFSS, HHA, SNV/LPN, PT/OT/ST	All other waiver services (CADI, CAC, DD, BI) including Case Management
Care Coordination & Case Aide	Medicaid covered DME
	MHM
	HSS
	CFSS Consultation Services

Note for EW Care Coordination & Case Aide:
If the Delegate agency cannot be found as a provider under Services & Supports, revert to entry under People & Community organization that support me.

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SUPPORT PLAN SERVICE UPDATES

- Removed 8.50 Member Change Letter
- When there are updates to the support plan for a new service, new service provider, change in service hours/units, change in service provider, Care Coordinators must now:
  - Create a Revision to the most recent completed Support Plan
  - Include a description of what service(s) is being changed or added
  - Are Signatures required? Choose Yes.
  - Inform the member you will be sending an updated copy of their Support Plan to sign and return acknowledging their agreement to the change(s)
  - Mail an updated copy of the Support plan & signature page. Include a copy of the MSHO or MSC+ Language block.

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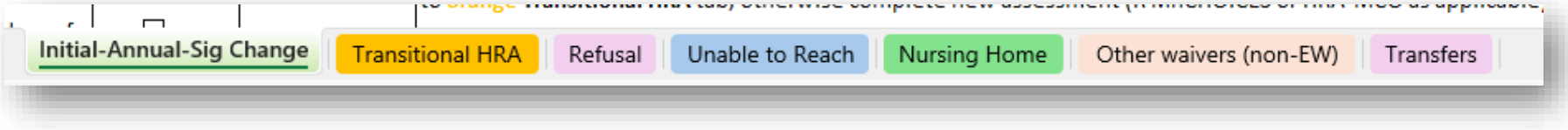
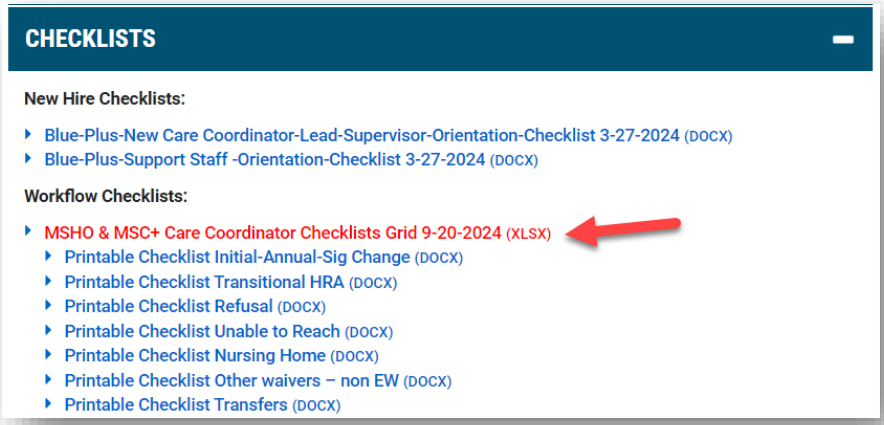
GUIDELINES UPDATES - MNCHOICES

New optional checklists!



One spreadsheet with multiple tabs to include the following scenarios:

- Initial-Annual-Sig Change for EW/CW
- Transitional HRA
- Refusal
- Unable to Reach
- Nursing Home
- Other waivers (non-EW)
- Transfers



By request, we added individual printable checklists.

2025 MSHO SUPPLEMENTAL BENEFITS

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WHAT'S RETURNING IN 2025

Health and Well Being Benefits

- Blood Pressure Monitoring System
- Friendly Helper **
- Health & Wellness Classes
- Household Supports (new vendor) **
- Medically Tailored Meals and Food and Nutrition Education (chronic conditions) **
- Music Therapy
- OTC benefit

Caregiver Supports

- Caregiver Emergency Care Plan
- Caregiver Empowerment Program

Health Services (Medical/Dental/Vision)

- Additional Dental Services **
- Additional Podiatry Services
- Eyeglass Upgrades

Fitness

- SilverSneakers Fitness Benefit
- **See: "What's Changing in 2025"*

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WHAT'S RETURNING IN 2025

Post-Discharge Services

- Post-Discharge Home-delivered Meals **
- Post-Discharge Healthy Transitions-Certified Community Health Worker **

Equipment/Supplies/Safety Items

- Electric Toothbrush/Replacement heads
- $750 Safety Item Benefit
- Medication Dispenser & Reminders (Dose Health) **
- Personal Emergency Response System (PERS) **

Animatronic Pets

Transportation (BlueRide)

- Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Health and Wellness Classes SilverSneakers fitness facility locations
- Transportation to grocery store: (Blue Ride)
  - Maximum six round trips per month Maximum 45 miles one-way (90 miles round trip)
  - Shopping time is one hour

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WHAT'S CHANGING IN 2025

The following items will no longer be covered in 2025:

- Disposable Face Masks
- Fitness Tracker- Fitbit Inspire 3
- Incontinence Package
- Wheelchair/Walker Safety

WHAT'S CHANGING IN 2025

BlueCross BlueShield Minnesota

2024

Friendly Helper- 60 hrs/member/yr

Household Supports-

- CVS
- $120/month allowance
- 10 eligible chronic conditions

Medically Tailored Meals and Food- 10 eligible chronic conditions

Additional Dental Services-

- one additional preventive exam
- Two crowns
- One additional x-ray
- Two root canals

Post-Discharge Home-Delivered Meals-

- 56 meals in 4 weeks/episode of care

Post-Discharge Healthy Transitions-

- 4 visits/episode of care

Medication Dispenser and Reminders-

- available to members living in community

Personal Emergency Response System- available to members living in community

2025

Friendly Helper- 48 hrs/member/year

Household Supports-

- myFlexCard
- $260/quarter allowance
- 3 eligible chronic conditions

Medically Tailored Meals and Food- 3 eligible chronic conditions

Additional Dental Services-

- one additional preventive exam
- Two crowns

Post-Discharge Home-Delivered Meals-

- 28 Meals in 2 weeks/episode of care

Post-Discharge Healthy Transitions-

- 3 visits/episode of care

Medication Dispenser and Reminders- Available to members living in community and not on a HCBS waiver

Personal Emergency Response System- available to members living in community and not on HCBS waiver

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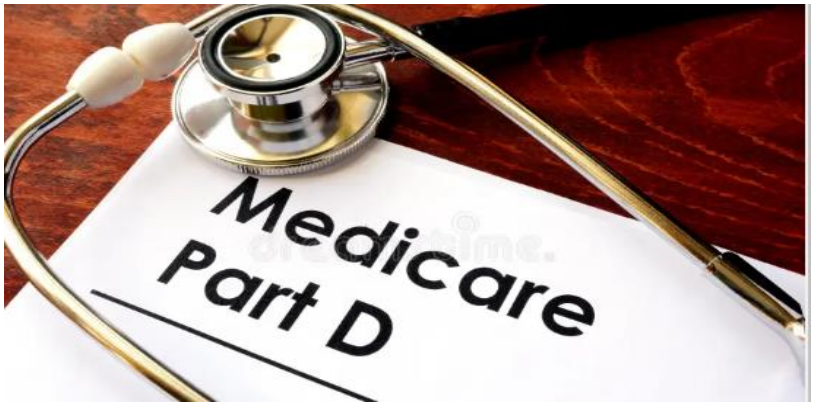
2025 MEDICARE PART D CHANGES

- Effective 1/1/2025, **ALL** MSHO members will have a $0 copay on all Part D drugs.



- All MSHO members will receive a $50 gift card upon completion of a Comprehensive Medication Review, which is part of our Medication Management Therapy program (limit one card/member)

MTM PROGRAM

- **What is MTM program?** A Complete Medication Review by a pharmacist for all medications including all Rx and OTC
- **What are some reasons for a referral for MTM?**
  - Therapy duplications
  - Drug interaction concerns
  - Appropriate doses for age and comorbid conditions
  - Gaps in care noted for:
    - Poor Blood sugar control (A1c >9%)
    - Blood pressure >140/90
    - No statin use and has diabetes or has cardiovascular disease
    - Recent bone fracture but has not had DEXA scan or is not taking osteoporosis medication (other than calcium)
  - Member on medication(s) without an indication
  - Multiple prescribers
  - Drug Side Effects/Adverse Drug Event- member may be experiencing an unwanted effect from a medication
  - Concern for safe use of medication for the member
  - Medication effectiveness
  - Adherence issues- member self modifies medication doses or frequency, member forgets to take medication, member confused on complex dosing regimen, member non-adherent.

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REMINDERS

Care Coordinators now have access to free CEU's through BCBS of MN Learning Center: https://bcbsmn.availitylearningcenter.com/

- Access instructions sent via Communication 7/26/2024.
- Ask your PR Consultant for instructions.

Consults: CC's can consult with any of our internal medical or behavioral health clinicians at any time by sending in the "Case Management Referral Form".