Nursing Home/Intermediate Care Facility Care Coordination Guidelines

Secure Blue - MSHO
(Minnesota Senior Health Options)

Blue Advantage - MSC+
(Minnesota Senior Care Plus)

Updated 1-31-2025

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Contact Information

See Blue Plus MSHO MSC+ Key Contacts Resource for contact information for the following:

- Member & Provider Services
- BlueRide
- Health Programs (Case Management, Gener Services, Quitting Tobacco, Nurse Line, etc.)
- Mental Health Resources
- And More!

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

When possible, 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 in-person 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/MnC Support 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/MnC support plan with other member care plans/MnC support plan, as appropriate (i.e., hospice care plans/support plan and/or home care agency's care plans/support plan, 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/MnC support 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.

Consent: Informed choice means a member/responsible party understands all options available to them, including the benefits and risks of their decision. When providing information about remote and in-person reassessments, the Care Coordinator must consider what information is important for the person to make an informed choice.

Delegate: 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 monthly assessment tracking form, Quality Improvement Project reporting, enrollment report discrepancies, Hospice care plans, missing residential service living tools, and late screening document entry follow up.

Model of Care (MOC): 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 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: 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.

Transfer: Defined as an existing (already enrolled) Blue Plus member who has been transferred to a new Blue Plus delegate.

Recommended Caseload per worker: Blue Plus has established the below policy and criteria for determining *Care Coordinator caseload ratios. Delegate Supervisors should use the following criteria to develop and assign caseloads to include but not be limited to:

- Care Coordinators' experience and agency tenure
- Care Coordinators' capacity to provide quality service to member: demonstrated by member engagement and compliant completion of administrative tasks
- Care Coordinators' other responsibilities (Fee for Service, Public Health tasks, other Managed Care Organization cases, other waiver cases, adult protection accountabilities, etc.)
- Care Coordinator access to administrative support

<u>Factors for determining case mix:</u>

- Number of members on Elderly Waiver or other waivers

- Mix of living arrangements
- Members with low English proficiency or need for interpreter
- High intensity case due to mental health, physical health, SDOH (Social Determinants of Health) needs or CDCS (Consumer Directed Community Supports)
- Cases where member lacks informal supports/family support
- Travel time
- Members who are Community Well and are accessing PCA/CFSS services

Blue Plus provides caseload **maximums** as delegates have overall management of their staff while employing the above criteria. Maximums would not be expected for all Care Coordinators/caseloads. As stated in the Blue Plus Care Coordination contract, each Delegate shall employ an adequate number of staff to *effectively* manage their assigned MSHO and MSC+ members. Staff qualifications must be consistent with the requirements established by Blue Plus. Blue Plus may annually survey Delegate caseload ratios and the process for determination.

Caseload Maximums (Blue Plus desired caseload for continuity of care = mix of all rate cells):

- Elderly Waiver, Community Well and Nursing Home/ICF mix - 85
- Elderly Waiver/Community Well mix -85
- Nursing Home/ICF only - 120
- Community Well only -100
- Elderly Waiver only- 65
- Nursing Home/ICF and Community Well mix - 120

*Care Coordinator must provide the assessment and ongoing care coordination functions for the member including support planning.

Member ID/Bridgeview ID: This number is 8+PMI. The prefix for SecureBlue MSHO is MQS and the prefix for BlueAdvantage MSC+ is MQG.

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/MnC support 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 on our Care Coordination website. 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.

Enrollment

Enrollment Reports

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 10th of each month which includes the following flags:
    - **NEW ENROLLEE:** Brand new enrollees who enrolled after DHS capitation
    - **GRACE PERIOD ENDING:** Lists Month/Date/Year which will be 90/60/30 calendar 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 calendar days. See *90 Day Grace Period (MSHO only)* section of the guidelines for care coordinator tasks.
    - **PRODUCT CHANGE:** Changed from MSC+ to MSHO or vice versa (these members are treated as brand new enrollees and will need a new assessment).
    - **REINSTATED:** Members who were going to term but were reinstated with no lapse in coverage
    - **TERMED:** Coverage termed for reasons listed on the report.
    - **TERMED FUTURE:** Lists Month/Year. Members 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.
    - **TRANSFER TO:** Existing enrollee who transferred from your enrollment roster to another Delegate.
    - **TRANSFER FROM:** Existing enrollee who transferred to your enrollment roster from another Delegate.

3. **DAILY report(s):** Includes new enrollees who were retroactively enrolled or termed by either DHS or CMS after both the New CAP and Full Detail reports were processed; these can come at any time in the month.
    a. When a member terms early from a Grace Period, payment will stop for care coordination. CCs should notify providers that services should end.

Delegate Responsibilities upon Notification of Enrollment

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 calendar 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 calendar 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 calendar days** of notification of enrollment.
4. During initial phone contact, CC must confirm the member's PCC. If member is unable to recall name of their PCP, CC must use other methods to determine who PCP is (including Helios, prescriber of medications, and/or obtaining permission from the member to contact the clinic to obtain the PCP name).

    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 Summary of Requirements & Timelines* 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 or CC's can update address using this link: https://edocs.mn.gov/forms/DHS-8354-ENG
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

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 based on the member's circumstances.

- Members residing in the Veteran's Administration Nursing Home – follow the outlined processes and timelines in the Nursing Home Care Coordination Guidelines.
- Members residing in select Veterans Affairs Home participating in The Domiciliary Program*- follow the outlined processes and timelines in the Community Care Coordination Guidelines. In these cases, the Care Coordinator must confirm and document that the member is enrolled in The Domiciliary Program.

* The Domiciliary Program are beds that are considered independent living.

Currently there are only two locations offering The Domiciliary Program. The VA Home in Hastings and Minneapolis. These homes have a limited number of rooms allotted to The Domiciliary Program. Not every member residing at the Hastings or Minneapolis VA Home locations are participating in The Domiciliary Program.

Note: Please be aware members living in a Veteran's Administration Nursing Home are designated by DHS as a Rate Cell A (Community Well). They 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 and proceed with Care Coordination activities and timelines based on the member's circumstances above.

Medical Assistance (MA) Renewals

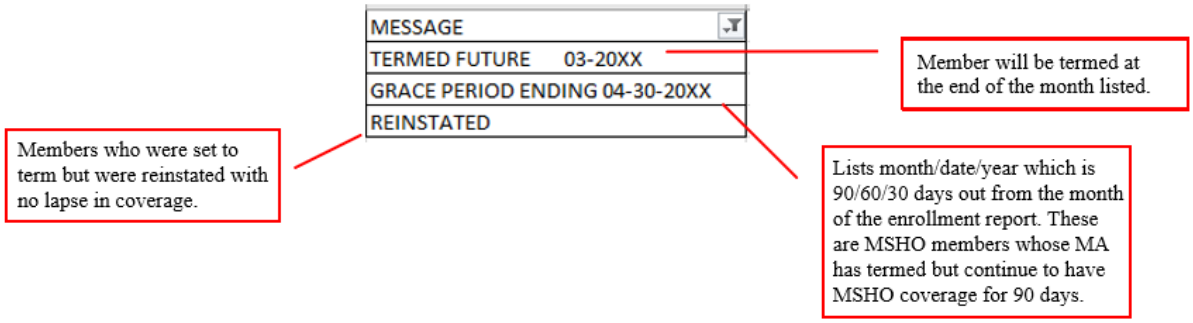
Minnesota Health Care Program (MHCP) enrollees must verify that they continue to meet the program's eligibility requirements at the end of each year to continue their coverage into the

following year. MHCP enrollees are sent a notice by DHS and must complete the renewal paperwork within 45 calendar 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 Medical Assistance (MA) Renewals page for guidance and resources.

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.

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. The following PCC's provide primary care and care coordination:

        i. Bluestone Physicians
        ii. Essentia Health
        iii. Genevive

    b. If the member's PCC is contracted with Blue Plus to provide care coordination, 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 Transfer in Care Coordination Delegation form.

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

    c. If the CC needs to confirm who the new Care Coordination Delegate will be, refer to Care Coordination Delegate Listing and Contact Table or contact your Partner Relations Consultant.

SecureBlue MSHO 90-Day Grace Period

MSHO Members Only:
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.

Members in the 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. Direct members to Senior Linkage Line (1-800-333-2433) to choose a new Part D plan.

2. Contact the member and encourage that they complete their MA renewal paperwork.
3. Notify providers including supplemental benefit providers that the members MA has termed and they may want to "halt" services until it is reinstated.
    a. If the member is not reinstated, notify providers to end services.
4. Complete any assessments or re-assessments during their 90-day grace period and retain in the members record.
5. 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.

MSC+ Members:

Care Coordinators are required to complete re-assessments for Elderly Waiver (EW) and CFSS 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.

If the member's annual EW and/or CFSS re-assessment is due during the 90-day term window the Care Coordinator must complete and retain the following documents:

- Comprehensive assessment
- Applicable MnCHOICES Support 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.

*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.

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 assessment.	No, unless member due for annual community assessment.	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 Blue Plus.

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 Blue Plus PAS Team 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:

- If completing the assessment in the Revised MnCHOICES, complete the OBRA Level I in R-MnCHOICES. This can be accessed under Form Category "Evaluation and Screening" under Form "OBRA I".
- Delegate will be contacted via secure email by Blue Plus PAS team 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 Blue Plus 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 in-person assessment is required. The assigned Care Coordinator or back-up staff will conduct the in-person 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, Blue Plus 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 MnCHOICES 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 Blue Plus.

Contact Requirements

Member Contact

1. One in-person visit per year at minimum.
    - There must be documented face-to-face contact with the member. 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.
    - If member is unable to fully participate in the assessment, the CC is required to reach out at a minimum one time to the member's guardian, POA, or responsible party**.** Contact with the member's guardian, POA, or responsible party should also be documented in section IV. Care Coordinator Tasks.
    - Care Coordinators cannot document a refusal for a Nursing Home member, as it is required that an attempt to visually assess the member be made, and a review of the members Nursing Home chart be completed.

2. One mid year member contact per year at minimum.
    - This contact may be in-person or over the phone with the member or responsible party, or at a care conference.
    - If the member is unable to fully participate in the assessment, the CC is required to reach out at a minimum one time to the member's guardian, POA, or responsible party**.** The Care Coordinator documents this mid-year contact on the Nursing Home-ICF Member Assessment and Support Plan form.

3. Contact as needed per significant changes in member's health status.

- These contacts can be documented in Case Notes.

4. Contact for new facility admission/determination of long-term placement:

   The Care Coordinator shall conduct the Nursing Home-ICF Member Assessment and Support Plan when a member transfers from the community to long-term placement in a skilled facility. This assessment must be conducted:

   - Within **45** days of notification of long-term placement; or,
   - Within **45** days of the transfer effective date if the long-term placement results in a transfer of Care Coordination Delegation; or
   - Within **365** days of the previous assessment, whichever is sooner.

Contact Requirements *All members must be notified of their Care Coordinator's information within 10 calendar days of enrollment notification or change in Care Coordinator.*		
Contact/year	**MSHO**	**MSC+**
Initial Assessment (includes product changes)	In-person w/in 30 days	In-person w/in 60 days
Annual Assessment	In-person within 365 days	
Mid-year contact	In-person or over the phone with the member or responsible party, or at a care conference	
Long Term Care Placement	Within 45 days of notification of LTC placement or within 365 days of previous assessment (whichever is sooner)	
Member Request	Member request for a MnCHOICES assessment must be completed within 20 calendar days of the request	

Primary Care Provider Contact Requirements

Initial and Re-assessments:

- Within 90 days following assessment, send the *NH-ICF Post Visit Summary Letter-Intro to Primary Care Provider Letter*.
  - For initial assessments for new enrollees, must be sent within 90 days of notification of enrollment.

- For clinic delegates, notification to primary care provider documented per clinic process using an EHR is acceptable.

Change in Care Coordinator:

- Send the *Change in CC - Intro to Primary Care Provider* letter to notify PCP of change in Care Coordinator.

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).

Note: As nursing home members have their needs met while residing in a 24-hour care facility, Care Coordinators should review the report to identify potential unidentified needs or gaps. If a need is identified, the CC should reach out to the Interdisciplinary Care Team (ICT) as needed.

The report includes the following:

Mental Health Targeted Case Management (MH-TCM)	Special Transportation	ADL and Behaviors
Restricted Recipient	Dental	CFSS/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
In-patient Stays		

2. 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.

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. What is their primary diagnosis? (ie: Dementia, Cancer, ESRD)

b. Has the member recently been hospitalized?
c. Has it been awhile since they've had contact with previous CC?
d. Is there anything listed under "CURRENT ISSUES/CONSIDERATIONS" needing immediate attention (Ie. upcoming appts, surgeries, etc.)?

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

Complete the following requirements for all new enrollees:

1. Verify member's eligibility prior to delivering Care Coordination services
2. Use optional Nursing Home checklist (available on the website under checklists).
3. Inform the member of the name, number, and availability of the Care Coordinator within **10 calendar days** of notification of enrollment. This requirement can be met by sending the Intro Letter.
4. Welcome call/Intro Letter to member within 30 calendar days after notification of enrollment
5. Assign Care Coordinator to the member in Bridgeview.
6. Review and confirm with the member correct demographic information as displayed in Bridgeview including the following. If any are incorrect, the CC must update it in Bridgeview, if allowed, and send DHS 5181 to the financial worker. Refer to Bridgeview Care Coordination User Guide).
    a. Residential and mailing address – discrepancies impact mailings from Blue Plus and DHS (ie. Medicaid Renewals)
        a. Residential: where member currently resides
        b. 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 a NH but displays as Rate Cell A, this is a red flag to contact the Financial Worker to update the living arrangement.
    d. Primary Care Clinic.

a. 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. Schedule a visit to the facility and complete the Nursing Home-ICF Member Assessment and Support Plan within **30 calendar days for MSHO or 60 calendar days for MSC+** of enrollment date, OR if delegate receives late notice of enrollment, within 30 or 60 calendar days of this notification.
9. Send *NH-ICF Post Visit Summary Letter-Intro to Primary Care Provider Letter* after the assessment is completed and within 90 days of notification of enrollment.
    - For clinic delegates, notification to primary care provider documented per clinic process.

Reminder: product changes are considered new enrollees. All applicable letters are required to be sent again for product changes.

Assessment

Initial Assessment Responsibilities

1. Complete the Nursing Home-ICF Member Assessment and Support Plan.

   The initial assessment must include but is not limited to the following:

    - In-person assessment: Care Coordinators must engage the member in participation of the assessment. There must be documented face-to-face contact with the member. 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.
    - In addition, if the member is unable to fully participate, the CC is required to reach out **at least once** to the member's guardian, POA, or responsible party in attempts to complete the Member/Responsible Party Interview.
    - Care Coordinators cannot document a refusal for a Nursing Home member, as it is required that an attempt to visually assess the member be made, and a review of the members Nursing Home record be completed.

    - Review of the member's facility record including facility's care plan. The care plan must be dated and show member goals, interventions and target dates.
    - Desire and/or ability to relocate back to the community or another facility
    - Review of the role of Care Coordinator.

- Review explanation of Supplemental Benefits using 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.
- Interview facility staff. For members residing in an Intermediate Care Facility (ICF), the Care Coordinator must contact the member's DD case manager and document this on Nursing Home-ICF Member Assessment and Support Plan.
- As a reminder, members residing in the facility do not have the ability to "refuse" Care Coordination.

2. Enter the assessment information into Bridgeview by the 10th of the following month. (see Bridgeview Manual for entry instructions)
3. Mailing of the following member letters are required:
   - Intro letters:
     a. Intro Letter within 30 days of enrollment (includes product changes)

   - Post-assessment letters (within 90 days following the assessment and within 90 days of notification of enrollment). Send one of the following two letters, as applicable:
     a. NH-ICF Visit Summary Letter to the member or if member was unable to participate to the guardian, POA, or responsible party. Letter must additionally be sent to parties identified by the member.

     Or

     b. Responsible Party UTR NH-ICF Visit Summary Letter to the POA or Responsible Party. To be sent if the Care Coordinator has been unable to reach the POA or Responsible Party.
4. See *Primary Care Provider Contact Requirements* for required provider letters.

Nursing Home/ICF Product Change

A member is defined as a new enrollee when there is a product change within Blue Plus (i.e., MSC+ to MSHO or vice versa). Care Coordinators must complete the following upon notification:

1. Complete **one of the two** following Heath Risk Assessment options (within 30 days of notification of product change for MSHO and 60 days for MSC+):

   - Perform an in-person visit and complete a new Nursing Home-ICF Member Assessment and Support Plan. The next annual assessment is due 365 days from the date of this assessment. **or**

   - Perform a nursing home transitional HRA if there is a current Nursing Home-ICF Member Assessment and Support Plan completed within the last 365 days. Care Coordinators should offer that this be done in person but can be done telephonically with member/responsible party consent.

- Review and make any updates to this assessment/care plan and discussions with member and/or Responsible Party and complete *Section VI. Nursing Home-ICF Transitional HRA for Product Change* located at the end of the current assessment.
- Care Coordinators cannot document a refusal for a Nursing Home member, as it is required that an attempt to visually assess the member be made, and a review of the members Nursing Home record be completed.
- The next annual assessment is due 365 days from the date of the original Nursing Home-ICF Member Assessment and Support Plan not the date of the Transitional HRA.

2. Enter the nursing home assessment date or the date the *Section VI. Nursing Home-ICF Transitional HRA for Product Change* was completed into Bridgeview by the 10th of the following month.
3. Review explanation of Supplemental Benefits using 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. In addition, mailing of the following member letters are required with product changes:
   - Intro letters:
     a. Intro Letter within 30 days of enrollment (includes product changes)
   - Post-assessment letters (within 90 days following the assessment and within 90 days of notification of enrollment). Send one of the following two letters, as applicable:
     a. NH-ICF Visit Summary Letter to the member or if member was unable to participate to the guardian, POA, or responsible party. Letter must additionally be sent to parties identified by the member.

        Or

     b. Responsible Party UTR NH-ICF Visit Summary Letter to the POA or Responsible Party. To be sent if the Care Coordinator has been unable to reach the POA or Responsible Party.

5. See *Primary Care Provider Contact Requirements* for required provider letters.

Mid-year Contact Responsibilities

All members, regardless of 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.

The Care Coordinator's mid-year contact may be in-person, a care conference or over the phone. If member is unable to fully participate the CC must reach out additionally to the guardian, POA or responsible party. CC is required to reach out at a minimum one time to the guardian, POA, or

their responsible party. This must be documented as the Mid-year Contact on Nursing Home-ICF Member Assessment and Support Plan which includes a discussion of:

- recent acute episodes or hospitalizations
- significant changes in condition or level of care
- desires and/or ability to relocate back to the community or another facility
- unmet needs/care concerns

Reassessment Responsibilities

1. The Delegate is responsible to verify member's eligibility prior to delivering Care Coordination services.
2. Annual reassessments must be a in-person visit conducted within 365 days of the previous assessment. There must be documented face-to-face contact with the member. 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.

3. If member is unable to fully participate in the assessment the CC must reach out additionally to the guardian, POA or responsible party. CC is required to reach out at a minimum one time to the guardian, POA or their responsible party.
4. Complete Nursing Home-ICF Member Assessment and Support Plan. The annual assessment must include but is not limited to the following:

    - In-person assessment
    - Review of the member's facility record including the facility's care plan
    - Review of the role of Care Coordinator
    - Desire and/or ability to relocate back to the community or another facility
    - Review explanation of Supplemental Benefits using 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.
    - Interview facility staff.

5. Care Coordinator must also:

    - monitor progress and review any health status changes,
    - evaluate and adjust the timeliness and adequacy of the services the member is receiving
    - solicit and analyze relevant information from all sources
    - communicate with the member as well as the member's interdisciplinary team

6. Mail within 90 days of in-person assessment the:

   - NH-ICF Visit Summary Letter to the member or if member was unable to participate to the guardian, POA, or responsible party. Letter must additionally be sent to parties identified by the member.
   - *Responsible Party UTR NH-ICF Visit Summary Letter* to the POA or responsible party. To be sent if the Care Coordinator has been unable to reach the POA or responsible party.
   - Send *NH-ICF Post Visit Summary Letter-Intro to Primary Care Provider Letter*. For clinic delegates notification to primary care provider documented per clinic process using an EHR is acceptable.

7. Enter the assessment information into Bridgeview by the 10th of the following month.

*****If member is temporarily in the hospital at the time reassessment is due, an HRA is still required to be completed within 365 days. CC should use professional judgement to complete an assessment within the timeframes. Document any delays in reassessments in your case notes.

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.

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 My Move Plan Summary must be offered when a member who is expected to go on EW (i.e. from the facility) is moving to a new residence.

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

1. EW members who are permanently moving into a Nursing Home/ICF
2. NH members who are moving residences and not going on EW

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

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:

1. Evaluate the member's needs,

2. Build and share the Summary with the member,
3. Update the My Move Plan Summary,
4. Update the Collaborative Care Plan (if applicable) or MnC Support Plan
5. Communicate information to others involved (if applicable), and
6. 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:

1. on the day of the move,
2. within the first week of the move,
3. within the first 45 days of the move,
4. 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.

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

Review of Facility Plan of Care

The Care Coordinator must review the facility's care plan and ensure that it both identifies the member's needs in a way that maximizes the member's inclusion, self-determination and choice and should incorporate an interdisciplinary, holistic, and preventive focus.

The Care Coordinator facilitates the integration of these concepts into the plan of care if they are found to be missing upon review. The Care Coordinator must complete thoroughly all sections of the Nursing Home-ICF Member Assessment and Support Plan. While reviewing the facility care plan, the Care Coordinator can determine if the facility care plan is addressing all the required elements listed below:

1. The care plan must be dated and include the member's goals, interventions, and target dates for meeting their goals.
2. The care plan should incorporate a preventive focus employing a thorough plan for addressing the health and safety needs of the members including, but not limited to diagnoses, medications, immunizations, nutritional needs, alcohol and tobacco usage, fall risk, etc. The care plan should have a person-centered focus and should include informal and formal supports as applicable.
3. The care plan or facility member record must indicate advance directive planning for the member. The Care Coordinator should be prepared to initiate ongoing discussion with the member and/or authorized family members or guardians when the lack of a documented advance directive is identified through the care plan review process. The Care Coordinator can enlist the assistance of the primary care provider in helping the member with advance directive planning as well.
    a. Advanced Directives discussions: if during your HRA the member requests to receive and complete an Advanced Directive, Care Coordinators may use the following resources: BCBSMN Advance Directive and Advanced Directive Cover Letter to Member
4. The Care Coordinator works in partnership with the member, authorized family members or guardians, primary care providers and in consultation with other specialists and providers in caring for the member. The Care Coordinator must provide documentation of this consultation in the member's file.
5. The Care Coordinator must retain a copy of the care plan reviewed in the member's file. Blue Plus may request a copy at any time for audit purposes. Be sure the copy of the care plan is dated and includes the member goals, interventions, and target dates.

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 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 practices apply to all but not be limited to:

- Assessment/reassessment
- Planning process
- Review of services and care plans
- Transitions

Members and or their responsible party 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

Case Management and Behavioral Health Case Management Consultation

Complex Case Management/Disease Management/Behavioral Health Case Management Consultation is available when members are identified as needing additional support for:

- 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 for a consult 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.

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.
- **Emergency room stay:** the department of a hospital that provides immediate treatment for acute illnesses and trauma. No TOC log or activities are required for emergency room visits.
- **Observation stay:** is an outpatient hospital stay during which an individual receives medical services to help the doctor decide whether they should be admitted as an inpatient or discharged. If a member is on an observation stay, a TOC log and activities are not required.
- **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. TOC logs are required if the CC learns of a transition while the member is in any phase of the transition process. See grid below for specific instructions on how to complete each field of the TOC log.

2. 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.

   Also, in the infrequent event that a member has communicated to the Care Coordinator they want no verbal and/or written contact from the Care Coordinator, the Care Coordinator is not required to contact the member but is required to case note the circumstance.

3. **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.

4. **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.

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 Support 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.

5. 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.

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

6. **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. CC may have been notified of a pending discharge day prior to the actual discharge. CC can document the date they are notified on the TOC Log but TOC activities as outlined below must take place within one business day AFTER the member actually returns to their usual care setting. Documentation on the log should clearly note the actual date of discharge.

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.

- **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.

- **What if I am unable to reach my member/responsible party?** Care Coordinator must attempt to reach by phone and document the date of first attempt on the TOC log with a note. Best practice would be to also mail the General Unable to Reach letter so member knows the Care Coordinator was attempting to reach to assist post discharge.

TOC log instructions

#	Transition Tasks	Description
1	Notification Date	Enter the date you or your agency was first notified of the transition. Notification date should be the date you are notified of the transition - even if notified after the fact.
2	Transition Date	Enter the date the member moved to the first transitional setting. If date not known, leave this field blank and document "unknown transition date" in the Comments section.
3	Transition From	Enter the type of care setting the member transitioned from: e.g. home, assisted living, skilled nursing facility (SNF), hospital, transitional care unit (TCU)/rehabilitation facility, mental health or chemical dependency residential treatment.
4	Transition To	Enter the type of care setting the member transitioned to: e.g. hospital, SNF, TCU/rehabilitation facility, mental health or chemical dependency residential treatment.
5	Shared CC contact info, Support Plan/services with receiving setting	To be completed by the Care Coordinator within one (1) business day of notification of transition. Enter the date relevant Support Plan info was shared with the receiving setting. Document the date of first attempt if CC unable to reach someone right away. Relevant info at a minimum should be CCs contact information but can also include the following: copy of Support Plan; current services, informal supports, advance directives, medication regimes. This may be communicated via phone, fax, or in person. If CC finds out about the transition after they have already discharged from Transition #1 setting, leave this date field blank and document "notified after discharge from this setting" in the Comments section.

6	Notified PCP of transition – Date completed	Notify PCP of this transition within one business day of notification of transition. Enter the date the member's PCP was notified or date CC confirmed the member's PCP was notified.
7	Confirmed the member's PCP was notified	Check this box if CC confirmed that PCP was notified by other means therefore CC does not need to notify (i.e., PCP was the admitting/discharging physician; SNF notified PCP; CL notified PCP; etc.)
8	Reason for Admission/Comments	Include a brief note explaining the reason for admission: e.g. hospital admission due to [reason]; change in current health status. Also include documentation if CC was notified of the transition after member already discharged from this transition setting. Additional comments are not required, only if applicable.
#	**Return to usual or new usual care setting tasks**	**Description** **Any boxes checked "No", must include an explanation or follow up in comments box.**
1	Date completed	CC must follow up with member within one (1) business day of notification of member's return to their usual care setting or new usual care setting. • 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. • If you are unable to reach the member or they refuse to complete this part of the TOC log/activities, document the date of attempt.
2	Care transition process and changes to the member's health status, including sharing Care Coordinator contact information for additional support.	The care coordinator discusses any additional support member may need including providing contact information. The transition process includes identifying members who have a greater risk of readmission including those with frequent hospitalizations, more than one chronic condition or new acute diagnosis, low health literacy, falls risk, on >10 medications. This is an opportunity to discuss with the member if they feel they've had a significant change in their health status (change in ADL needs, cognitive decline, need for more support/services, etc.). Would the member benefit from completion of a new health risk assessment? Does the member understand the changes to their health? Is there a new diagnosis? Could member benefit from a referral to case/disease management?
3	Support plan required updates:	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. Yes: indicates an update to the member's support plan was needed for DME/medical supply changes, service/support changes, and/or goal updates resulting from a change in the member's health status. No: indicates the discussion with member/and discharge planner directs that no changes are required/requested to the member's support plan from this transition(s).
4	Education about transitions and how to prevent unplanned transitions/readmissions.	Provide education related to prevention of readmission and future unplanned care transitions: e.g. readmission to a nursing home, rehospitalization. Discussion can include but is not limited to talking about reducing fall risk, improving medication management, improving nutritional intake, additional services, advance Support Planning, etc. communicating and helping the member to plan and prepare for transitions, and follow-up care after the transition.
5	Four Pillars for Optimal Transition below (these tasks can be confirmed with facility staff for those residing in a residential/facility setting):	The primary goal is to engage and empower individuals and their caregivers to manage their own care, improve health outcomes and prevent avoidable readmissions.
6	Pillar one: Does the member have a **follow-up appointment** scheduled with primary care/specialist within 15 days or behavioral health within 7 days?	The care coordinator discusses any additional support member may need including providing contact information. The transition process includes identifying members who have a greater risk of readmission including those with frequent hospitalizations, more than one chronic condition or new acute diagnosis, low health literacy, falls risk, on >10 medications. Communication should include an update of known medication changes, durable medical equipment (DME) needs, services needed, etc., resulting from a change in the member's health status.
7	Pillar two: Can the member **manage their medications** or is there a system in place to manage medications?	Check yes that discussion occurred about the member managing their medications after returning home. Determine whether member/designated representative understand current medication regimen. Suggested questions include: Were there any changes made to your medications and do you understand them? Do you have a supply of your current medications and your new medications? How do you get your medications from the pharmacy? Do you need help with setting up or taking your medications? What questions do

		you have about your medications? Assess need for referral to home health services or Medication Therapy Management (MTM) program.
8	Pillar three: Can the member verbalize **warning signs and symptoms to watch for** and how to respond?	Check yes that discussion occurred about member knowledge of warning signs of problems with healing or recovery. Suggested questions include: What are the warning signs that might indicate you are having a problem with healing or recovery? What should you do if these symptoms appear? Who do you call if you have questions or concerns? Do you have those phone numbers readily available? Suggestions include calling nurse line on back of health plan ID card or using Doctor on Demand if primary care physician is not available. (Consider this a possible lead-in to the discussion about personal health care records.)
9	Pillar four: Does the member use a **Personal Health Care Record?**	Check yes that a discussion occurred about whether the member/designated rep use a personal health care record for tracking health history and current regimes. Check "Yes" if visit summary, discharge summary, and/or healthcare summary are being used as a PHR. Suggested talking points include: Point out the advantages of having an organized account of personal health information. Explain that this is a good place to record their medical history, allergies, medications, visits, test results, immunizations, and hospitalizations. Encourage member to bring this record to their provider appointments and to write down questions for their health care team.
10	Comments	Free form text field for documenting reason why "no" is checked for any tasks or pillars listed above or other details related to this transition. Additional comments are not required, only if applicable.
11	**MSHO Members only:** Inform member about post-discharge benefits	All community MSHO members should be referred to LSS for Post-Discharge Community Companion services. Click on this link to access the form. Refer to CC website for details on this benefit. CC should inform member/designated rep that a Community Health Worker from Lutheran Social Services will be contacting them within 72 hours.
12		If the member has medication related questions or concerns, inform the member about the Medication Therapy Management program where a pharmacist can complete a comprehensive medication review to make sure they are working appropriately together. If member wants to speak to a pharmacist, complete the MTM referral form and email to MTM.Pharmacy@bluecrossmn.com only if member requested.

13		Discuss Care Management referral to assist member with additional support as needed and complete the Case Management Referral Form.
14		Review and discuss Dose Health (DoseFlip) and $750 MSHO Supplemental Safety Item Benefit, as applicable.

Outpatient Procedures/Hospital/ER Observation stays

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/Hospital/ER Observation stays.

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. If 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 in-person 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 nursing facility back to the community, the following best practices are recommended:

- If the assessor is different than the assigned 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 with the assessor.
    - Sharing of member's needs and wishes.
    - Assurance 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 "transfers" refers to either:

> an existing Blue Plus enrollee whose Care Coordination is transferring from one contracted Blue Plus Delegate to another contracted Blue Plus Delegate as a result of a move, change in living arrangement, or a change in primary care.
>
> Or an existing Blue Plus enrollee who has disenrolled and is now moving to another health plan or back to fee for service see *Transfers after Disenrollment*.

New Blue Plus enrollees moving from straight Medicaid or from another health plan 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 Care Coordination Delegate Listing and Contact Table or contact your Partner Relations Consultant.
2. Send form Transfer in Care Coordination Delegation form and all transfer documents (assessments and care plans, etc.) directly to the new Delegate. **Optional:** complete DHS-6037 HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form
3. Update the member's address, county of residence and/or PCC in Bridgeview.
4. Notify the member's financial worker by completing the DHS 5181. For address changes, CC's can use this link: https://edocs.mn.gov/forms/DHS-8354-ENG

5. 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 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 the member 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 home/ICF. 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 & MSC+ only in select nursing facilities)
    - Genevive (MSHO and MSC+ members in Hennepin County with Allina PCC)
2. If the CC needs to confirm who the new Care Coordination Delegate will be, refer to Care Coordination Delegate Listing and Contact Table or contact your Partner Relations Consultant.
3. 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 Transfer in Care Coordination Delegation form and all transfer documents (assessments and care plans, etc.) directly to the new Delegate. **Optional:** complete DHS-6037 HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form

2. The **transferring** Care Coordinator is required, at a minimum, to share the following **directly** with the new delegate:
    - The next in-person assessment date (within 365 days of previous assessment)
    - Current Comprehensive Assessment
    - Care Plan; including plan signature page and service provider signature documentation
    - My Move Plan Summary
    - Housing and Stabilization Service (HSS) documents and service plan, if applicable
3. The **transferring** Care Coordinator must communicate the following to the member's financial worker:
    - Address change
    - EW eligibility
4. If a member enters an inpatient setting such as a hospital, Residential Treatment Center, etc. outside of the county the member resides in, the Care Coordination responsibility continues with the current Care Coordinator. Once it is determined the member will not be returning to the original county, the transferring Care Coordinator should proceed with the transfer process outlined here and change the PCC (if applicable).
5. 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 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 CM Change Intro letter may be used to notify the member of a change in Care Coordinator.
2. Enter the name of the assigned Care Coordinator in Bridgeview following the process outlined in the Bridgeview Manual. Notify the financial worker of the assigned Care Coordinator's name.

3. Notify the member's primary care provider using *Change in CC - Intro to Primary Care Provider Letter.* For clinic delegates notification to primary care provider documented per clinic process using an EHR is acceptable.
4. Confirm the PCC is correct in Bridgeview. If incorrect, update following the process outlined in the Primary Care Clinic (PCC) Change section of these Guidelines.
5. 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.
6. Follow the process for completing the health risk assessment and care plan if no current assessment/care Plan is received from the transferring Delegate.
7. Keep copies of all forms and letters related to the transfer for your records.

Optional: Either Delegate may update the address and County of Residence in Bridgeview. This will be done automatically after the Financial Worker makes their changes; however, those changes may take up to a month to reach Bridgeview. **Changing the address and county of residence manually will update the current month's enrollment report.** Follow the process outlined in the Bridgeview manual 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

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 CM Change Intro letter)
2. Update the Care Coordinator assigned in Bridgeview
3. Notify the financial worker of the change in Care Coordinator.
4. Notify the member's primary care provider using *Change in CC - Intro to Primary Care Provider Letter*. For clinic delegates notification to primary care provider documented per clinic process using an EHR is acceptable.

Transfers after Disenrollment

When an existing Blue Plus enrollee has disenrolled and is now moving to another health plan or back to County fee-for-service the Care Coordinator/Delegate must:

1. Confirm health plan or coverage change in Mn-ITS

2. Send MnCHOICES Lead Agency Transfer and Communication Form (DHS 6037-ENG) to the new health plan or county..
3. Send any applicable paper documents directly to the new health plan or County.

Discharge Planning

The Care Coordinator shall coordinate a comprehensive assessment within 20 calendar days of the member's request for Home and Community Based Services (EW services).

If the Care Coordinator currently following the member does not administer the comprehensive assessment, they are responsible for contacting the local Blue Plus Delegate who conducts the assessment. If you are unsure who the local Assessor is, contact your Partner Relations Consultant.

- For members assigned to a Nursing Home only Care Coordination Delegate, the member should remain assigned to the nursing home Care Coordinator until there is confirmation that the member has physically discharged to the community and care coordination has been officially transferred. The nursing home Care Coordinator remains responsible for completing and coordinating all other care coordination responsibilities.

It is Blue Plus's expectation that both the facility Care Coordinator and the Assessor work together to complete all discharge planning.

The primary responsibilities of the Assessor are:

- Complete the Comprehensive Assessment and determining EW eligibility
- Develop the Support Plan
- Coordinate any home care and EW services
- Complete Residential Services tool, if applicable
- Initiate the My Move Plan Summary if member will be going on the Elderly Waiver.

The Facility Care Coordinator must:

- Complete TOC activities and TOC log
- Act as a resource and share information with the assessor as needed
- Upon discharge, initiate the transfer process
- update the PCC, if needed, in Bridgeview.
- Refer to Transfers section of the guidelines for complete details.

And may assist the Assessor with the following tasks, if applicable:

- Locate another living arrangement
- Coordinate any physician discharge orders
- Assure member's pharmacy needs are in place post discharge
- Arrange transportation for day of discharge

- Coordinate any post discharge follow up appointments
- Coordinate any medical supply or equipment needs

Relocation Targeted Case Management

As part of their usual role, Care Coordinators provide relocation services to members planning on returning to the community from a facility. However, if a new member has been receiving Relocation Targeted Case Management services at the time of initial enrollment to Blue Plus, the member must be given the choice to continue to work with their current Relocation Targeted Case Manager. If the member chooses to continue to work with this individual, the Care Coordinator is expected to work with the Relocation Targeted Case Manager on the member's plan of care. It remains the Care Coordinator's responsibility to ensure all activities included in the Care Coordination Guidelines are completed within the necessary timeframes. If a member does not wish to work with their Relocation Targeted Case Manager, the Care Coordinator will provide all necessary relocation service coordination.

Housing Stabilization Services

Housing Stabilization Services (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 Comprehensive 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/MnC Support 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 comprehensive assessment 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. Other select MHM post discharge, community support services, may be warranted when the service(s) is not available under care coordination, MA, EW, other HCBS waiver, or another payer source. These services can be authorized for up to 365 days post discharge in one span. Ideally, members will require a MnCHOICES within 60 days of discharge. This assessment will be used to determine their waiver eligibility (if the services under the medical benefit and waiver can meet the member's identified transitional needs) and open the waiver upon discharge. MHM has an exception regarding the requirement of assessment and opening to a home community-based service waiver (HCBS) upon discharge for members in a licensed IMD facility enrolled as a 1115 Substance Use Disorder Reform Demonstration. 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.

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. 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.

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

- Notify Financial Worker via DHS 5181
    - Care Coordination activities must continue until member officially terms off enrollment

Term due to lapse in MA coverage

- Continue care coordination activities if member is on MSHO through 90-day grace period.

MA closing and will not re-open

- 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. Send any applicable paper documents directly to the new health plan or County

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, 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 so 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.

BlueRide Transportation

All SecureBlue MSHO and Blue Advantage MSC+ members have coverage for transportation to medical appointments through BlueRide.

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 facility
- 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 2 business days prior to the appointment
- 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 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, Support 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.

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 providers listed in the Resource linked below.

Over the Phone services:
Reach out to individual interpreter services provider for their process.

See the Interpreter Resources document located on our Resources page on the Care Coordination website for a list of interpreter providers.

For any providers where a PIN is required to use their services, please reach out to your PR Consultant.

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 Medicare 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 take on your own as self-administered and are not generally covered by Medicare benefits during an outpatient, observation, or ER stay. (Examples include Ibuprofen and insulin, etc.).

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
MTM: Medication Therapy Management program	All **MSHO** members meeting the following criteria are eligible for the MTM program at the beginning of the year	• Telephonic visit scheduled with internal MTM team. • MTM Pharmacist follows standard	• Educate member on benefits of having CMR if contacted. • Care Coordinators should complete the Medication Therapy Management

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).	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, osteoporosis, or dyslipidemia (high cholesterol) • at least **8** Part D prescriptions, • a minimum drug spend for those Part D medications as defined by CMS ($5,330 in 2024). **Criteria B:** Any **MSHO** member can elect to have their medications reviewed by a pharmacist. These members can be referred by a care coordinator for MTM services. Examples of MTM referral criteria include: • Drug side effect/adverse drug event • Polypharmacy (4 or more meds) • Adherence issues	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 medication-therapy problems identified during the CMR to ensure recommendations made to the member and/or provider were accepted.	(MTM) Referral form and email to: MTM.Pharmacy@ @bluecrossmn.com

	• Medication interaction or dosing concerns • Chronic conditions • Frequent ER/hospital visits		

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.
3. **Vulnerable Adults Mandated Training** Web-based training is available at no cost to all mandated reporters here.
4. **Documentation:** The Care Coordinator shall document all activities in the member's contact notes.
5. The Care Coordinator shall comply with any applicable Federal and State laws that pertain to member rights including HIPAA laws and the Minnesota Data Privacy Act and your organization's confidentiality policy.
6. The Care Coordinator should be coordinating with local agency case managers (mental health, developmental disabilities, adult protection, etc.), financial workers and other staff as necessary to meet the member's needs. This includes using the Case Manager/Financial Worker Communication Form (DHS # 5181) when:

- A member requests waiver service
- A member receiving waiver services has a change in circumstances (exits waiver, moves to SNF, expires, etc.)

7. 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 facility, 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 & Written Grievances Policy

Filing Oral Grievances:

- Care Coordinators should direct members to report all oral grievances to Blue Plus by calling Member Services, seven days a week 8:00 a.m. to 8:00 p.m. Central Time.
- Care Coordinators may also assist members in calling Blue Plus to report an oral grievance by conference call or a warm transfer to Member Services. Calls to these numbers are free.
  - MSHO 1-888-740-6013
  - MSC+ 1-800-711-9862
  - TTY users call: 711

Filing 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 Blue Plus Appeals and Grievance department at 651-662-6287 within **one business day** of the receipt of the grievance.
- The information faxed to Blue Plus should include both the written grievance and all other pertinent information or other applicable, related documentation.
- Blue Plus may contact the Delegate for additional information during the investigation of the grievance.
- Documentation must be maintained in member's file by the Delegate.

Member and Provider Appeals

Members receive details in their Member Handbook regarding their privacy rights, protection of their PHI, and their rights to file a grievance, or appeal a denied service, and the process to follow.
If a member would like to file an appeal, they must first appeal to Blue Plus. Appeals may be filed orally or in writing, following guidance in the Member Handbook.

Annually, Care Coordinators must:

- Explain to members that the MSC+ or MSHO Member Handbook includes information about their privacy rights, protection of PHI, and the process for how to file a grievance or appeal a denied service.
- Inform members that Blue Plus will send them a yearly postcard detailing how to access the Member Handbook online or how to request that one be mailed to them.
- Provide a reminder that appeal rights are also sent with any Denial, Termination, or Reduction (DTR) of service(s).
- Inform members that Blue Plus sends a written notice regarding PHI called "Notice of Privacy Practice" annually which can also be found in the Member Handbook.

Member handbooks are located at this webpage: https://www.bluecrossmn.com/shop-plans/minnesota-health-care-programs. Members can request the mailing of one by calling Member Services.

Blue Plus 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 Blue Plus to participate in the hearing. Blue Plus 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. 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.

There is no coverage for care out of the state of Minnesota unless urgent or emergent.

There is no coverage for urgently needed care or any other non-emergency care received outside of the United States.

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

For member's discharging to the community and are interested in using an out of network CFSS/PCA or State Plan Home Care provider, 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.

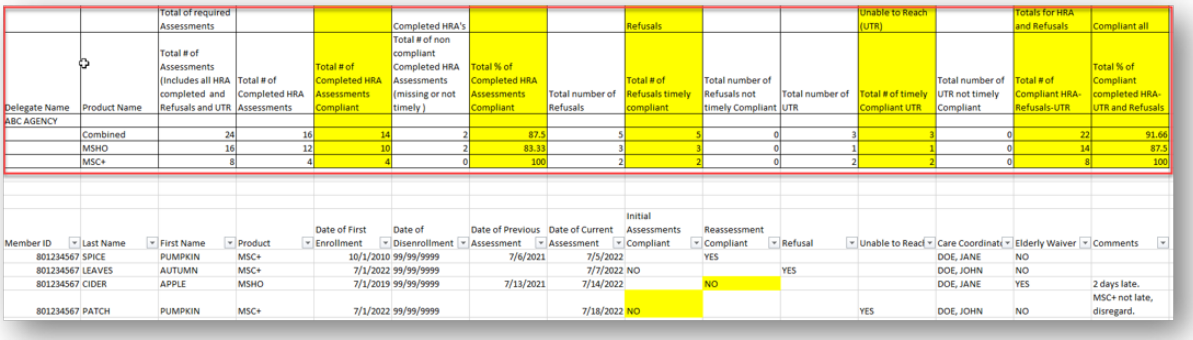
The Partner Relations team will forward this information on to our Contracting department.

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.

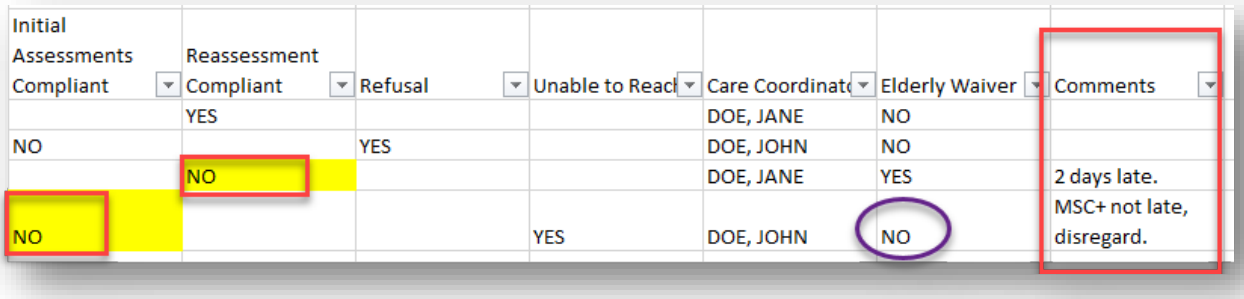
The top of the report includes overall # of assessments completed for both products including data on initials, re-assessments, refusals, and Unable to Reach.



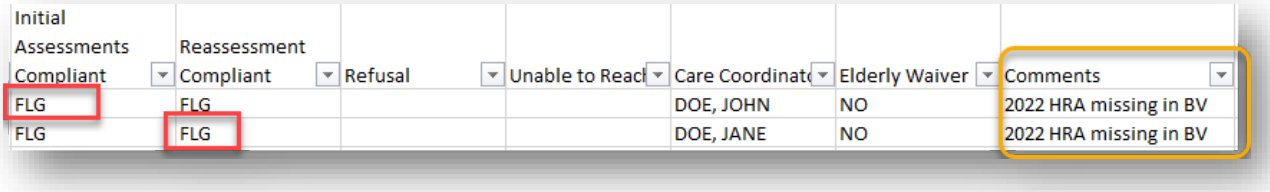
		Total of required Assessments			Completed HRA's			Refusals			Unable to Reach (UTR)		Totals for HRA and Refusals	Compliant all
Delegate Name	Product Name	Total # of Assessments (Includes all HRA completed and Refusals and UTR	Total # of Completed HRA Assessments	Total # of Completed HRA Assessments Compliant	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 Reach	Care Coordinator	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 Reach	Care Coordinator	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.

Audit Process

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. HRA information in Bridgeview are compared to the assessment documentation submitted. Delegates are audited on a monthly, quarterly or semiannual basis. See Bridgeview Care Coordination User Guide for details on the audit process.

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. 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 assessment, 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 95.00% compliance standard for samples 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.