Community
Care Coordination Guidelines

Secure Blue - MSHO
(Minnesota Senior Health Options)

Blue Advantage – MSC+
(Minnesota Senior Care Plus)

Updated 12-1-2025

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

The Care Coordinator is key to supporting the member's needs across the continuum of care by leveraging member involvement, Blue Plus and County case management, and program referral processes. The Care Coordinator works closely with both the member, via 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 the 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 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 Support Plan with other member care plans, as appropriate (i.e., hospice and/or home care agency's care 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 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 MnCHOICES Assessor: Person who completes training and obtains certification from DHS and performs MnCHOICES 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: 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: is defined as the agency, such as counties, private agencies, and clinics, which are contracted to provide Care Coordination services for Blue Plus. Delegates are responsible for periodic reporting to Blue Plus as requested and needed to meet business requirements. Examples include but are not limited to: Quality Improvement Project reporting, enrollment report discrepancies, Hospice care plans, missing residential services tools, and late screening document entry follow up.

Model of Care (MOC): is Blue Plus's plan for delivering coordinated care to SecureBlue (MSHO) members. The Center for Medicare and Medicaid Services (CMS) requires all Special Needs Plans (SNPs) to have a MOC. The Model of Care (MOC) documents the staff, systems, procedures, and improvement activities Blue Plus utilizes to simplify access to healthcare and reduce fragmentation of care delivery for SecureBlue members. The MOC also describes how Care Coordination delegates work together with Blue Plus providers and staff to coordinate access and delivery of all preventives, primary, specialty, acute, post-acute, and long-term care services, including discharge planning, among different health and social service professionals and across health settings. Care Coordination delegates are required to complete annual training on the MOC included as part of Blue Plus's Annual Fall Training.

New Enrollee: is defined as a 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 are 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.

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

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

Recommended Caseload per worker: 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

Factors for determining case mix:

- 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 PCS/Community First Services & Supports (CFSS)

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.

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 include 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 Web Tool and Revised MnCHOICES User Access Request Form* to notify Blue Plus of the new staff and request access to Bridgeview and MnCHOICES, as applicable. This form must also be used to remove access and update User contact information such as name changes; phone number; and e-mail address.
2. After sending the 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 calendar 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 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.

Care Coordination responsibilities and tasks must be initiated upon official notification of enrollment. Best practice is to document the date you were notified of enrollment.

1. **Full Detail report:** A comprehensive list of all members assigned to the Delegate agency available in Bridgeview the first week of each month which includes the following flags:
    - **NEW ENROLLEE:** New member for the enrollment month
    - **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).
    - **RATE CELL CHANGE:** Member rate cell changes to/from A (Community Well); B (Elderly Waiver); or D (Nursing Home)
    - **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.

2. **DAILY report(s):** Includes new enrollees who were retroactively enrolled or termed by either DHS or CMS after the Full Detail report was processed; these can come at any time in the month.

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 reports to check for discrepancies and report 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:*

    - Review Full Detail report and document date of notification of new enrollees.
    - Compare new Full Detail to the previous month's Full Detail report and compare for accuracy.
    - Review "DAILY" report(s) as they are received.
        - The Delegate will receive an email if there's a DAILY 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.
        - **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.
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. This can be met by mailing of the Intro Letter.
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).
    - If the PCC indicated does not match what is listed in Bridgeview, see *Primary Care Clinic (PCC) Change* section for next steps.
    - 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 below 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 research, 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.

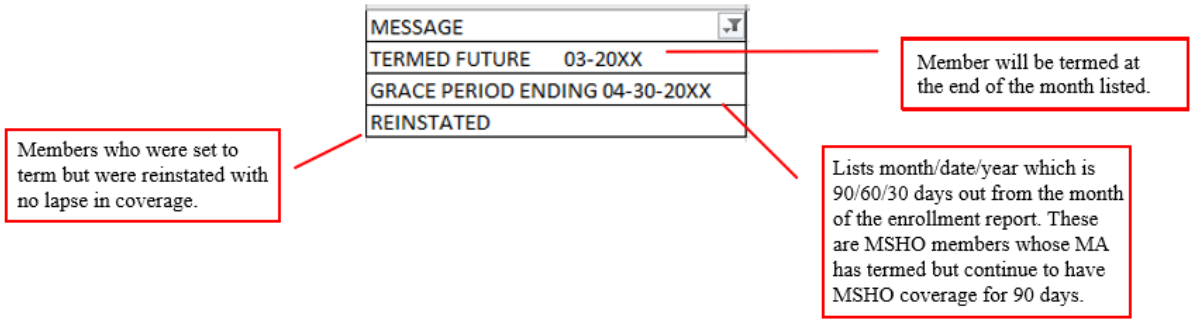
Medical Assistance (MA) Renewals

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 ensure 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:
    - Update the PCC field in Bridgeview. The field includes a list of all PCC's from our Primary Care Network Listing (PCNL) in a drop-down format. You must choose a clinic from one that is listed.
    - If the member's PCC is not listed in Bridgeview, it may not be in our Primary Care Network. Please contact Member Services or your Partner Relations Consultant with any PCC network questions.
2. Determine if change in PCC requires a change in Care Coordination:
    - The following PCC's provide primary care and care coordination:
        1. Bluestone Physicians
        2. Essentia Health
        3. Genevive
    - 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.
        1. Send notification to SecureBlue.Enrollment@bluecrossmn.com for enrollment miss-assignments.
        2. If PCC change is for an existing member resulting in a transfer to another Delegate, see *Transfers section* which includes sending in the ***Blue Plus Transfer in Care Coordination Delegation form*** form.

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

- 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.

90 Day Monitoring after Medicaid becomes inactive (includes MSHO grace period and MSC+ guidance)

When an MSHO or an MSC+ member is showing on enrollment with a current term or future term flag, the member may not have completed their Medicaid renewal timely. The Care Coordinator must follow-up with the member and/or the member's financial worker to confirm the reason for the term.

If it is expected the member's MA will be reinstated within 90 days and the member will be re-enrolled onto Blue Plus with no gap in coverage, Care Coordinators must complete any reassessments and support planning for any MSHO or MSC+ member during this time.
See product specific details below:

MSHO Members

When Medicaid eligibility ends for a member on MSHO, they will get an additional 90 days of coverage referred to as a "grace period". 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. Continue Care Coordination until they officially term off the enrollment report. The only exception to this is if the member moves out of state.
2. Notify service 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.
3. Contact the member's financial worker to determine the reason for MA disenrollment.
    a. If expected to reinstate:

i. Keep the member's case open and work with the member and their financial worker to assist with reinstatement of MA as quickly as possible.

ii. Keep waiver span open in MMIS and all service agreements open in Bridgeview.

b. If not expected to reinstate:

i. Direct members to call Minnesota Aging Pathways (formerly the Senior LinkAge Line) at 1-800-333-2433 for assistance in choosing a new Part D plan.

ii. Once enrolled in a new Part D plan, member will term from the MSHO grace period the same month the Part D plan is effective.

4. If a member is due for reassessment or mid-year contact during the 90 day grace period, Care Coordinators must offer and complete all requirements, including Refusals and Unable to Reach.
5. Per DHS requirements, if member is open to Elderly Waiver and the member's MA is not reinstated by day 60, complete the DHS 6037 and send it with all the pertinent transfer documents to the County of Residence by the 60th day.
6. If not reinstated after 90 days:
    a. Close member to EW in MMIS back to MA closure date
    b. Close Service Agreements in Bridgeview back to MA closure date

MSC+ Members

When Medicaid eligibility ends for a member on MSC+, they do **not** get an additional 90 days of coverage. These members will appear on your enrollment with a TERMED MM/DD/YYYY flag.

Care Coordinators must contact the member's financial worker to determine the reason for MA disenrollment. If the financial worker clearly states that the member is expected to reinstate within the next 90 days, Care Coordinators must:

1. Keep the member's case open and work with the member and their financial worker to assist with reinstatement of MA as quickly as possible.
2. Notify service providers that the members MA has termed and they may want to "halt" services until it is reinstated.
3. Keep waiver span open in MMIS and all service agreements open in Bridgeview.
4. If a member is due for reassessment or mid-year contact within the following 90 days, Care Coordinators must offer and complete all requirements, including Refusals and Unable to Reach.

If the member's financial worker tells you the member's MA is terming and member is not expected to reinstate or the member is not resinstated after 90 days, Care Coordinators must:

1. Close member to EW in MMIS back to MA closure date
2. Close Service Agreements in Bridgeview back to MA closure date
3. Enter Screening Document into MMIS to exit member from EW
4. Notify service providers the member's MA has termed

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

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

Summary of Requirements & Timelines

* These tables are not all inclusive of Care Coordinator tasks and requirements. Refer to other sections below for more detailed requirements.

MSHO & MSC+ Elderly Waiver

MSHO & MSC+ Elderly Waiver				
All members must be offered an in-person visit but can consent to a telephonic visit when applicable. Both offerings must be clearly documented in case notes.				
Tasks	**Initial**	**Product Change**	**Mid-Year**	**Annual/Significant Change**

<table>
<tr><td colspan="5">Member requests an assessment for Elderly Waiver and/or CFSS or as needed: assessment must be completed within 20 business days of request.</td></tr>
<tr><td rowspan="2">Contact requirements</td><td colspan="2">CC contact info provided within 10 calendar days of notification of enrollment (can be met with mailing of Intro Letter within 10 days)</td><td rowspan="2">In-person or telephonic contact with member consent</td><td rowspan="2">In-person assessment within 365 days of previous assessment and prior to capitation (for annual reassessments).</td></tr>
<tr><td>In-person assessment within 30 days of notification of enrollment</td><td>In-person assessment or member-documented consent to a telephonic assessment within 30 days of notification of product change</td></tr>
<tr><td>Every other year, a remote assessment option</td><td colspan="4">The Care Coordinator may perform a remote Elderly Waiver reassessment every other year if their previous assessment was completed in person and the member or member's legal representative was offered an in-person assessment but chooses and consents to complete a remote annual assessment. See the Elderly Waiver Remote Assessments section.</td></tr>
<tr><td>Tasks</td><td>Initial</td><td>Product Change</td><td>Mid-Year</td><td>Annual/Significant Change</td></tr>
<tr><td>Member Letters</td><td>• Within 30 days of notification of enrollment, mail Intro Letter to member.
• Within 30 days of Support Plan completion, send a copy to the member using Support Plan Cover Letter.</td><td>• Within 30 days of notification of enrollment/product change, mail Intro Letter to member.
• If service change updates are made to Support Plan, CC must create a revision and send to member for signature.</td><td>• If UTR at mid-year after making 2 contact attempts, send General Unable to Reach Letter.
• If service change updates are made to Support Plan at mid-year, CC must create a revision and send</td><td>Within 30 days of Support Plan completion, send a copy to the member using Support Plan Cover Letter.</td></tr>
</table>

			to member for signature using *Member Service Change Signature Cover Letter.*	
Assessment tools	Full MnCHOICES or Blue Plus Transitional HRA (must include most recent assessment if paired with legacy tools)	Blue Plus Transitional HRA (must include most recent assessment if paired with legacy tools)	N/A	Full MnCHOICES
Attachments	Add the following as Attachments in the MnCHOICES application as applicable: • Blue Plus Transitional HRA form • MnCHOICES Support Plan Signature Page (if not obtained electronically) • DHS 6914 Caregiver Questionnaire • Medication list (if not included in assessment) • DHS-3428M-ENG Mini-Cog© Instructions for Administration and Scoring • DHS 3936 My Move Plan Summary • Refusal/UTR Member Support Plan letters • EW Provider signatures (as applicable) • Any manual/handwritten changes sent to the member using DHS 6791K			
Support Planning tools	Within 30 days of assessment, complete MnCHOICES Support Plan	If using THRA, attach most recent Support Plan (if using legacy tools)	Review/update Support Plan including goals	Within 30 days of annual/significant change, complete MnCHOICES Support Plan

Provider/Care Team Letters	• Within 90 days of notification of enrollment and after Support Plan completion, send *Support Plan Summary Letter – Intro to Primary Care Provider* (including use of Transitional HRA). If member chooses, include entire Support Plan.
	  ○ For clinic Delegates, notification to PCP documented per clinic process.
	• Per member choice, send EW provider(s) *Service Provider – Support Plan Summary letter* or *Service Provider Support Plan Cover letter* within 30 days of Support Plan completion (2nd attempt, if applicable, within 60 days).
	• Following Support Plan completion, send a copy to member chosen Interdisciplinary Care Team (ICT) Members (i.e. other waiver case manager,
		• Within 90 days of notification of enrollment and after Support Plan completion, send *Support Plan Summary Letter – Intro to Primary Care Provider* (including use of Transitional HRA).
		  ○ For clinic Delegates, notification to PCP documented per clinic process.
		• If changes are made to reviewed Support Plan, CC must (per member choice), send any EW provider(s) *Service Provider – Support Plan Summary letter* or *Service Provider Support Plan Cover letter* within 30 days of Support Plan completion (2nd attempt, if applicable, within 60 days).
			• None unless there's a change in EW services.	• Within 90 days of Support Plan completion, send either the *Support Plan Summary Letter – Intro to Primary Care Provider* or the entire Support Plan per member choice.
				  ○ For clinic Delegates, notification to PCP documented per clinic process.
				• Per member choice, send EW provider(s) *Service Provider – Support Plan Summary letter* or *Service Provider Support Plan Cover letter* within 30 days of Support Plan completion (2nd attempt, if applicable, within 60 days).
				• Following Support Plan completion, send a copy to member chosen Interdisciplinary Care Team (ICT) Members (i.e. other waiver case manager, specialists, behavioral health providers).

	specialists, behavioral health providers).			
Change in Care Coordinator	• New CC must provide contact info within 10 calendar day of change (can be met by sending *CM Change Intro letter*) • Notify member's PCP by sending *Change in CC - Intro to Primary Care Provider* letter (clinic delegates may use EHR notification)			

MSHO & MSC+ Community Well

MSHO & MSC+ Community Well All members must be offered an in-person visit but can consent to a telephonic visit when applicable. Both offerings must be clearly documented in case notes. If declined, see MSHO & MSC+ Refusals Grid.				
Tasks	**Initial**	**Product Change**	**Mid-Year**	**Annual/Significant Change**
Member requests an assessment for Elderly Waiver and/or CFSS or as needed: assessment must be completed within 20 business days of request.				
Contact requirements	CC contact info provided within 10 calendar days of notification of enrollment (can be met with mailing of *Intro Letter* within 10 days)		In-person or telephonic contact with member consent	In-person or telephonic assessment within 365 days of the previous assessment
	MSHO: In-person or telephonic assessment within 30 days of notification of enrollment MSC+: In-person or telephonic assessment within 60 days of notification of enrollment	MSHO: In-person or telephonic assessment within 30 days of notification of product change MSC+: In-person or telephonic assessment within 60 days of notification of product change		
Member Letters	• Within 30 days of notification of enrollment, mail	• Within 30 days of notification of product change,	• If UTR at mid-year after	• Within 30 days of Support Plan completion, send a

	Intro Letter to member. • Within 30 days of Support Plan completion, send a copy to the member using *Support Plan Cover Letter.* • If receiving PCA/CFSS , within 10 days, send member a copy of the PCA/CFSS assessment and include the MSHO or MSC+ Language Block	mail *Intro Letter* to member. • If service change updates are made to Support Plan, CC must create a revision and send to member for signature.	making 2 contact attempts, send *General Unable to Reach Letter*. • If service change updates are made to Support Plan at mid-year, CC must create a revision and send to member for signature using *Member Service Change Signature Cover Letter.*	copy to the member using *Support Plan Cover Letter.* • If receiving PCA/CFSS , within 10 days, send member a copy of the PCA/CFSS assessment and include the MSHO or MSC+ Language Block
Tasks	**Initial**	**Product Change**	**Mid-Year**	**Annual/Significant Change**
If the member requests EW services, the Care Coordinator must pivot to completing a full MnCHOICES assessment as noted in the Elderly Waiver requirements above.				
Assessment tools	HRA-MCO or Blue Plus Transitional HRA (must include most recent assessment if paired with legacy tools)	Blue Plus Transitional HRA (must include most recent assessment if paired with legacy tools)	N/A	HRA-MCO

Attachments	Add the following as Attachments in the MnCHOICES application as applicable: • Blue Plus Transitional HRA form • MnCHOICES Support Plan Signature Page (if not obtained electronically) • DHS 6914 Caregiver Questionnaire • Medication list (if not included in assessment) • DHS-3428M-ENG Mini-Cog© Instructions for Administration and Scoring • DHS 3936 My Move Plan Summary • Refusal/UTR Member Support Plan letters • EW Provider signatures (as applicable) • Any manual/handwritten changes sent to the member using DHS 6791K			
Support Planning tools	Within 30 days of assessment, complete MnCHOICES Support Plan or if using THRA, attach recent care plan if paired with legacy tools.	If using THRA, attach recent care plan if paired with legacy tools	Review/update Support Plan goals	Within 30 days of annual/significant change, complete MnCHOICES Support Plan
Provider/Care Team Letters	• Within 90 days of notification of enrollment and after Support Plan completion, send *Support Plan Summary Letter – Intro to Primary Care Provider* (including use of Transitional HRA). If member chooses, include entire Support Plan. ○ For clinic Delegates, notification to PCP documented per clinic process.	• Within 90 days of notification of enrollment and after Support Plan completion, send *Support Plan Summary Letter – Intro to Primary Care Provider* (including use of Transitional HRA). ○ For clinic Delegates, notification to PCP documented per clinic process.	• None unless there's a change in PCA/CFSS services.	• Within 90 days of Support Plan completion, send either the *Support Plan Summary Letter – Intro to Primary Care Provider* or the entire Support Plan per member choice. ○ For clinic Delegates, notification to PCP documented per clinic process. • If receiving PCA/CFSS , within 10 days, send provider a copy of

	• If receiving PCA/CFSS , within 10 days, send provider a copy of the PCA/CFSS assessment. • Following Support Plan completion, send a copy to member chosen Interdisciplinary Care Team (ICT) Members (i.e. other waiver case manager, specialists, behavioral health providers).			the PCA/CFSS assessment. • Following Support Plan completion, send a copy to member chosen Interdisciplinary Care Team (ICT) Members (i.e. other waiver case manager, specialists, behavioral health providers).
Change in Care Coordinator	• New CC must provide contact info within 10 calendar day of change (can be met by sending *CM Change Intro letter*) • Notify member's PCP by sending *Change in CC - Intro to Primary Care Provider* letter (clinic delegates may use EHR notification) • If applicable, mail *Intro Letter to Other Waiver CM* or document notification of CC assigned in case notes for those open to non-EW waivers			

MSHO & MSC+ Refusals

MSHO & MSC+ Refusals All members must be offered an in-person visit but can consent to a telephonic visit when applicable. Both offerings must be clearly documented in case notes. ***Important:*** Members receiving EW, PCA/CFSS, and/or MA covered home care services cannot refuse or be unable to reach for their reassessment and maintain eligibility for services.				
Tasks	**Initial**	**Product Change**	**Mid-Year**	**Annual**
Contact requirements	CC contact info provided within 10 calendar days of notification of enrollment (can be met with mailing of *Intro Letter* within 10 days)		• CC's must reach out and offer to complete in person HRA-MCO.	• Within 365 days of previous initial/annual contact attempt(s), CC's must reach out and offer to
	• Within 30 days of notification of enrollment	• Within 30/60 days of notification of product change, CC's		

	for MSHO and 60 days for MSC+, CC's must reach out and offer to complete an in-person HRA-MCO. • If declined, must offer to complete telephonically. • If still declined, must document offerings in case notes.	must reach out and offer to complete in-person HRA-MCO. • If declined, must offer to complete telephonically. • If still declined, must document offerings in case notes.	• If declined, must offer to complete telephonically. • If still declined, must document offerings in case notes.	complete in person HRA-MCO. • If declined, must offer to complete telephonically. • If still declined, must document offerings in case notes.
Tasks	**Initial**	**Product Change**	**Mid-Year**	**Annual/Significant Change**
Member Letters	• Within 30 days of notification of enrollment, mail *Intro Letter* to member • Within 30 days of refusal, mail *Refusal Member Support Plan Letter.*	• Within 30 days of notification of product change, mail *Intro Letter* to member • Within 30 days of refusal, mail *Refusal Member Support Plan Letter.*	If member was previously a refusal and is Unable to be Reached at mid-year after making 2 contact attempts, send *General Unable to Reach Letter*.	Within 30 days of refusal, mail *Refusal Member Support Plan Letter.*
If the member requests EW services, the Care Coordinator must pivot to completing a full MnCHOICES assessment as noted in the Elderly Waiver requirements above.				
Tasks	**Initial**	**Product Change**	**Mid-Year**	**Annual/Significant Change**
Attachments	Add the *Refusal Member Support Plan Letter* as an Attachment in the MnCHOICES application.			
Provider/Care Team Letters	Within 90 days of notification of enrollment, send the *UTR/Refusal Support Plan*	Within 90 days of notification of product change, send the *UTR/Refusal Support Plan Summary – Intro to*	N/A	Within 90 days of mailing the *Refusal Member Support Plan Letter* to member, send the

	Summary – Intro to Primary Care Provider Letter • For clinic Delegates, notification to PCP documented per clinic process.	*Primary Care Provider Letter* • For clinic Delegates, notification to PCP documented per clinic process.		*UTR/Refusal Support Plan Summary – Intro to Primary Care Provider Letter* • For clinic Delegates, notification to PCP documented per clinic process.
	For members who are Refusals and declined to validate or confirm they have no PCC, Care Coordinator must case note and are not required to send a *UTR/Refusal Support Plan Summary-Intro to Primary Care Provider Letter*.			
Change in Care Coordinator	• New CC must provide contact info within 10 calendar days of change (can be met by sending *CM Change Intro letter*) • Notify member's PCP by sending *Change in CC - Intro to Primary Care Provider* letter (clinic delegates may use EHR notification) • If applicable, mail *Intro Letter to Other Waiver CM* or document notification of CC assigned in case notes for those open to non-EW waivers			

MSHO & MSC+ Unable to Reach

MSHO & MSC+ Unable to Reach All members must be offered an in-person visit but can consent to a telephonic visit when applicable. Both offerings must be clearly documented in case notes. ***Important:*** Members receiving EW, PCA/CFSS, and/or MA covered home care services cannot refuse or be unable to reach for their reassessment and maintain eligibility for services.				
Tasks	**Initial**	**Product Change**	**Mid-Year**	**Annual**
Contact requirements	CC contact info provided within 10 calendar days of notification of enrollment (can be met with mailing of *Intro Letter* within 10 days)		Total of 2 attempts to reach member to offer in person or	Total of 4 attempts to reach member to offer in -person or telephonic assessment options within 365 days
	Total of 4 attempts to reach member to offer in-person or telephonic assessment options	Total of 4 attempts to reach member to offer		

	within 30 days of notification of enrollment (60 days for MSC+)	in-person or telephonic assessment options within 30 days of notification of product change (60 days for MSC+)	telephonic assessment.	previous initial/annual
Member Letters	• Within 30 days of notification of enrollment, mail *Intro Letter* to member • 4th and final attempt to contact member must be the *UTR Member Support Plan* letter and must be dated within 30 days of notification of enrollment	• Within 30 days of notification of product change, mail *Intro Letter* to member • 4th and final attempt to contact member must be the *UTR Member Support Plan* letter and must be dated within 30 days of notification of product change	If member is unable to be reached at mid-year, CC must mail the *UTR Member Support Plan* letter again. Do not enter mid-year UTR attempts into Bridgeview and/or MnCHOICES.	4th and final attempt to contact member must be the *UTR Member Support Plan Letter* and must be dated within 365 days of initial/annual mailing of *UTR Member Support Plan Letter*
Assessment tools	Enter date of *UTR Member Support Plan Letter* as HRA date into Bridgeview	Enter date of *UTR Member Support Plan Letter* as HRA date into Bridgeview	Do not enter mid-year mailing of the *UTR Member Support Plan* letter into Bridgeview	Enter date of *UTR Member Support Plan Letter* as HRA date into Bridgeview
Attachments	Add the *UTR Member Support Plan Letter* as an Attachment in the MnCHOICES application.			
Provider/Support Team Letters	Within 90 days of notification of enrollment, send the *UTR/Refusal Support Plan*	Within 90 days of notification of product change, send the	N/A	Within 90 days of mailing the *UTR Member Support Plan Letter* to

	Summary – Intro to Primary Care Provider Letter • For clinic Delegates, notification to PCP documented per clinic process.	*UTR/Refusal Support Plan Summary – Intro to Primary Care Provider Letter* • For clinic Delegates, notification to PCP documented per clinic process.		member, send the *UTR/Refusal Support Plan Summary – Intro to Primary Care Provider Letter* • For clinic Delegates, notification to PCP documented per clinic process.
	If the PCC is unknown, CC should attempt to confirm correct PCC is listed in Bridgeview by reviewing the DHS New Enrollee Report or Helios. If PCC can be identified in one of these areas, CC should send the UTR/Refusal Support Plan Summary-Intro to Primary Care Provider Letter. If PCC cannot be determined and letter cannot be sent, CC must case note.			
Change in Care Coordinator	• New CC must provide contact info within 10 calendar days of change (can be met by sending *CM Change Intro letter*) • Notify member's PCP by sending *Change in CC - Intro to Primary Care Provider* letter (clinic delegates may use EHR notification) • If applicable, mail *Intro Letter to Other Waiver CM* or document notification of CC assigned in case notes for those open to non-EW waivers			

Initial Contact with New MSHO and MSC+ Enrollee

New Enrollee is defined as a:

- member who is newly enrolled in Blue Plus, or a
- member who changes products within Blue Plus (i.e., MSC+ to MSHO or vice versa).

****The mailing of all initial member and provider letters is required for product changes.

Note: a change in rate cell/living arrangement does not mean the member is newly enrolled even if it results in a change in Care Coordination

1. The Delegate is responsible to verify member's eligibility prior to delivering Care Coordination services

2. Use the optional workflow checklists located on the Care Coordination page of our website.
3. Delegate will inform the member of the name, number, and availability of the Care Coordinator within 10 calendar days of notification of enrollment. This can be met by mailing of the Intro Letter within 10 calendar days.
4. Welcome call/Intro Letter to member within 30 calendar days after notification of enrollment.
5. Explanation of Care Coordinator's role.
6. Review and confirm with the member correct demographic information as displayed in Bridgeview. If any are incorrect, the CC must update in Bridgeview, if allowed, and send DHS 5181 to the financial worker. For address changes, CC's can use this link: https://edocs.mn.gov/forms/DHS-8354-ENG

   Review the following:

   - Residential and mailing address – discrepancies impact mailings from Blue Plus and DHS (ie. Medicaid Renewals)
     - Residential: where member currently resides
     - Mailing: may be different than residential if member has mail go to an authorized rep or guardian
   - Living arrangement (community or nursing home)
   - Rate cell – example: if a member resides in 24 hour CL but displays as Rate Cell A instead of a Rate Cell B, this is a red flag to check your MMIS Screening Document entry.
   - Waiver begin date/end date
   - Primary Care Clinic.
     - See *Primary Care Clinic (PCC) Change* if the PCC listed is incorrect.
7. Complete and send DHS 5181 to member's financial worker with request in *Section D – Comments* to be added to the "Social Worker Panel".
8. Review current services authorized by the Care Coordinator to determine if change in service provider is required. See *Blue Plus Network* section.
9. Have the following discussions for MSHO/MSC+ members and document on the member's Support Plan under the Support Plan Signature Sheet under Person> Materials shared> Other information> Enter a list of other materials shared:

   a. MSHO Enrollees:

i. Explain MSHO supplemental benefits using resource *Explanation of Supplemental Benefits*.

ii. **Required** for MSHO members - Safe Disposal of Medications: When seen in-person at both initial and annual visits, provide community members with Safe Disposal of Medications flyer. Also provide the member with, at least two sites from either:

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

Members may use any site they prefer. Case note the discussion and information provided in the Other Information section of the Support Plan.

b. MSC+ Enrollees:

i. Discuss SecureBlue MSHO product and provide enrollment resources, if applicable. See SecureBlue MSHO Enrollment Resources page on the website.

1. MSC+ enrollees with an MA spenddown are not eligible to enroll into MSHO. CC can document this in case notes and not send referral.

ii. **Optional** for MSC+ members - Safe Disposal of Medications. When seen in-person at both initial and annual visits, provide community members with Safe Disposal of Medications flyer. Also provide the member with, at least two sites from either:

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

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

10. Confirm the correct Primary Care Clinic (PCC). A PCC may have been chosen by the member or auto assigned if one was not indicated at the time of enrollment.

Prioritizing Initial Outreach to New Enrollees

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

1. The Care Coordinator must review the *"New Enrollee Utilization Report".* Blue Plus will send this report to each Delegate within two business days from date of receipt from DHS. This report includes information about MN Health Care Program (MHCP) recipients

who are new to Blue Plus (i.e., new from FFS MA, SNBC, Families and Children, or another health plan).

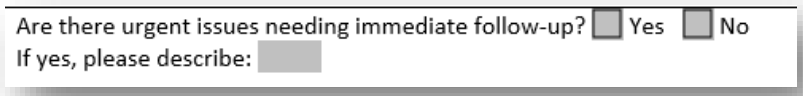
Care Coordinator is required to reach out to members with any needs in these areas within one business week so that potential urgent needs are addressed. If initial contact has already taken place the Care Coordinator must review to determine if additional outreach is required.

- DME Claims—claims for Durable Medical Equipment during the previous 12 months.
    - This should be reviewed for continuity of current services/needs.
- Pharmacy Prior Auths—prescriptions for certain drugs that were prior authorized in the previous 4 months.
    - Review expiration dates of PA if applicable and assist with obtaining new PA if needed.
- MH Non-TCM (Mental Health Non-Targeted Case Management)—information on non-targeted mental health encounters during the previous 4 months (i.e., ACT Assertive Community Treatment, ARMHS Adult Rehabilitative Mental Health).
    - Helpful to determine if there needs to be a discussion with member about any mental health needs or services.
- Inpatient Stays—all inpatient admissions and discharges within the previous 4 months.
    - Helpful to determine potential service needs.
- Care Coordinators should pay close attention to #27 Eligibility Review Date information. This will allow CC to assist members with Medical Assistance paperwork as needed. Follow guidance in *Medical Assistance (MA) Renewals* section.

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

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

2. Care Coordinators can document any urgent issues identified in case notes and/or on the Blue Plus Transitional HRA form.



3. When the CC receives *Aging & Disability Services: MnCHOICES Lead Agency Transfer and Communication Form DHS 6037* from the previous health plan or county, the CC must review it for information which may require urgent/immediate discussion with the member including:
    a. Does the member have another case manager?
    b. What is their primary diagnosis? (ie: Dementia, Cancer, ESRD)
    c. Has the member recently been hospitalized?
    d. Has it been awhile since they've had contact with a CM or CC?
    e. Is there anything listed under "CURRENT ISSUES/CONSIDERATIONS" needing immediate attention (Ie. upcoming appts, surgeries, DME /equipment needs, essential services listed)?

Mid-Year Contact Requirements

All members, regardless of living arrangement/rate cell, are required to have a mid-year contact. See *Summary of Requirements & Timelines*.

The timeline for the mid-year contact requirement is anytime between months 5 and 7 following the member's initial or annual assessment.

Quarterly visits (in-person/telephonic) are not required, and this should not be the standard Care Coordinator contact plan. Members can receive quarterly visits but must be member driven/requested. 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.

See each Health Risk Assessment option below for specific mid-year requirements.

Health Risk Assessment Options & Requirements

See *Summary of Requirements & Timelines* above for assessment timelines and required member and Primary Care Provider letters.

See *Support Planning Options & Requirements* below for instructions on Support Planning after completion of the assessment.

Assessment edits (as applicable)

Care Coordinators must use form DHS 6791K MnCHOICES Revision Cover Letter to communicate with the member if/when there are any manual/handwritten changes or additions made to the member's MnCHOICES assessment and support plan documents. This may include handwritten and electronic corrections, or a printed screen from the online MnCHOICES system.

- Any manual/handwritten changes sent to the member using DHS 6791K must be attached to the member's profile in MnCHOICES.

Location/Staff Assignments

Assign the Care Coordinator in the member profile under Staff Assignments as Care Coordinator in MnCHOICES and check "Is Primary Assignment" if there is no other waiver case manager. Must assign correct lead agency organization combination for both Location and Staff role <Delegate Name - Blue Plus>.

Important: For members on another HCBS waiver - only assign Care Coordinator role. Do not select "Is Primary Assignment".

Full MnCHOICES Assessment

Required Assessment tool for initial and annual assessments for:

- New enrollees needing access to EW and/or PCA/CFSS services
- Annual re-assessments (within previous 365 calendar days)
- To determine Elderly Waiver eligibility for anyone requesting Elderly Waiver or PCA/CFSS.
- Significant changes (members who had a change in their health status and require a change in their EW case mix)

Care Coordinator is required to:

1. Complete the MnCHOICES assessment in its entirety. If a section is not applicable, enter N/A. Be sure to select "yes" to question "I am the Care Coordinator and Need the Staying Healthy Section".
    - If an Informal Caregiver is identified during the assessment, CC must offer the DHS 6914 Caregiver Assessment and document offering (ie. CG assessment was offered and/or declined, mailed and/or completed etc.) under Functional Assessment - Community Living> Relationships Informal Supports comment box.

- Reminder: Add caregiver name under relationship type "Informal Caregiver" in member profile in order to display in informal caregiver drop down list.

2. Complete required OBRA Level I in the MnCHOICES application including for CFSS.
3. If applicable, clearly label and attach in the member's attachments in MnCHOICES:
    - Blue Plus Transitional HRA form
    - MnCHOICES Support Plan Signature Page (if not obtained electronically)
    - DHS 6914 Caregiver Questionnaire
    - Medication list (if not included in assessment)
    - DHS-3428M-ENG Mini-Cog© Instructions for Administration and Scoring
    - DHS 3936 My Move Plan Summary
    - Refusal/UTR Member Support Plan letters
    - EW Provider signatures (as applicable)
4. Address all identified risks on the Support Plan.
    - Include care coordination and/or case aide services as applicable under "Services that Support Me".
5. Determine if there is a need for referrals which may include specialty care, other home care services, case management.
6. Document any delays in scheduling of the assessment.
7. Document any delays of enrollment notification.
8. Enter the assessment type and date into the Bridgeview Company's web tool (refer to Bridgeview Care Coordination User Guide) by the 10th of the following month.
9. Enter an LTC Screening Document in MMIS (*See Entry of LTC screening document information into MMIS section*)
10. See Support Planning Options & Requirements.
11. Re-assessment is due within 365 calendar days of the date of this assessment.

Mid-year:

At mid-year (anytime between months 5 and 7), Care Coordinators are required to reach out by phone, at minimum, to review and document the member's progress towards their Support Plan goals and review of services. See *Mid-year Support Plan review* section for requirements.

If member is unable to be reached at mid-year after making 2 contact attempts, CC must document their attempt(s) in the member's case notes including a Support Plan revision to add comments in the monitoring section of each goal.

- CC must also send *General Unable to Reach letter*.

Elderly Waiver Remote Assessments

In accordance to DHS guidance and the Minn. Stat. §256B.0911, subd. 3a (r), the Care Coordinator may perform a remote Elderly Waiver reassessment every other year if their previous assessment was an in-person assessment and the member or member legal representative was offered an in-person assessment and chooses to complete a remote annual assessment. (*When available, DHS recommends using interactive video to allow for observation (including observation of the person's environment) and completion of screenings like the mini-cog.)*

- Remote reassessments may be conducted by interactive video or telephone to substitute for in-person reassessments every other year for Elderly Waiver. This remote Elderly waiver assessment may only be substituted for one Elderly Waiver reassessment and must be followed by an in-person reassessment.

A remote Elderly Waiver reassessment is permitted only if the member being reassessed, or the member's legal representative (if applicable), consents to a remote assessment after getting the information they need to make an informed choice from the Care Coordinator. The Care Coordinator must document that the member was able to make an informed choice, according to the standard. When selecting a remote reassessment in MnCHOICES, the Care Coordinator must document in the corresponding text box that they offered informed choice.

What is Informed choice? Informed choice means a person 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.

Example of considerations include:

- Potential communication considerations (e.g., the need for an interpreter, hearing loss and memory loss).
- Advantages of an in-person reassessment (e.g., observation).
- The person's individual situation (e.g., a recent move, hospital stay, other institutional stay or changes to the person's physical health, mental health, or support needs).
- The person's preferences, concerns and feedback about the information provided.

- The member being reassessed, or the member's legal representative, has the right to refuse a remote reassessment at any time and have an in-person assessment. If the Care Coordinator determines an in-person reassessment is necessary during a remote reassessment, the Care Coordinator should schedule an in-person reassessment.
- All other requirements of an in-person reassessment shall apply to a remote reassessment, including updates to a member's Support Plan, provider signature requirements, and member signature requirements.

Blue Plus Transitional HRA/DHS Transfer Functional Needs Update (Transfer FNU) Assessment Options

For new enrollees or Blue Plus to Blue Plus Product changes (MSHO to MSC+ or MSC+ to MSHO) who have had a MnCHOICES or an HRA-MCO assessment within the previous 365 calendar days, there are two assessment options:

- Blue Plus Transitional Health Risk Assessment (HRA) form
- DHS Transfer Functional Needs Update (FNU) in MnCHOICES

Use of the Blue Plus Transitional HRA/DHS Transfer Functional Needs Update process DOES NOT apply for Blue Plus to Blue Plus delegate agency transfers.

Completion of either of these assessment options following the guidance and scenarios below will meet the requirements for completion of an initial health risk assessment. These assessments can be reviewed either in person or telephonically to ensure the information has not changed and the Support Plan addresses the members' needs. Care Coordinators must document if an in-person visit was offered.

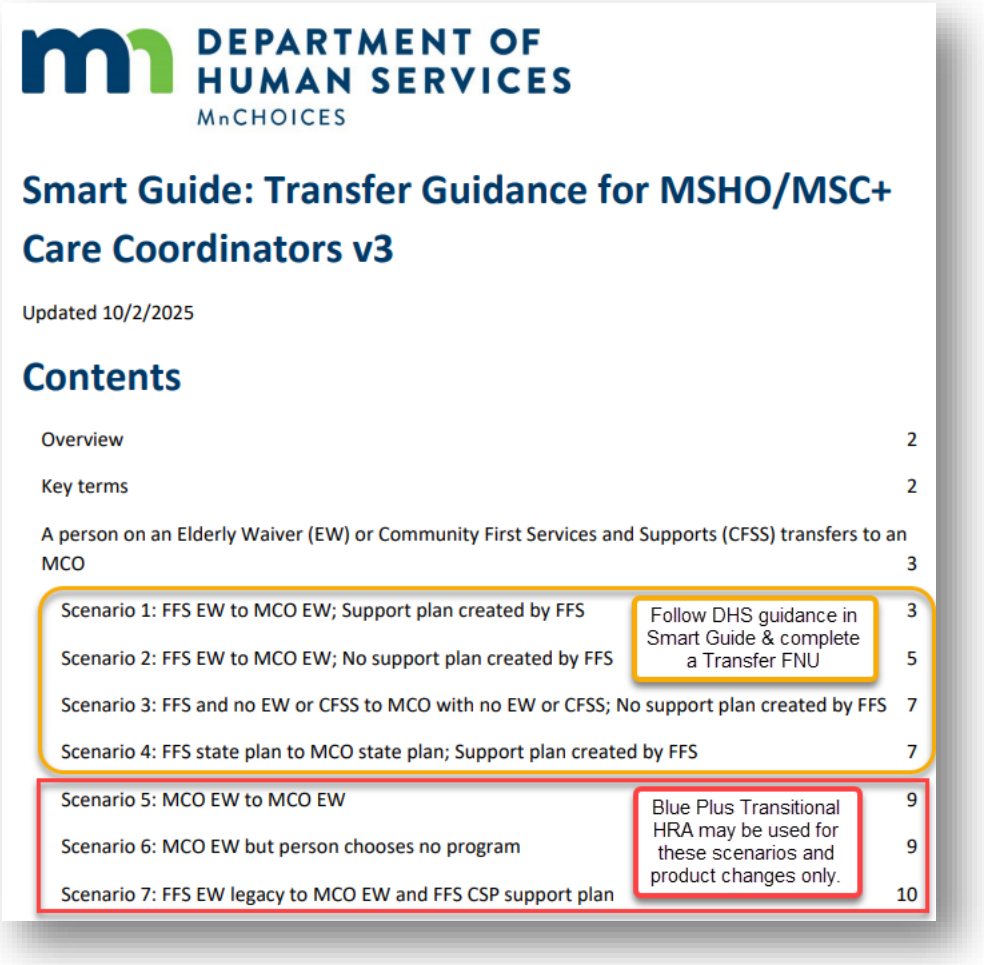
In addition, Care Coordination requirements for completion of all new enrollee tasks must be followed as outlined in the Summary of Requirements & Timelines tables including:

- assessment of any urgent needs that require immediate follow-up
- following all assessment/support planning timelines
- mailing of applicable member and provider letters
- Bridgeview entry
- reassessment within 365 days from the date of the last MnCHOICES assessment

The assessment and support plan paired with the Transitional HRA/DHS Transfer FNU assessments become the Care Coordinator's assessment and support plan. CC's assume responsibility for the assessments and must review and revise when any information is missing -- including goals, signatures, and documentation of goals and support for assessed needs, health conditions, and diagnosis. See Documentation of diagnoses, health conditions, and needs in the Support Plan for more details.

- CC's are required to mail an updated Support Plan to the member if there are changes made.
- A Member Signature is only required if there are service or goal changes.
- **Note:** For new enrollees (transferred from another health plan or fee-for-service) the CC must assess for any urgent needs that require immediate follow-up.

To determine which assessment option to use, Care Coordinators should reference the following scenarios:



DEPARTMENT OF HUMAN SERVICES
MnCHOICES

Smart Guide: Transfer Guidance for MSHO/MSC+ Care Coordinators v3

Updated 10/2/2025

Contents

Follow DHS guidance in Smart Guide & complete a Transfer FNU

Blue Plus Transitional HRA may be used for these scenarios and product changes only.

When to complete a TRANSFER FNU in MnCHOICES following guidance outlined in DHS Smart Guide:	
Scenario	Guidance
#1: FFS EW to MCO EW with support plan	Follow MnCHOICES specific tasks which includes completion of the required Staying Healthy section.
#2: FFS EW to MCO EW with no support plan	Follow MnCHOICES specific tasks which includes completion of the required Staying Healthy section and new support plan.
#3: FFS no waiver to MCO no waiver with no support plan (community well members)	New HRA-MCO and support plan required.
#4: FFS with state plan home care to MCO with state plan home care with support plan	Follow MnCHOICES specific tasks which includes completion of the required Staying Healthy section.

When to complete a Blue Plus Transitional HRA form:	
Scenario	Guidance
#5: MCO EW to MCO EW	Complete Blue Plus Transitional HRA following guidance on the form.
#6: MCO EW but member chooses not to open to EW	Complete Blue Plus Transitional HRA following guidance on the form. Discard EW support plan and complete an HRA-MCO Support Plan.
#7: FFS EW LTCC to MCO EW	Complete Blue Plus Transitional HRA following guidance on the form.
Blue Plus to Blue Plus Product Changes	Complete Blue Plus Transitional HRA following guidance on the form.

Important notes when utilizing the above assessment/support planning options:

- Both the DHS Smart Guide and the Blue Plus Transitional HRA can be found on the Care Coordination page of our website.
- See the Bridgeview Care Coordination User Guide for how to document Blue Plus Transitional HRA or Transfer FNU into Bridgeview by the 10th of the following enrollment month.
- See *Checklist – Transitional HRA* on the Care Coordination page of the website for specific details, requirements, and completion timelines.
- If a member refuses completion of an initial Blue Plus Transitional HRA or TRANSFER FNU and is receiving any EW/state plan home care services, CC's can authorize services through the current service authorization/waiver span.
    - It is very important to remind the member they cannot refuse re-assessment and continue to receive any services. This would be entered as a Refusal into Bridgeview with mailing of Refusal Member Support Plan letter. CC should remind member of need to complete annual EW reassessment to continue receiving services in the letter.

Mid-year:

At mid-year (anytime between months 5 and 7), Care Coordinators are required to reach out by phone, at minimum, to review and document the member's progress towards their Support Plan goals and review of services. See *Mid-year Support Plan review* section for requirements.

For Transitional HRA's and/or Transfer Functional Needs Update:

- Mid-year goal review should be done via Support Plan revision.
- If the previous assessment was done telephonically, the CC must be offer an in-person visit but member can consent to a telephonic visit.
- Both offerings must be clearly documented in case notes.
- If member is unable to be reached at mid-year after making 2 contact attempts, CC must document their attempt(s) in the member's case notes including a Support Plan revision to add comments in the monitoring section of each goal.
    - CC must also send *General Unable to Reach letter*.

- For members that are unable to reach to complete a Blue Plus Transitional HRA form or Transfer Functional Needs Update as a new enrollee, review goals from existing support plan not the unable to reach support plan.
- For members who refuse completion of a Blue Plus Transitional HRA form or Transfer Functional Needs Update as a new enrollee, review goals from existing support plan not the refusal support plan.

HRA-MCO

Assessment option for initial and annual assessments for members:

- who are Community Well and do not receive or are not requesting Elderly Waiver or PCA/CFSS services.
- on non-EW waivers (DD, CAC, CADI or BI)
    - if the Waiver CM is the same as the Blue Cross Care Coordinator, they still need to complete an HRA-MCO assessment in conjunction with the MnCHOICES.
    - see Members open to another waiver (non-EW) or rule 185 case management section for additional CC tasks.

This assessment option in MnCHOICES is used for members who agree to complete either an in-person or if declined, a telephonic assessment and the Care Coordinator determines the member does not need to be assessed for EW eligibility and EW services, or authorization of PCA/CFSS.

- For Community Well members, Care Coordinators must first offer to complete an in-person HRA-MCO.
- If refused, the CC must offer to complete the HRA-MCO telephonically.
- Document both offerings in case notes.
- If during the HRA-MCO assessment the member is found to have a need for EW or PCA/CFSS services, a full MnCHOICES assessment must be completed.

Care Coordinator is required to:

1. Complete the HRA-MCO with the member following the contact timeline requirements.
    - If an Informal Caregiver is identified during the assessment, CC must offer the DHS 6914 Caregiver Assessment and document offering (ie. CG assessment was offered and/or declined, mailed and/or completed etc.) under Everyday Life>Taking Care of Self in the comment box.
    - Reminder: Add caregiver name under relationship type "Informal Caregiver" in member profile in order to display in informal caregiver drop down list.
2. If applicable, clearly label and attach the following in the members attachments in MnCHOICES:
    - Blue Plus Transitional HRA form
    - MnCHOICES Support Plan Signature Page (if not obtained electronically)
    - DHS 6914 Caregiver Questionnaire
    - Medication list (if not included in assessment)
    - DHS-3428M-ENG Mini-Cog© Instructions for Administration and Scoring
    - DHS 3936 My Move Plan Summary
    - Refusal/UTR Member Support Plan letters
    - EW Provider signatures (as applicable)
3. See Support Planning Options & Requirements.
4. Enter the assessment type and date into the Bridgeview Company's web tool (refer to Bridgeview Care Coordination User Guide*)* by the 10th of the following month.

Mid-year:

At mid-year (anytime between months 5 and 7), Care Coordinators are required to reach out by phone, at minimum, to review and document the member's progress towards their Support Plan goals and review of services. See *Mid-year Support Plan review* section for requirements.

If member is unable to be reached at mid-year after making 2 contact attempts, CC must document their attempt(s) in the member's case notes including a Support Plan revision to add comments in the monitoring section of each goal.

- CC must also send *General Unable to Reach letter*.

Refusals

Refusals can only be made by the member or responsible party. Refusals are when a member is refusing to complete an in person or telephonic/remote assessments.

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

- Care Coordination services are still required even if the member refuses completion of an assessment.

Members cannot refuse an assessment/reassessment and receive the following services:

- Elderly Waiver services
- PCA/CFSS services
- MA covered home care services (SNV, HHA, Physical, Occupational, Respiratory, and Speech Therapy)

Note: For member's refusing a re-assessment, authorization of MA covered home care services would be allowed if the member is on a disability waiver and has had a comprehensive assessment completed by the Case Manager. See *Home Health Care Authorization Processes*.

If a CW member refuses to meet with the CC timely due to personal obligations and can meet later, Care Coordinators must enter a refusal in Bridgeview and send the Refusal Member Support Plan letter. The Care Coordinator is still required to complete the assessment on member's requested schedule.

If member is on EW and refuses their next annual MnCHOICES assessment, the waiver will expire at the end of the waiver span. CC must follow the DTR process.

The CC is required to:

1. Offer an in-person HRA-MCO and Support Plan.
    a. If declined, the CC must then offer to complete the HRA-MCO and Support Plan telephonically.
2. Care Coordinators must clearly document in their case notes offering all assessment options listed above. The case note must state the member refused the in-person and telephonic assessment offerings.
3. Mail the Refusal Member Support Plan Letter to the member.
4. In MnCHOICES, attach a copy of this letter and make clear what you are attaching in the description including the assessment date.
5. Enter the assessment type and date of the refusal into the Bridgeview Company's web tool (refer to Bridgeview Care Coordination User Guide) by the 10th of the following month.
6. Within 90 days of the refusal, send the UTR/Refusal Support Plan Summary – Intro to Primary Care Provider Letter or for clinic Delegates, notification to PCP documented per clinic process.

Mid-year Refusal:

At mid-year (anytime between months 5 and 7), if the CW member previously refused the CC's assessment offerings, CC must offer to complete:

1. An in-person HRA-MCO and Support Plan.

a. If declined, the CC must then offer to complete a telephonic HRA-MCO and Support Plan.
b. Care Coordinators do not need to send another Refusal Member Support Plan letter at mid-year. No Bridgeview or MnCHOICES entry is required.

2. Care Coordinators must clearly document in their case notes offering all assessment options listed above. The case note must state the member refused the in-person and telephonic assessment offerings.

Note: If the member was previously a refusal and is Unable to be Reached at your mid-year contact attempt after making 2 contact attempts, CC must mail the General Unable to Reach letter.

Annual Refusals

1. For annual re-assessments, the CC must reach out at a minimum of 2 weeks in advance of the 365-calendar day deadline to allow enough time for scheduling an assessment with the member if they agree to it.
2. Then follow steps 1 – 6 above.

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

In the rare circumstance a member is on Elderly Waiver, and they refuse the offered assessment date in the allowed time frame (365 calendar days) but they can meet with the Care Coordinator after the 365 days and prior to waiver span end date, the Care Coordinator will:

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

Member request for no contact:

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

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

- Within 365 days of the previous refusal, CC must case note the member continues to want no verbal or written communication and enter the refusal into Bridgeview MnCHOICES.

Unable to Reach

Unable to Reach are members who the Care Coordinator has not been able to contact after multiple attempts. CC is required to make three contact attempts and send a letter (total of 4 contact attempts) to offer completion of an assessment both initially and annually, if applicable.

For annual re-assessments, the CC must reach out at a minimum of 2 weeks in advance of the 365-calendar day deadline to allow enough time for required attempts and scheduling with the member.

Care Coordinators should reach out to other contacts (such clinics or the financial worker), as feasible, to obtain a valid member phone number. These contact attempts do not count toward the four attempts to reach the member.

Care Coordinator is required to:

1. Make a total of **four** attempts to contact the member:
    - The first 3 attempts must be made on different dates at different times and documented in case notes.
    - The 4th attempt must be mailing UTR Member Support Plan Letter to the member. This can be sent on the same day as the 3rd attempt.
    - Case note documentation must include date, time, method, and outcome of each attempt.
        - The Care Coordinator is encouraged to use different methods of outreach for each attempt including phone, e-mail, or letter to offer an assessment.
2. In MnCHOICES, document the required information in the Health Risk Assessment-MCO under “Assessment Information” section for a UTR.
    - Attach the UTR Member Support Plan Letter. The date of this letter must match the “Date of Health Risk Assessment” in MnCHOICES and Bridgeview.

3. By the 10th of the following month enter "Unable to Reach" as the Type of Assessment in Bridgeview and document the dates for each of these attempts in Bridgeview following the process outlined in the Bridgeview Care Coordination User Guide.
    - The assessment date in BV must be the date of the 4th attempt which is the date of the UTR Member Support Plan letter.
4. Within 90 days of the 4th attempt, send the UTR/Refusal Support Plan Summary – Intro to Primary Care Provider Letter or for clinic Delegates, notification to PCP documented per clinic process.
5. If a member later reaches out to the Care Coordinator and refuses the in-person and telephonic assessments, the Care Coordinator should follow the process outlined in the Refusal section. This will reset the 365-calendar day date span.
6. If a new enrollee (transferred from another health plan or fee for services and/or existing Blue Plus member with product change) is on elderly waiver and is unable to reach after the required attempts above, follow steps 1-4 and continue to authorize existing services.
7. If member is on EW and unable to be reached at their annual assessment, the waiver will expire at the end of the waiver span. CC must follow the *DTRs—Coordination of Potential Denials, Terminations, and Reduction of Services* process.
    - Care Coordinator must send the Unable to Reach Support Plan letter and notify the member of potential waiver closure if assessment is not completed prior to waiver span end date.

Mid-year—UTR:

If member was previously an 'Unable to Reach (UTR)' at initial or reassessment and contact is made at mid-year, the CC must:

1. Offer an in-person HRA-MCO and Support Plan.
2. If declined, the CC must offer telephonic completion of the HRA-MCO and Support Plan.
3. If member refuses assessment offerings, see *Refusals* section.

If member was previously an 'Unable to Reach (UTR)' at initial or reassessment and is still unable to be reached at mid-year, the CC must:

1. Make a total of **2** attempts to contact the member via phone, e-mail, or letter to offer an assessment.
    - Attempts must be made on different dates at different times and documented in case notes.

- Mail the UTR Member Support Plan Letter to the member.
- Bridgeview entry is not required for mid-year.

Members open to another waiver (non-EW) or rule 185 case management

Members open to a non-EW waiver (DD, CAC, CADI or BI) or have a rule 185 case manager already have assessments and Support Planning completed by another case manager. While the primary case management responsibility will remain with the other case manager, the MSHO/MSC+ Care Coordinator must collaborate with the other case manager. Members open to another HCBS waiver or that have a rule 185 case manager will show on your enrollment list as Community Well/Rate Cell A. These members must be assessed following these community guidelines.

For MSHO and MSC + members with a developmental disability who are living in an intermediate care facility (ICF), they will show on your enrollment report as residing in a nursing facility. Care Coordinators must follow the processes and timelines outlined in the ***Nursing Home/Intermediate Care Facility Care Coordination Guidelines***.

Care Coordinators are not required to offer completion of a full MnCHOICES assessment for members open to a non-EW waiver. Care Coordinators must offer completion of an in-person HRA-MCO. If the member or guardian refuses an in-person visit, CC's must offer to complete HRA-MCO telephonically. If both assessment options are refused, follow the steps outlined in the *Refusals* section.

In addition to all requirements outlined under the HRA-MCO section, care coordinators are required to:

1. Mail *Intro Letter to Other Waiver CM* or document notification of CC assigned in case notes for those open to non-EW waivers
    a. Document all MCO paid services authorized on the Support Plan under "Services and Supports".
    b. Document other waiver services on the Support Plan under "People and community organizations that support me".
    c. Do not select "Primary" assignment in MnCHOICES, as the other waiver or 185 case managers are considered "primary" as they are responsible for determining if the member is eligible for the waiver/program.
    d. If the member open to another waiver wishes to change to Elderly Waiver:
        i. If assessment was completed more than 60 days ago, a new assessment and support plan must be completed for EW eligibility by the Care Coordinator.
        ii. For assessments completed within last 60 days, (whether member is new to Blue Plus or not), Care Coordinator will complete Transfer guidance scenario #1. The only exception to scenario #1 will be to change 3e.

a. If new to Blue Plus, CC will document in Note section: "Transferred to Blue Plus" and "Program Change".

b. If not new to Blue Plus, CC will document in Note section: "Program Change" only.

Case Type – Person is enrolled with Managed Care	Actions
Person A: On disability waiver, person turns age 65, enrolls with MSHO or MSC+, opens to EW Person enrolls with MSHO or MSC+ and will change to the EW program at age 65.	Case manager and care coordinator work together to ensure uninterrupted services. Health plan may use the last face-to-face screening to open to EW if completed within the last 60 days. If so, the fee-for-service disability waiver service agreement is closed, and enter an exit screening document with Activity Type 07 and Assessment Result 23/10 using the last day the disability waiver. If the last face-to-face visit was more than 60 days in the past or the health plan wants to complete a new visit, enter the exit screening document for the disability waiver with an Activity Type Date and Effective Date the day prior to the new visit. Close the disability waiver service agreement as of this date. Enter an opening screening document for the EW program with Activity Type 07 and Assessment Result 10. Enter an EW service agreement only if a tribal agency is case managing the EW services.

e. Enter assessment into Bridgeview. CC does not need to enter the date of the other waiver CM's assessment.

f. Mid-year member contact and monitoring of goals completed on Support Plan

g. Transition of Care activities

h. Blue Plus Care Coordinator is responsible for authorizing MA covered home care services, including PCA/CFSS. The CC must review assessment(s) and approve the recommendation for home care services request provided by the other waiver case manager and follow the process outlined in the Home Health Care Authorizations and PCA/CFSS Services for members open to non-EW waiver sections. If known, use the other waiver case manager's support plan span for the Services and Supports section under People and Community Organizations that support me. This will allow for your service authorization entered in Bridgeview to match the waiver case manager's. If the other waiver case manager's span is not known, use the care coordination assessment span.

i. Care Coordinators are allowed to authorize MA covered home care services if the member has refused the HRA-MCO or has been unable to reach if there is a completed comprehensive assessment done by the other case manager.
ii. Enter authorizations for MA Home Care including CFSDS into Bridgeview.

2. Review MSHO 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.
    - MSC+ enrollees with an MA spenddown are not eligible to enroll into MSHO. CC can document this in case notes and not send referral.
3. Sign and date the member's Support Plan.
4. Obtain member/responsible party signature on Support Plan.
5. Provide a copy of MnCHOICES HRA-MCO/Support Plan to the member and other waiver Case Manager
6. Provide a copy of MnCHOICES HRA-MCO/Support Plan or a Support Plan summary letter to the Primary Care Provider.
7. For members on other waivers (DD, CAC, CADI & BI), do not enter waiver service agreements into Bridgeview.

Tribal Community Member on Blue Plus

Members who belong to a Tribe should be informed about the ability to receive services through the Tribe. In addition, the following Tribal Nations currently administer and manage HCBS and long-term services and supports, including Elderly Waiver:

Tribal Nation
Leech Lake Band of Ojibwe
Red Lake Band of Chippewa Indians
White Earth Nation

Click here CBSM - Tribal administration and management of HCBS programs (state.mn.us) for additional information about tribal entities and listings of MN counties served.

As dual citizens, tribal members of the above Tribes have a choice between tribal management or health plan management of Home and Community Based Services such as Elderly Waiver and other waiver programs. Blue Plus Care Coordinators are responsible for providing eligible members a choice to receive tribal case management or health plan care coordination during an initial assessment and at annual reassessments. Health plans are also responsible for accepting assessments and Support Plans from Tribal Case Managers.

Members on Elderly Waiver with the Tribe are treated as if they are on another waiver requiring the Blue Plus Care Coordinator to offer and/or complete the HRA-MCO, to include Support Planning, and following Refusal and UTR responsibilities.

Blue Plus Care Coordinator (CC) and Tribal Case Manager (CM) role for Blue Plus members:

- Care Coordinators must follow all requirements as outlined in the Care Coordination guidelines and checklists including but not limited to:
    - Contact/letter requirements
    - Transitions of Care
    - Support Plan updates/goal review.

- Tribal members, who are managed care enrollees living on or off a reservation, who elect to access services through the Tribe, the Tribe notifies Blue Plus. Or if the Blue Plus CC becomes aware that our member wants to collaborate with the Tribe, the Blue Plus CC will notify the Tribe.
- The Tribal Case Manager conducts the MnCHOICES assessment.
- The Tribal Case Manager develops the Support Plan.
- The Tribal Case Manager enters the service agreement in MMIS for services when:
    - The Tribe administers the services directly or the member is using services provided by Indian Health Services. These providers bill DHS (MMIS) directly.

- The Tribal Case Manager sends the DHS 5841 Recommendation for State Plan Home Care Services form and the MnCHOICES assessment when requesting authorizations to the Blue Plus Care Coordinator when members choose to use non-tribal Elderly Waiver or State Plan Service providers.
- Using the results of the Tribal assessment and information found on the DHS 5841, the Blue Plus Care Coordinator will enter service agreements into Bridgeview for the requested services, including in-network or out of network providers (out of network providers must be enrolled with DHS).
    - After their review, the CC must send the form with their signature to the Tribal case manager within 10 working days stating if the Care Coordinator: approved, denied, or is requesting additional information. (the Tribal CM is responsible to ensure services remain within waiver budget)

- If after reviewing the assessment, Support Plan, and DHS 5841, the Blue Plus Care Coordinator does not approve of the service authorizations, the Blue Plus Care Coordinator should discuss concerns/duplications/findings with the Tribal CM.
- If a DTR is required for any services paid for by Blue Plus, the Care Coordinator should follow DTR process.

Significant Change Assessments

A significant change assessment must be completed when a member is experiencing a health change expected to be long-term, and member may need a higher EW case mix for increased service needs. Care Coordinators must complete a new MnCHOICES. Refer to the *MnCHOICES* section.

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

1. Create new Support Plan following the *Support Planning Requirements* and section including Service *Provider and Member Signature Requirements*.
2. Enter the assessment type and date into the Bridgeview Company's web tool (refer to Bridgeview Care Coordination User Guide) by the 10th of the following month
3. EW only—Enter an LTC Screening Document in MMIS (*See Entry of LTC screening document information into MMIS section)*
4. In Bridgeview, end current LTCC & Case Mix tab and current service agreements.
5. In Bridgeview, add new LTCC & Case Mix tab and service agreements.
6. Create new RS tool (if applicable) for those residing in a residential setting.
7. Re-assessment is due within 365 calendar days of the date of this MnCHOICES

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. See Refusals section. 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 summary is not required for temporary placements or for members who are not on a waiver.

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

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

The My Move Plan Summary is <u>optional</u> in the following scenarios:

- EW members who are permanently moving into a nursing facility
- CW members who are moving residences
- NH members who are moving residences and not going on EW

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

The Care Coordinator is responsible to:

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

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

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

If the My Move Plan Summary was not completed, the Care Coordinator must indicate the reason on DHS-3936 and retain a copy in member's case file:

- CC was not aware of the move, or
- Member declined to complete a move plan summary, or
- Other reason.

Please see the DHS Person Centered Protocol for more information about the My Move Plan Summary form and Person-Centered Practices.

Support Planning Options & Requirements

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 access and opportunity as all other members. A member's unique life experiences such as culture, ethnicity, language, religion, gender and sexual orientation must be embraced in the planning process to enhance the member's quality of life.

Person-centered requirements apply to all but not be limited to:

- Assessment/re-assessment
- Planning process
- Creation of service plans
- Review of service plans and Support Plans
- Transitions

Members and or authorized representatives should be encouraged to:

- Direct their own services and supports, when desired
- Include preferences, strengths, skills, and opportunity to promote dignity and respect
- Include community presence, participation, and connections

Documentation of diagnoses, health conditions, and needs in the Support Plan

The Centers for Medicare and Medicaid Services (CMS) states the Care Coordinator must address active health conditions and diagnoses identified in the health risk assessment (HRA) in the support plan. This applies to all assessment types including initials/reassessments and use of the Transitional HRA and Transfer FNU (for product changes, health plan changes, transitions from FFS into managed care).

Defining diagnoses and health conditions in the context of MnCHOICES assessments:

- Active Diagnoses: ICD codes/diagnoses from a member's MnCHOICES profile that are pulled into the MnCHOICES assessment
- Health conditions: Any disease, illness, injury, and assessed need (dentures, glasses, transportation, etc.) referenced anywhere within the MnCHOICES assessment – including narrative sections – impacting their physical or mental well-being.
- Reminder that current DHS Protocols require an enrollee's assessed needs and concerns—related to primary care, acute care, long-term services and supports, mental health, behavioral health, and other service needs—be addressed in the Support Plan.

If the member chooses not to include a goal for an active health condition, diagnosis, or assessed need, this preference and the support they receive must be documented in the Support Plan. This can be listed in any comment field in the support plan; Staying Healthy, Current Health Conditions, Services and Supports – Support Instructions, etc. as long as it is addressed somewhere in the support plan.

Example: Jane did not wish to create a goal for diabetes, high blood pressure, and anxiety, she plans to see her PCP regularly for support.

This language:

- ✓ Shows intentionality.
- ✓ Affirms member engagement in the planning process.
- ✓ Affirms the members' choices.

Care coordinators may utilize the "Support Planning Requirement Templates" located on the Care Coordination page of the website under "Assessments and Support Planning" to help with meeting this support planning requirement.

Support Plan Components

The Support Plan must employ an interdisciplinary/holistic approach incorporating the unique primary care, acute care, long term care, mental health and social services needs of the individual with appropriate coordination and communication across all providers.

Support plans should additionally include:

- Case mix/caps
- Collaborative input with the Interdisciplinary Care Team which, at a minimum, consists of the member and/or his/her representative, the Care Coordinator, and the Primary Care Provider.
- Assessed needs
- Member strengths and requested services

- Accommodations for cultural and linguistic needs
- Care Coordinator/Case Manager recommendations
- Formal and informal support
- Person-centered goals and objectives, target dates, on-going monitoring of outcomes through regular follow-up.
- Identification of any risks to health and safety and plans for addressing these risks. This should include informed choices made by the member.
- Advanced Directives discussions: 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
- Preventive discussions to educate and communicate to member about good health care practices and behaviors which prevent putting their health at risk.
- Documentation that member has been offered choice of HCBS and nursing home services and providers.

Care Coordinators shall develop a comprehensive Support Plan in collaboration with the member, caregiver, and/or other interested persons at the member's request, within 30 calendar days of completing the member's health risk assessment.

Support Planning Requirements

The Care Coordinator must:

1. Complete all sections of the appropriate Support Plan.

- Ensure the goals are person-centered and in SMART format (**S**pecific, **M**easurable, **A**chievable, **R**elevant, and **T**ime-Bound).

2. Have the following discussions with the member and document on the Support Plan under the Support Plan Signature Sheet under Person> Materials shared> Other information> Enter a list of other materials shared:

    - Provide Safe Disposal of Medications flyer and list of take back sites to member
    - MSHO: Reviewed Explanation of MSHO Supplemental Benefits with member.

      OR

    - MSC+: Discussion of SecureBlue MSHO product benefits and enrollment (see guidelines and Care Coordination website for talking points and resources).
    - If an informal caregiver was identified in the assessment, CC must document if DHS 6914 Caregiver Questionnaire was offered and declined or mailed. If completed add as an attachment into MnCHOICES.

3. Include the following services:

- Under Services & Supports:
  - All formal supports including:
    - EW services
    - MA covered home care services: PCA/CFSS, HHA, SNV/LPN, PT/OT/ST
- Under People & Community Organizations that Support Me:
  - All informal supports and informal caregiver(s) identified in the member's assessment
  - MSHO Supplemental Benefits
  - All other waiver services (CADI, CAC, DD, BI)
  - Medicaid covered DME
  - Moving Home Minnesota (MHM)
  - Medicare covered home care
  - Hospice care

4. Include the cost of Care Coordination and Case Aide (required for EW – optional for CW):
   - Enter as a formal paid service under Services & Supports.
   - If Delegate agency cannot be found as a provider under Services & Supports, revert to entry under People & Community Organizations that Support Me.
5. Explain to members that the MSC+ or MSHO Member Handbook includes information about their privacy rights, protection of PHI, and the process on how to file a grievance or appeal if they disagree with their Support Plan or are denied a service. See ***Member and Provider Appeals*** section
6. Sign the Support Plan.
7. Obtain the member's signature. See Support Plan Signature Requirements.
8. Provide a complete copy of the Support Plan within 30 days of the assessment to the member and any care team members chosen by the member using the Support Plan Cover Letter.
9. Provide a copy of the MnCHOICES Assessment Summary to EW members and/or legal represenatitive within 60 days of the assessment.
10. For members found eligible for CFSS, send the member/representative and provider (if known or once known) with **10 business days** of the assessment:
    - A copy of the Supplemental Summary Charts and Assessment Summary from the MnCHOICES assessment.
    - A copy of the Support Plan, if complete (with member's documented approval).
    - A copy of "My Supports" of the Support Plan is the Support Plan is not yet completed.

11. Provide a copy of the Support Plan or Support Plan summary to the member's primary care provider using the Support Plan Summary Letter - Intro to Primary Care Provider within 90 days of completion of the Support Plan. For clinic delegates, notification to primary care provider documented per clinic process.

    - Document the date sent in MnCHOICES support plan in the "date support plan shared with primary doctor".

12. Obtain necessary service provider signatures *Service Provider Signature Requirements for sharing Support Plan information.*

Mid-year Support Plan Review

Care Coordinators are required to monitor and document progress towards the members' Support Plan goals during each mid-year contact and at reassessment.

The timeline for the mid-year contact requirement is anytime between months 5 and 7 following the member's initial or annual assessment.

Care Coordinators are required to review the goal(s) progress and document whether the goal was achieved, will be discontinued, modified or continued to the next Support Plan.

In MnCHOICES, the care coordinator must create a revision when making updates to goals; documenting goal progress and outcomes and changes to member's services (including DME), service frequency, service units, and/or service providers. New member signatures are required for changes in services and supports.

Updating existing Support Plan goals at mid-year:

1. Log into R MnCHOICES application
2. Go to the person record
3. Go to Forms tab
4. Go to filter and select "*Support Plan*" (only support plans in plan approved status will display the revise capability)
5. Locate form, click on ellipsis, and select "revise"
6. Under Reason for Support Plan Select "*Plan Revision*"
7. Revision Reason enter **"*Midyear goal monitoring MMDDYY*"**
8. Review existing goals and determine if new goals are necessary and update goal monitoring accordingly

9. If there are any service updates, must select "*Yes*" if there are any changes to supports & services and/or providers.
    a. When updating or making changes to existing services/supports:
        i. edit the original service line entry with the end date of the provider and/or units (follow the DTR process as applicable)
        ii. next, add a new service line entry for the revised services/supports
    b. Inform the member that you will be sending an updated copy of their Support Plan and that they need to sign and return acknowledging their agreement to the change(s).
    c. Using the *Member Service Change Signature Cover Letter*, mail member/responsible party an updated copy of the Support Plan including a signature page for member to sign.
    d. Upload a copy of the *Member Service Change Signature Cover Letter* to fulfill MnCHOICES signature requirements in order to close your newly revised Support Plan. When you receive a signature back from the member, upload as an attachment upon receipt.
10. If the member is choosing to share pertinent Support Plan information and support instructions with EW and PCA/CFSS (if applicable) providers, follow the process outlined in section *Service Provider Signature Requirements*.

End-of-year Support Plan Review

There are two options for documenting the required end of year goal review and documentation of goal outcomes in MnCHOICES.

Option 1 – only choose this option if goal closure is completed prior to creating your re-assessment:

- Revise goals on current "Plan-Approved" support plan using Achieved, In-Progress, or Discontinued status if completed prior to creating a new assessment and support plan for reassessment.

Option 2 – only choose this option if you have already completed your re-assessment:

- Revise current "Plan Approved" support plan and under "Reason for Support Plan" select "Annual/Reassessment".
- Update the plan "Effective Date Range" to the new annual date span.

- All goals will carry over from the previous plan. Review previous goals and update their status accordingly (Achieved/In Progress/Discontinued) with brief dated comment in the monitoring progress comment field, especially if discontinuing a goal.
- Care Coordinators can remove Achieved or Discontinued goals at the next mid-year if goal(s) is no longer applicable. Doing so will prevent too many goals being carried over at the next reassessment.

Before moving support plan into "Plan Approved" status:

- Review narratives and dates that may have carried over from the previous support plan for accuracy.
- For customized living, no rate inputs or dates will come over – these will need to be re-entered.

Service Updates to the Support Plan

Updates to the Support Plan must be made when there are any changes including the following:

- New Service
- New Service Provider
- Change in Service Provider
- Change in hours/units

The Care Coordinator must:

1. Discuss with the member or representative the change in service(s). This includes changes to the support plan for any MA covered home care services, CFSS/PCA, and Elderly Waiver services.
2. Care Coordinators must create a Revision to the most recent completed Support Plan in the MnCHOICES application. Complete applicable fields being sure that the following are selected:
    a. Reason for Support Plan: Plan revision
    b. Revision Reason: include a description of what service(s) is being changed or added
    c. Are Signatures required? Choose Yes.
    d. When updating or making changes to existing services/supports:
        i. edit the original service line entry with the end date of the provider and/or units (follow the DTR process as applicable)
        ii. next, add a new service line entry for the revised services/supports

e. Inform the member that you will be sending an updated copy of their Support Plan and that they need to sign and return acknowledging their agreement to the change(s).

f. Using the *Member Service Change Signature Cover Letter*, mail member/responsible party an updated copy of the Support Plan including a signature page for member to sign.

g. Upload a copy of the *Member Service Change Signature Cover Letter* to fulfill MnCHOICES signature requirements in order to close your newly revised Support Plan. When you receive a signature back from the member, upload as an attachment upon receipt.

3. If the member is choosing to share pertinent Support Plan information and support instructions with EW and CFSS/PCA (if applicable) providers, follow the process outlined in section *Service Provider Signature Requirements*.

Support Plan Signature Requirements

Care Coordinators:
Blue Plus allows electronic signatures when necessary, using these options:

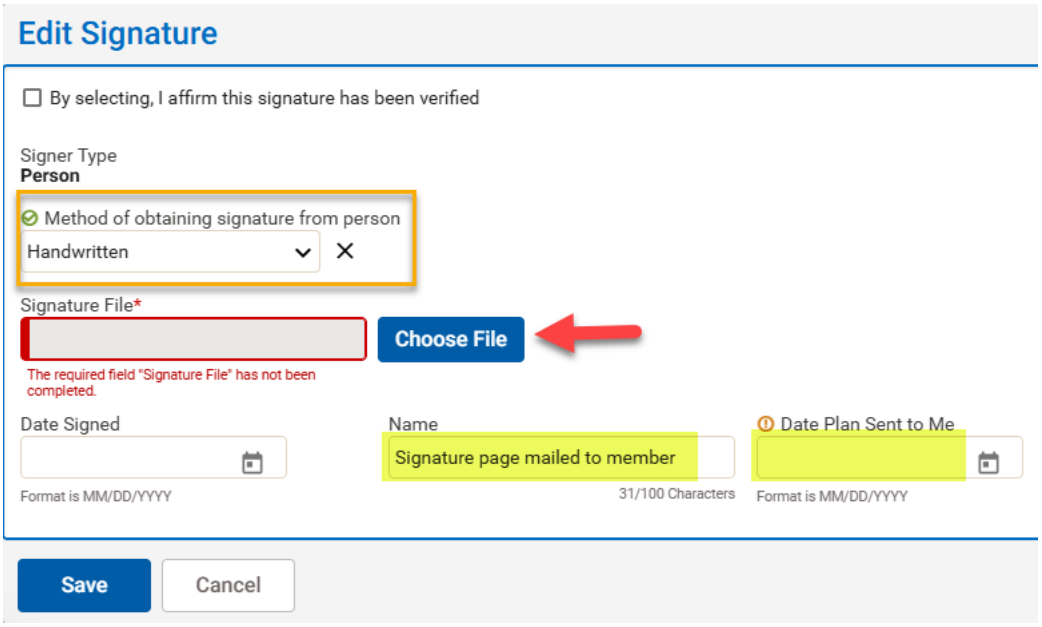
- Electronically typed as: /s/ Jane Doe
- Computer software (such as DocuSign or Adobe) which captures and date stamps electronic signatures

Members:

- Care Coordinators should always attempt to obtain an electronic signature when possible.
- If an electronic signature isn't possible, Care Coordinators must use the MnCHOICES Support Plan Signature page found on the Care Coordination page of our website which includes our BCBS language block.
    - Do not keep the support plan open while waiting for member signature. The Support Plan should be in its final status within 60 days of the assessment activity date or sooner.
    - If a member signature is not obtained and Support Plan needs to be in a final "Plan Approved" or "Completed" status:
        - Send the Support Plan Cover Letter with a copy of the Support Plan and MnCHOICES Support Plan Signature page
        - Upload the blank MnCHOICES Support Plan Signature page to the member Signatures section of the Support Plan. Choose the 'Edit' icon

and select ‘Handwritten, enter “Signature page mailed to member” in the ‘Name’ field and ‘Date Plan Sent to Me’.

- Upload signed signature page to Attachments upon receipt.



  - If signature not received, attempts to obtain should be made at mid-year and at reassessment. Document all attempts to get member signature.

EW/CFSS Service Provider Signature Requirements

***Sharing Support Plan information and obtaining Service Provider signature requirements apply only to members on Elderly Waiver.**

The Care Coordinator must discuss with the member/rep the DHS and CMS requirement of sharing their Support Plan and service information with EW and CFSS providers.

CCs should discuss the value of sharing information from the support plan with providers to help them deliver services in a person-centered manner. However, the person may make an informed decision not to share the plan or portions of the plan with any given provider.

Members need to make informed decisions about the following:

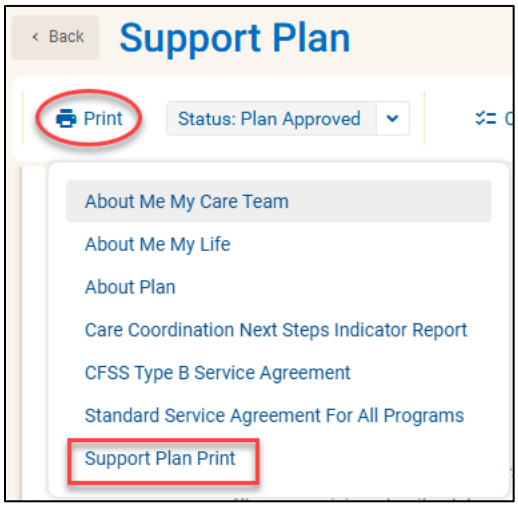
- Which providers receive a copy of the plan
- Whether to share the entire plan with each provider, various sections of the plan, or only the sections that pertain to the services provided

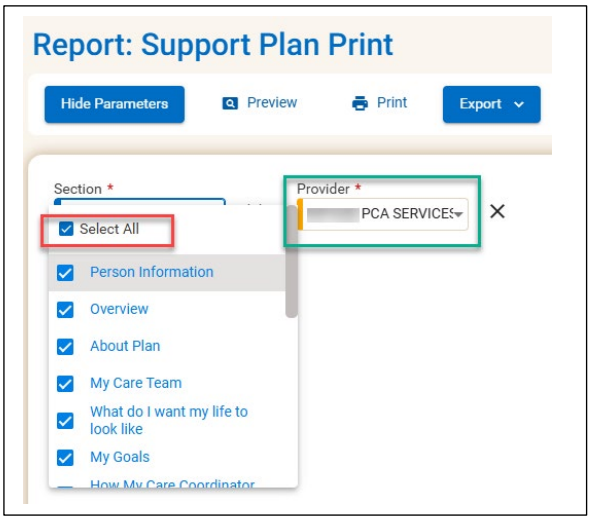
EW and CFSS providers must sign to indicate their acknowledgement of the services and supports in the plan and their agreement to deliver them as outlined.

The following options are instructions for printing/sharing support plan information and obtaining provider(s) signature from MnCHOICES as chosen by the member:

<u>Option 1 - Member chooses to share the entire support plan:</u>

- Go to the Support Plan and choose “Print”.

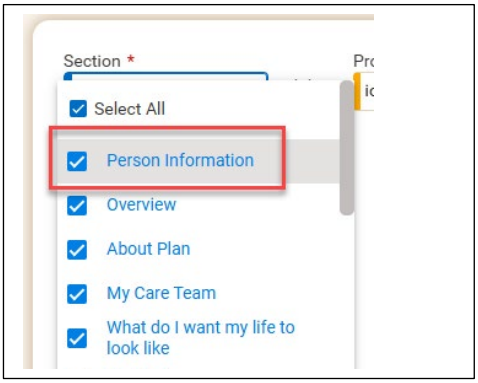


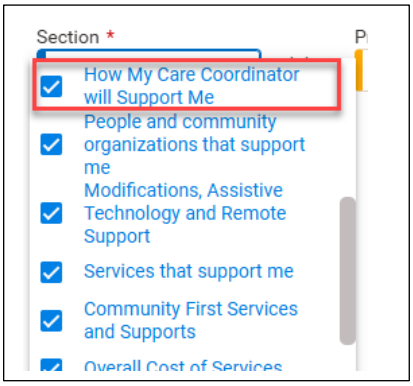


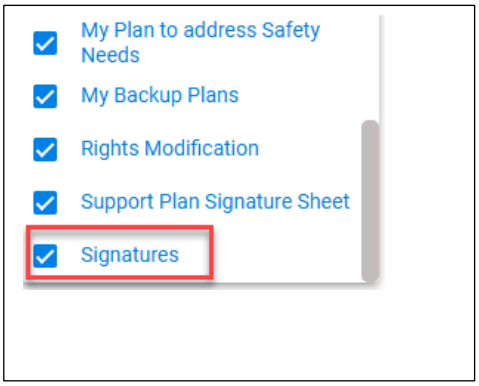
- ‘Select All’ is the default support plan print option.
- Send support plan to the selected provider(s) using the Provider Signature Cover letter.

<u>Option 2: Member chooses to share specific sections of the support plan with the provider(s):</u>

- CC must always choose the sections in Red.
- Then, check only the sections(s) of the Support Plan member wishes to share with the provider.
- Send support plan to the selected provider(s) using the Provider Signature Cover letter.





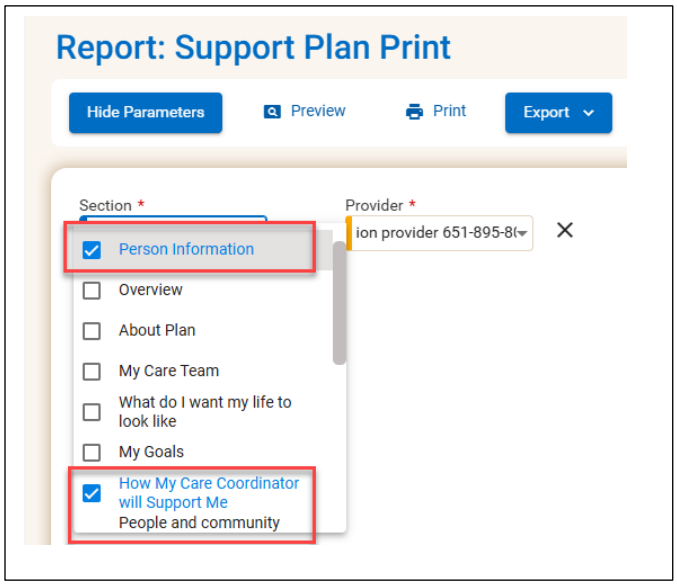


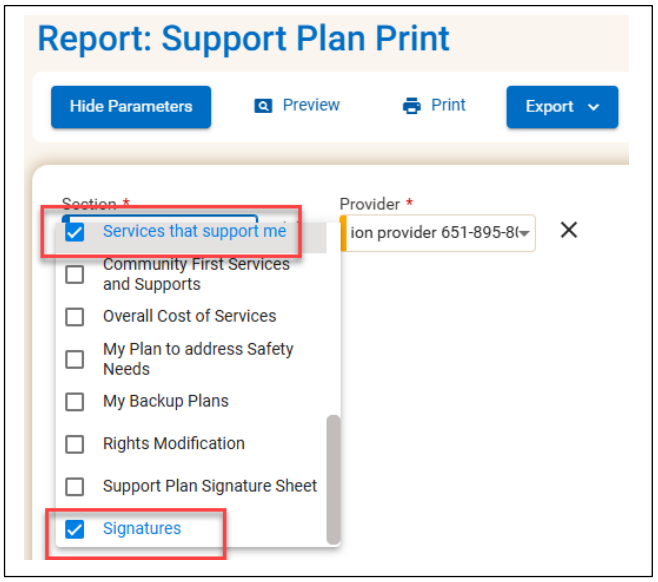
<u>Option 3: Member chooses to share only service specific details with the provider</u>

- If the member chooses to share only service specific details with the provider, Care Coordinators should only print the following sections for the applicable provider(s):

- Person information
- How My Care Coordinator will Support Me
- Services that support me
- Signatures

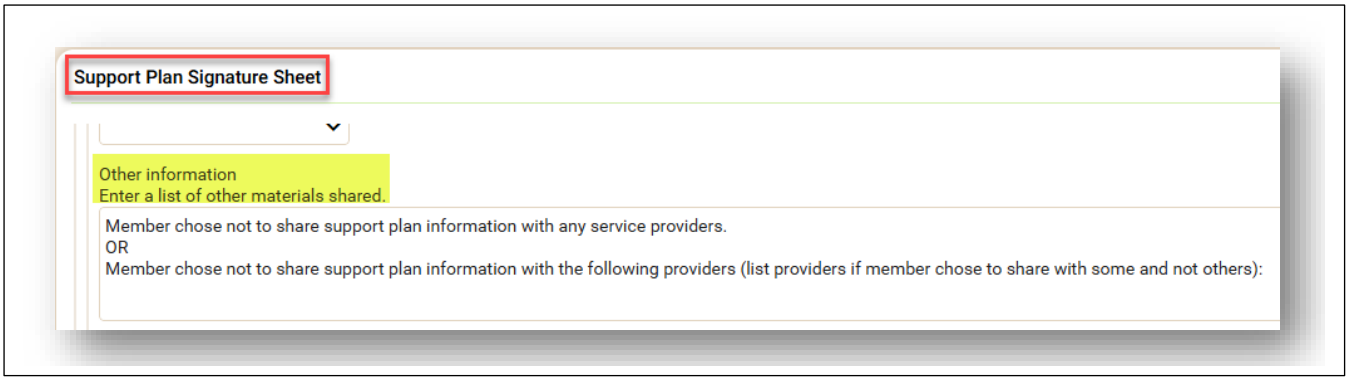
- Send support plan to the selected provider(s) using the Provider Signature Cover letter.



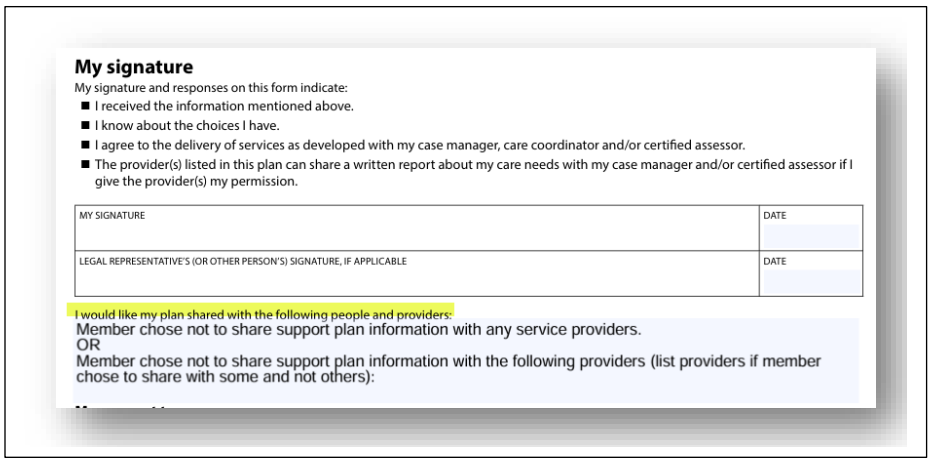


<u>Option 4: Member chooses not to share any support plan information with some or all providers</u>

- Electronic member signature: If the Care Coordinator obtains an electronic signature from the member, CC's should document on the Support Plan Signature Sheet which provider(s) member chose not to share under "Other information" here:



- Handwritten member signature: If the Care Coordinator obtains a handwritten signature utilizing the MnCHOICES Support Plan Signature Page, CC's must document which provider(s) member chose not to share in this section here:



My signature

My signature and responses on this form indicate:

- I received the information mentioned above.
- I know about the choices I have.
- I agree to the delivery of services as developed with my case manager, care coordinator and/or certified assessor.
- The provider(s) listed in this plan can share a written report about my care needs with my case manager and/or certified assessor if I give the provider(s) my permission.

MY SIGNATURE	DATE
LEGAL REPRESENTATIVE'S (OR OTHER PERSON'S) SIGNATURE, IF APPLICABLE	DATE

I would like my plan shared with the following people and providers:

Member chose not to share support plan information with any service providers.
OR
Member chose not to share support plan information with the following providers (list providers if member chose to share with some and not others):

Sharing of support plan information with Residential Service Providers

If the member is choosing not to share any support plan information but resides in a Residential Service setting such as customized living, the Care Coordinator must still provide a copy of the RS/CL provider's service section of the support plan to provide them with the individual rate inputs for selected areas of need.

- Note: if the member's goal that is printed is not specifically tied to the residential service(s) received, Care Coordinators may use the "redact" function in Adobe Acrobat to remove it prior to sending to the provider.

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

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

Member decision to share Support Plan information with EW and CFSS/PCA Providers and CCs requirement to obtain their signatures is required for:

- Initial assessments
- Annual assessments
- Changes to existing plan and anytime a new EW or CFSS/PCA (if applicable) service is added throughout the year. (i.e., changes in hours/units, change in service provider, new service).

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

Service Provider signatures **not** required for:

- Members not on EW
- MA Covered Home Care Services: Home Health Aide and Skilled Nursing Visits (only required for MA covered CFSS/PCA)
- Community Well members who have CFSS/PCA
- Medical supplies/Durable Medical Equipment including T2029 Specialized Equipment & Supplies
- Approval-option: purchased-item services
- Consumer Directed Community Supports (CDCS)
- Individual Community Living Services (ICLS) Service Planning tool. The CC can send the ICLS Service Planning tool (DHS-3751) to the service provider in lieu of the entire Support Plan if the member makes an informed choice to do so. The ICLS Service Planning tool includes a provider signature field.
- Any services already started prior to Health Plan enrollment (such as member already on EW and then enrolls in a health plan) does not require the Care Coordinator to obtain the service provider's signature. However, if there are any new providers, follow the same steps for sending the information and obtaining service provider signature as outlined above.
- Purchased-item service (formerly tier 3) transportation provided by a commercial or common carrier vendor. Commercial common-carriers include buses, taxicabs and light rails.

Case Management and Behavioral Health Case Management

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

- Catastrophic illness
- High medical costs
- Substance abuse
- Frequent hospitalizations
- Out-of-state providers

- When additional education or support is requested by a member's caregiver.

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

Entry of LTC Screening Document information into MMIS for EW and/or CFSS

Follow the directions as outlined in the DHS Instructions for Completing and Entering the LTCC Screening Document in MMIS for the MSHO and MSC+ Programs (DHS-4669) following the Blue Plus timeline requirements.

MMIS Reminders:

- The LTCC CTY field for all Blue Plus screening entries is **BPH**
- Upon entry of the screening document (SD) prior to saving, review the SD for edits and document status (do not leave the SD in a Suspended status).
- Case Manager Comment Screen is used for the Care Coordinator to add additional comments regarding the screening or assessment visit, as applicable.
- When using 05/98, in the comment screen clarify the purpose of the screening document i.e. Care Coordinator change, etc.
- DHS Comment Screen is used to communicate back to the Care Coordinator.
- SD type H: Cannot be used to open or reopen program eligibility nor extend or close program eligibility.
- All MnCHOICES assessments that determine program eligibility for EW and/or CFSS and any Functional Needs Update entries for those open to EW must be entered into MMIS.
- EW exits and EW restarts must be entered into MMIS.

Timelines for MMIS entry

Assessment entry for all members on EW

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

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

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

When the first month of the waiver eligibility span is:	Last Day to enter timely screening document into MMIS is:
January 2025	12/20/2024
February 2025	1/23/2025
March 2025	2/20/2025
April 2025	3/21/2025
May 2025	4/22/2025
June 2025	5/21/2025
July 2025	6/19/2025
August 2025	7/23/2025
September 2025	8/21/2025
October 2025	9/22/2025
November 2025	10/23/2025
December 2025	11/18/2025
January 2026	12/22/2025

For more information refer to Instructions for Completing and Entering the LTCC Screening Document and Health Risk Assessment into MMIS for the MSC+ and MSHO Programs (DHS 4669)

Home Health Care Authorization Processes

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

This section will cover the process for home care service authorizations except CFSS/PCA.

Medicare Skilled Home Care Services

Medicare billable skilled home care services do not require prior authorization or notification to Blue Plus Utilization Management (UM). The home care agency determines if the member qualifies for Medicare covered skilled home care services. If Blue Plus is notified of Medicare eligible skilled home care services, Blue Plus will advise the home care agency to contact the Care Coordinator to assure continuity of services.

Medical Assistance (MA) Covered Home Care Services

The following information relates to all members receiving Medical Assistance covered home care services, including those who are Community Well, and those on other HCBS waivers (DD, CAC, CADI, BI). Care Coordinators may approve a prescribed amount of MA covered home care services which requires a notification only to Blue Plus UM. Amounts exceeding what is allowed for Care Coordinator approval will require prior authorization from Blue Plus.

Blue Plus will **not** accept requests for authorization of services received directly from a home care provider. The provider will be advised to contact the Care Coordinator to review and make the request following the processes outlined below.

MA covered home care services include:

- Skilled Nurse visits (SNV)
- Home Health Aide visits (HHA)
- Physical, Occupational, Respiratory, and Speech Therapy
- Personal Care Assistance (PCA)/Community First Supports & Services (CFSS)

Service Agreement entry

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

Care Coordinator Role:

1. Consider the following in your home care decision making process:
    - Follow the guidelines outlined in the Home Care chapter of the Community Based Services Manual (CBSM).
    - For members on another waiver (CAC, CADI, DD, or BI) the Care Coordinator is responsible for reviewing other Case Managers recommendations and, if in agreement, authorizing MA covered home care services and entering the Service Agreement into Bridgeview.
    - Authorization must coincide with the member's current waiver span or assessment year if not on a HCBS waiver.
2. Determine need for MA covered home care services (except CFSS/PCA) by completing MnCHOICES assessment for members open to EW or HRA-MCO for community well members not open to EW or CFSS/PCA.

a. Assessment must first be offered to be completed in-person but can be done telephonically if in-person visit is declined.

3. Care Coordinators may also approve MA covered home care services if a comprehensive assessment has been completed by a Case Manager for members on another disability waiver (even if they refused to complete the HRA-MCO). For members receiving CFSS/PCA. Determine if home care agency is in the Blue Plus network by verifying with the home care providers directly or calling Member Services.

    a. If a **current** member is requesting to use a provider out of the Blue Plus network as it has been determined that an out-of-network provider has immediate availability or that the agency is meeting a cultural need that cannot be meet by an in-network provider, the CC can authorize the out-of-network provider when it is confirmed that the provider **is enrolled with DHS**.
    b. If the provider is not enrolled with DHS, the provider cannot be authorized. The CC will need to find an in-network provider or a provider enrolled with DHS. See directions for **new** enrollees requesting OON providers below.

4. Coordinate service needs with the provider including initial authorizations, acute changes in a member's condition requiring additional services, or at re-assessment.

5. Enter the Service Agreement into Bridgeview per the instructions found in the Bridgeview Care Coordination User Guide. CC must note in the Service Description if the provider is out-of-network provider and enrolled with DHS.

    - For Skilled Nurse Visits (SNV), Care Coordinators must differentiate whether the nursing visits will be provided by RNs, LPNs, or both. If the home care agency anticipates the member will receive visits from both, the CC must enter two service agreeements in Bridgeview: RN using procedure code T1030 and LPN using T1031.
    - If the provider is requiring an adjustment in the ratio of RN and LPN as currently authorized, the Care Coordinator/Case aide must modify the current service agreements in Bridgeview to match the provider's requested change. When making the changes to the original service agreements, the Care Coordinator/Case Aide must add a description to the Service Authorizations affected. An updated authorization letter will be mailed to the member and service provider.

6. When an initial determination is made to authorize a service, Care Coordinators must provide notification to the requesting provider by phone and document the notification in their case notes.

Process for Care Coordinator Approval of Home Care Authorizations

Care Coordinators may approve without UM review up to the following prescribed amounts. Care Coordinators will enter a Service Agreement into Bridgeview following the process outlined in the Bridgeview Care Coordination User Guide, for the following:

- Up to 52 Skilled Nurse Visits per year (not to exceed 2 visits per week)
- Up to 156 Home Health Aide visits per year (not to exceed 3 visits per week)
    - if the member does not live in Adult Foster Care or Customized Living
    - if the member is not receiving CFSS/ services
- Up to 20 visits per discipline per year of MA home therapy: physical, occupational, speech, or respiratory therapy
- Personal Care Assistant (PCA) Services/Community Firsts Services & Supports (CFSS)

Note: For an initial assessment done by the home care provider to determine home care service eligibility, the Care Coordinator can wait until after the initial visit to create the authorization. This visit must be included with the total number of visits needed in addition to any PRN (as needed) visits.

Process for Care Coordinator Request for Review for Blue Plus Home Care Authorizations

Blue Plus requires prior authorization to determine medical necessity for home care service amounts exceeding what is allowed for approval by the Care Coordinator. Care Coordinators will select "Request for Review" when entering a Service Agreement into Bridgeview following the process outlined in the Bridgeview Care Coordination User Guide for the following:

- Any visits exceeding notification limits above.
- Home Health Aide visits for members in Customized Living or Adult Foster Care (attach a copy of the member's Residential Services (RS) tool)
- Home Health Aide in conjunction with CFSS/PCA Services
- Acute changes in condition requiring more visits than currently authorized if they are beyond the limits or scope of what the Care Coordinator may authorize

When entering the authorization into Bridgeview, Care Coordinators must include in the service description the contact information for the home care provider so our Utilization Management team can request the CMS-485 Home Health Certification and Plan of Care to review.

Upon receipt of the prior authorization request, UM will:

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

New enrollees with previously approved MA covered home care services

If the member is new to Blue Plus with previously approved MA covered home care services, for continuity of care if the service is deemed medically necessary, the CC must honor the current authorization for up to 120 days. The Blue Plus Utilization Management Team may also review to determine if the service is medically necessary. If not, UM will contact the Care Coordinator to submit a DTR.

The CC must determine if the home care agency is in the Blue Plus network by verifying with the home care provider directly or calling Member Services.

1. If the agency is not an in-network provider, the CC may continue with authorizing the out-of-network (OON) provider as follows:
    a. Confirm with provider that they are enrolled with DHS.
    b. Enter the Service Agreement into Bridgeview following the directions outlined in the Bridgeview Care Coordination User Guide. CC must enter the dates of the remaining span from the previous authorization.
    c. Care Coordinator **must** add in the Service Description that this is for a new member and that the provider is OON and enrolled with DHS.
        i. If the OON provider is not enrolled with DHS, the provider cannot be authorized. The CC will need to find an in-network provider, or a provider enrolled with DHS.
        ii. Member must transition to an in-network provider when the authorization for the out-of-network provider ends.

Members on Elderly Waiver receiving MA covered home care services

For members open to Elderly Waiver, the following MA covered home care services must count towards and fit under their EW cap:

- Personal Care Assistance (PCA)/Community First Services & Supports (CFSS)
- Home Health Aide (HHA)
- Skilled Nurse Visit (SNV)

The following MA covered home care services do NOT need to fit under the EW cap:

- Physical Therapy (PT)
- Occupational Therapy (OT)
- Speech Therapy (ST)

Members who are open to another waiver (non-EW)

Other waiver case managers must request authorization for MA covered home care services by completing the *Recommendation for State Plan Home Care Services DHS-5841* and sending supporting documentation to either the MCO or directly to the Care Coordinator. If the form is sent to Blue Plus, we will forward the form and assessment(s), if included, to the assigned Care Coordinator. In the event the notification was by phone, the Care Coordinator must request the DHS-5841.

Care Coordinators must:

1. Review the full DHS-5841 to determine the reason for the recommended services. (Initial, increase in services, decrease in services)
2. Review assessment and Support Plan attached or request if not received.
3. After their review the CC must send the form with their signature to the other waiver case manager within 10 working days stating if the Care Coordinator: approved, denied, or is requesting additional information. (the other waiver CM is responsible to ensure services remain within waiver budget).
    - If the recommended services from the other waiver case manager is a decrease in service(s) and the CC agrees with this decision, the CC must issue a DTR.
    - If the recommended home care services are not approved by the CC they must communicate with the waiver case manager and the member to determine alternative services and the CC must submit a DTR when applicable. If MA covered home care services are modified during this

process a new DHS-5841 is required to be sent and approved by the Care Coordinator.

- If the CC is in agreement with services requested, Care Coordinators will then enter the Service Agreement into Bridgeview following the directions outlined in the Bridgeview Care Coordination User Guide.

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

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

Home Care Nursing (formerly Private Duty Nursing/PDN): Care Coordinators do not authorize. The home care provider will submit a prior authorization request directly to Blue Plus via Availity Essentials for review and authorization. Providers can be directed to Provider Services if they have any questions: 1-866-518-8448.

Blue Plus UM will:

1. Notify member and home care provider of the authorization via letter.
2. The Care Coordinator can view Active Authorizations in Helios.

Elderly Waiver Extended Home Care Services

To be eligible for extended home care services, the member must be accessing MA covered home care service benefits under Medical Assistance. If they need additional services than what is allowed under state plan, the Care Coordinator may approve extended home care services under EW as allowed within the member's EW budget. The Care Coordinator may only use extended services for the same services already authorized under the medical benefit (i.e., Home Health Aide is approved under the medical benefit, then the EW extended home care service must also be Home Health Aide). Extended home care services are not subject to Blue Plus prior authorization and notification guidelines.

Service Authorization Errors

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

Community First Services & Supports (CFSS) Authorization Processes

Community First Services and Supports (CFSS) offers flexible options to meet members' unique needs. CFSS allows members greater independence in their homes and communities, including the elderly and others with special health care needs. CFSS services are provided in members' homes or the community when activities take them outside the house. CFSS will replace personal care assistance (PCA) and the Consumer Support Grant (CSG) beginning on October 1, 2024.

The BCBS website's Care Coordination page provides CFSS and BCBS processes and additional tools.

Please refer to the Department of Human Services (DHS) CFSS website for additional information.

Elderly Waiver Services

The Elderly Waiver (EW) program is a federal Medicaid waiver program that funds home and community-based services for people 65 years old and older who are eligible for Medical Assistance (MA), require the level of care provided in a nursing home, and choose to live in the community. People enrolled in EW can receive waiver services and MA services funded through a managed care organization (MCO).

Care Coordinators must refer to DHS's MHCP Provider Manual for guidance on EW service policies.

Consumer Directed Community Supports (CDCS)

CDCS is a service option available under the Elderly Waiver which gives members more flexibility and responsibility for directing their services and supports including hiring and managing direct care staff. Refer to the Department of Human Services website for additional information regarding CDCS found here.

Guidance for utilization of CDCS and Blue Plus processes can be found on the Care Coordination page of our website which includes a comprehensive BCBS CDCS Resource and checklist.

Environmental Accessibility Adaptations (EAA)

Environmental accessibility adaptations are physical adaptations to a person's primary home or primary vehicle to ensure the person's health and safety or enable them to function with greater independence. Refer to the Department of Human Services website for additional information regarding EAA found here.

Guidance for utilization of EAA and Blue Plus processes can be found on the Care Coordination page of our website which includes a comprehensive BCBS EAA Home or Vehicle Modification resource and checklist.

EW Specialized Equipment and Supplies (T2029)

Prior to the Care Coordinator authorizing Specialized Supplies and Equipment under Elderly Waiver in Bridgeview, the CC must determine that EW is the appropriate payor and the most cost-effective item to meet the member's need the Care Coordinator must follow the EW T2029 DME Payor Determination Guidelines and Checklist found on the Care Coordination page of the website.

Authorization Process for Lift Chairs

DME Providers, Care Coordinators and Blue Plus Utilization Management (UM) all have a role in the process of obtaining authorization for lift chairs for members on EW. Coordination and communication are key.

Lift Mechanism Process:

If the DME provider determines the member meets Medicare/Medicaid criteria for coverage of the lift mechanism portion of the chair, the DME provider must:

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

   If approved under the Medicare benefit:

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

   If denied under Medicare benefit:

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

4. If the DME provider determines the member does NOT meet Medicare/Medicaid criteria* for coverage of the lift mechanism portion of the chair, the DME provider must:
    - Provide the Care Coordinator detailed reason for not meeting criteria. CCs may refer to the Medical Supply Coverage guide for the coverage criteria if needed.
    - Care Coordinator must enter the service agreement for the lift portion in Bridgeview and include the provider's reason in the service description:

    ***Example:** EW member does not qualify for coverage under Medicare/MA as member is unable to ambulate once standing. This specific reason **MUST** be indicated in the service description.

Chair Portion Process:

The Care Coordinator can review the chair portion of the lift chair following the EW eligibility criteria. In addition, if the lift mechanism is not being paid by the Medicare/Medicaid benefit, the CC can review for coverage of both the lift and the chair portion following EW eligibility criteria. If the CC does not approve of the lift chair (and lift mechanism, if applicable) under EW then follow the DTR process.

- Blue Plus has a maximum allowable amount for the chair portion of $1400. If the chair portion of the lift chair costs over $1400, the Care Coordinator is first required to obtain another quote for a lesser alternative or from another DME provider. If there is a medically necessary reason for the chair portion to exceed our maximum of $1400, the CC must consult with their supervisor and/or the Partner Relations Consultant prior to authorizing and entering a service agreement in Bridgeview. A detailed written quote must be used for this review. If approved, a note in the service description of the Service Agreement indicating the case was reviewed and approved by the Supervisor and/or Partner Relations Consultant is required.

Service Agreement Requirements:

- If lift mechanism is being paid for by Medicare/MA benefits, enter only one service agreement for the total cost of only the chair portion in Bridgeview.
- If lift mechanism is NOT being paid by Medicare/MA benefits, authorize the total cost of **both** the lift mechanism and chair portion and enter two separate service agreements in Bridgeview. One for lift mechanism. And one for the chair portion. The service agreement

for the lift mechanism must include a service description noting the reason why it was not covered under the medical benefit. Examples: Denial for lift mechanism obtained; or member does not meet the medical criteria as member is unable to ambulate once standing.

Elderly Waiver Authorizations

MHCP Enrolled Providers

EW services must be delivered by a service provider enrolled with Minnesota Health Care Programs (MHCP). Blue Plus does not contract directly with any Elderly Waiver providers. Providers must enroll directly with DHS to ensure EW payment for Blue Plus members. Care Coordinators must ensure EW providers are enrolled with DHS prior to authorizing services.

Providers should visit the Bridgeview website for more information.

Care Coordinators must ensure members are given information to enable them to choose among available DHS enrolled providers of HCBS. Care Coordinators may share with members the statewide listing of enrolled HCBS providers from the Minnesotahelp.info website. If the Care Coordinator uses a local list of Elderly Waiver providers, the list must indicate that additional providers from other areas of the state are available and include the phone number of the Care Coordinator to call for assistance.

Approval-Option Service Providers (Pass through billing)

A group of basic EW services can be delivered by an MHCP-enrolled provider, or a qualified vendor approved by a lead agency. These are referred to as Approval-Option Services.

Blue Plus contracts with Delegates who have agreed to bill in a “pass-through” capacity for approval-option service providers (direct delivery services and purchased item services). We expect the need for this will be limited. An example might be a chore service such as a neighbor snow shoveling or an environmental modification contractor. To confirm if your county/agency has a pass-through billing contract or would like information on becoming a contracted pass-through entity, contact your Partner Relations Consultant.

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

Service Agreements

Bridgeview processes all Elderly Waiver provider claims and Service Agreements for MSHO/SecureBlue and MSC+/Blue Advantage. Care Coordinators should follow the instructions in the Bridgeview Care Coordination User Guide.

Care will enter Service Agreements directly into Bridgeview. Care Coordinators are also responsible for EW Provider inquiries related to their Service Agreement entries.

Service Agreement Errors

If the Care Coordinator learns of a service agreement error after entering the authorization in Bridgeview, the Care Coordinator can modify it within Bridgeview following instructions in the Bridgeview Care Coordination User Guide.

Waiver Obligation

Information regarding a member's waiver obligation, if they have one, will be displayed in Bridgeview. Waiver obligations may change retroactively, and any questions should be referred to the member's county financial worker. Questions regarding which service provider the waiver obligation was applied to for a specific month may be directed to Bridgeview.

Inquiries related to EW claims and Service Agreements should be directed to Bridgeview staff.

MA Services Included in EW Case Mix Cap

Care Coordinators must calculate the following services in addition to the cost of all EW services into the monthly case mix budget cap:

MA covered home care services including:

- Skilled Nurse visits (SNV)
- Home Health Aide visits (HHA)
- PCA/CFSS **and**

Monthly Care Coordination **and**

Case Aide billing, if applicable

Temporary Waiver Exits and Restarts for admissions > 30-121 days

In the Communique sent on October 21, 2022, Blue Plus responded to the DHS announcement DHS eList Policy change about temporary admissions to certain facilities for 121 or fewer days, that effective retroactive to May 1, 2022, people who were admitted to certain settings for 121 or fewer days and were receiving HCBS may restart their previous waiver program without an assessment if they were not due for their reassessment during their admission.

Care Coordinators may use the temporary exit and restart the member's waiver span after discussing with the member or their legal representative, if it is determined that the member can safely return to the community within 121-days, and the member was not due for their reassessment during their facility admission.

This is accomplished by restarting their current waiver span and does not change the previously assessed case mix and/or extend the EW span. If the member has had a change in their assessed needs and requires new services and/or was due for their annual assessment when a temporary waiver exit (SD activity 07, assessment result 53) was entered, a new assessment should be completed to reassess the members needs to reopen (activity type 06, assessment result 11) the elder waiver. For more information, refer to the CBSM - Temporary waiver exits (state.mn.us).

Continue to follow the guidance for DTR's related to EW exits per usual process. Upon receiving the DTR confirmation from UM, CC must update SA in Bridgeview by closing the existing service agreements and previous case mix span. To restart EW after a temporary exit (activity type 07, assessment result 54 with effective date being the date of discharge), enter a new case mix span and service agreement(s) using the remaining waiver span.

Reminder: The Care Coordinator cannot use the temporary exit and restart a member's waiver following the "temp admissions to certain facilities for 121 days or fewer" if the member's annual reassessment would have been due during the facility admission. In this situation, the Care Coordinator must complete a new assessment and follow the normal process to reopen the member to the elderly waiver program.

Functional Needs Update for those with change in support needs (formerly Activity Type 10)

A Functional Needs Update is a remote assessment to document a change to a person's assessed need(s) any time during the service year. The Functional Needs Update replaces the Activity Type 10 when assessment was completed in MnCHOICES. The MnCHOICES application produces Activity Type 10 information for entry into MMIS when a CC completes a Functional Needs Update.

Care Coordinators can use a Functional Needs Update when a member has a change in support needs that cannot be met by current resources and to address changes prior to a reassessment if a member already has an assessed need for support. These changes may include changes that will affect their EW case mix budget or establish eligibility for 24-hour customizing living for EW.

Functional Needs Update may be used when all the following apply:

- The member is currently open to Elderly Waiver.
- The member is not due for their reassessment relatively soon.

• The member has had a significant temporary health change and needs additional services that exceed their previously assessed monthly case mix budget/EW CDCS case mix budget or the establishment of eligibility for 24hr CL rate.

If a member's assessed needs require an increase in PCA/CFSS hours that cannot be addressed by a 45-calendar day increase or by realignment of current supports and resources, do not use FNU. Care Coordinator must complete a full MnCHOICES.

Care Coordinators must:

1. Discuss with the member or their authorized representative if an in-person visit is preferred/necessary to include that a full reassessment can be completed, document this discussion in case notes.
2. Complete a Functional Needs Update in MnCHOICES and make any adjustments to the assessment based on the person's changes in need.
3. Communicate changes to appropriate parties as needed (e.g., customized living provider) to update relevant Support Plans and service agreements.
4. Enter the Functional Needs Update information as an Activity Type 10 document into MMIS.
5. Update all areas of Support Plan and distribute it to the appropriate parties (refer to CBSM – Support Planning for LTSS).
    a. Supports and Services, Goals, Safety Plan, and Signatures.
6. Share and obtain required signatures for the updated Support Plan with member/Authorized Rep, ICT members, PCP, and applicable providers.
7. Update Bridgeview
    a. Update LTCC & case mix
    b. Update/add MA and/or EW Service Agreements
8. Update all applicable providers of changes to Service Agreements.
9. Revise the Support Plan, revision to services cannot be prior to the date of the Functional Needs Update.

Reminders:
* Functional Needs Update entry does not create or extend an EW eligibility span. The new case mix span will be prorated to the remaining months in the current waiver span. The next reassessment is due from the last annual comprehensive assessment MnCHOICES.
*The Functional Needs Update "effective date" cannot be prior to the "activity date"; Functional Needs Updates cannot be used to make retroactive changes.

If an FNU or Activity Type 10 is completed for an acute temporary change in condition and members condition improves, the member may retain their FNU/Activity Type 10 for the remainder of their waiver span without the need for a new assessment. If the member chooses to reduce or terminate services, DTRs are required following the normal process for DTR's indicating member choice to terminate or reduce services.

EW Requests to Exceed Case Mix Budget Cap

If a member has a unique set of assessed needs that require Support Plan services above their EW budget cap, a request for a higher monthly case mix budget cap may be submitted to Blue Plus for review and consideration. It is expected that the Care Coordinator has a discussion with the member/authorized rep and has already considered reducing various services to keep all service costs within the Case Mix Cap before submitting a request. The Care Coordinator must consult with their supervisor if they decide they wish to submit a request to exceed. Care Coordinators may also consult with their Partner Relations Consultant prior to submitting the request.

Notes related to requests to exceeds:

- If the member has requested to exceed the EW Case Mix Cap and the Care Coordinator determines there is no assessed need, the Care Coordinator must request a DTR by faxing in the Care Coordinator Request for DTR form and notify the member within 24 hours of determination.
- Requests to exceed published Customized Living or 24 Customized Living rate limits are unallowable unless as part of an approved Conversion rate request.
- First-time requests must take place prior to the service initiation.
- A reauthorization request of a previously approved rate must be made at least 30 days prior to the end of the current authorization period.

Process to request an exception to Case Mix Budget Cap

Provide the following information to the Review Team via a secure email to Partner.Relations@bluecrossmn.com.

- Request to Exceed Case Mix CAP form
- Care Coordination case notes for previous 3 months
- If applicable, for those residing in customized living, include a copy of Residential Services tool if completed in MnSP
- PCA/CFSS assessment, if applicable.
- Any other supporting documents deemed appropriate
- Other documents requested by the Review Team
- A description of other options within the member's current budget which have been considered and why they are not possible must be included on the Request to Exceed Case Mix CAP form.
- Reauthorizations must include the previous EW RS Tool and/or PCA/CFSS Assessment, if applicable.

The EW Review Team will:

Review the request within 10 business days/14 calendar days, whichever is sooner, of the receipt of all the required information/documents

If approved, the EW Review Team will:

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

The Care Coordinator must:

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

If not approved, within 24 hours of the determination the Review Team will:

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

Withdrawal of a request to exceed case mix cap

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

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

   Be sure to include:

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

EW Conversion Requests

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

Note: For EW service rate limit conversion requests, the service rate must be based on service plans documented on the Elderly Waiver Residential Services Tool. Submission requirements of the EW RS Tool are determined either by the R-MnCHOICES Support Plan (MnSP) or in the revised R-MnCHOICES application, the Blue Plus Review team will review in R-MnCHOICES.

- First-time conversion requests must take place prior to the service initiation.
- Select and complete the appropriate form (with or without CDCS), including associated documents and return to Blue Plus.
- A reauthorization request of a previously approved rate must be made at least 30 days prior to the end of the current authorization period.

Process to request EW Conversion Rate

To request a conversion rate, the Care Coordinator must provide the following information to the Review Team via a secure email to Partner.Relations@bluecrossmn.com:

- DHS-3956 Elderly Waiver Conversion Rate Request or DHS-3956A Elderly Waiver Consumer Directed Community Supports (CDCS) Conversion Rate Request (both available on DHS e-Docs, do not fax of send to DHS).
- Care Coordination case notes for previous 2 months
- Current R-MnCHOICES (MnA)
    i. If the assessment was completed in the revised R-MnCHOICES application, include a note on the request form.
- Current Support Plan
- A description of other options within the member's current budget which have been considered and why they are not possible must be included on the form.
- If applicable, for those residing in customized living, include a copy of Residential Services tool if completed in MnSP
    i. If the assessment was completed in the revised MnCHOICES application, include a note on the request form.
- PCA/CFSS Assessment (if applicable)

i. If the assessment was completed in the revised R-MnCHOICES application, include a note on the request form.

- Any other supporting documents deemed appropriate
- Other documents requested by the EW Review Team
- Reauthorizations must include the previous EW RS Tool and/or PCA/CFSS assessment, if applicable.

The Review Team will:

1. Review the request within 10 business days/14 calendar days, whichever is sooner, of the receipt of all the required information/documents
2. Confer with the Care Coordinator if the documentation provided does not support the requested level of service
3. Consult with the submitting Care Coordinator to ask for clarification or request further documentation as needed
4. Consult with the Medical Management Medical Director as needed
5. Approve, deny, or recommend a change in the budget rate request
6. If request is approved, EW Review Team will determine the length of time for the approval.
    - **Initial Conversion Rate** for members transitioning out of a nursing facility, authorization will be given for a six-month period. This will allow the Care Coordinator and the EW Review team time to determine if the member is stable in their new community environment and if services and rates need to be adjusted to meet any changes in the identified needs of the member
    - **Reauthorization without Change in Level of Service:** If the EW Review team agrees with the level of services authorized for members who have previously transitioned to the community using an approved EW conversion budget, Blue Plus will reauthorize the budget for a twelve-month period. This applies to current and newly enrolled MSC+ /MSHO members
    - **Reauthorization with Change in Level of Service:** If the Review Team assesses the member to need a different level service than what was previously authorized for a member who has transitioned to the community using an approved EW conversion budget, the authorization period will be for six months. This will allow the Care Coordinator and the EW Review Team time to determine if the member is stable with the new service levels and if services and rates need to be adjusted to meet any changes in the identified needs of the member

If approved, the Review Team will:

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

The Care Coordinator must:

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

If the request is <u>not</u> approved, within 24 hours of the determination Review Team will:

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

    ** Refer to *<u>DTR section</u>* for additional information.

Process to withdraw EW Conversion Rate

If at any time the Care Coordinator decides to withdraw the Conversion request prior to the authorized end date, the Care Coordinator must:

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

DTRs—Coordination of Potential Denials, Terminations, and Reduction of Services

Definitions:

Denial

- **Definition:** The Care Coordinator is denying the request for an existing service authorization or denying a requested service not currently authorized (Elderly Waiver or MA covered home care services including PCA/CFSS).
- **Existing services:** The Care Coordinator is making the decision to deny an existing service authorization
- **Denying an increase to a service:** The Care Coordinator is making the decision to deny an "increase" to an existing service authorization..
- **Requested services:** The Care Coordinator is making the decision to deny a service requested by the member which does not have a current authorization.

Termination

Definition: The member requests, or the Care Coordinator makes the decision to, "terminate" existing service authorization(s).

Reduction

Definition: The member requests, or the Care Coordinator makes the decision to, "reduce" existing service authorization(s).

Resources for DTRs:

DTR Resources located on the Care Coordination page of our CC website:

1. Care Coordinator DTR Decision Guide includes:
   - List of scenarios to assist Care Coordinators in determining whether a DTR is required or not.
   - DTR Reference Guide for Hospital and Nursing Home Stays or vacation/temporarily out of state.
2. CDCS DTR Guide
3. Request for DTR form
4. DTR Form Instructions

Process for DTRs:

Blue Plus Utilization Management (UM) Team will review all requests for Denial, Termination, and Reduction of Services (DTRs) for: MSHO supplemental benefits; Elderly Waiver; and MA Covered home care services including PCA/CFSS within 10 calendar days.

If the Care Coordinator, not the provider, recommends a DTR, follow the process below:

1. Notify Blue Plus UM by completing and faxing the Request for DTR form within 24 hours of the determination.
2. Notify the service Provider and the member within 24 hours of a determination.
3. DTRs due to reassessment indicating a need for fewer hours for any service including PCA/CFSS require a DTR (See DTR Decision Guide for more scenarios).
4. Blue Plus UM will review the request and, if a DTR is needed, will email a copy of the DTR to the Care Coordinator and mail a copy to the provider and member.
5. The Care Coordinator must contact the member and the provider to discuss denial, termination, or reduction of the service, explaining that the 10 calendar days given on the letter they will receive from Blue Plus is the appeal window. If they choose to continue services during this appeal window and either does not appeal or the DTR is upheld on appeal, any claims paid during the appeal window will be adjusted and recouped.
6. EW and MA covered home care service agreements including PCA/CFSS: Close the service agreement in Bridgeview with the effective date provided by Blue Plus UM. Do not update any service agreements until you receive an email confirmation from UM with the DTR effective date(s) which are typically 10 calendar days from the date of determination.
7. MA covered Home Care Services and PCA/CFSS reductions: Blue Plus UM will automatically update any current service authorizations in Helios with the reduced amount.
8. For any inpatient or skilled nursing facility admissions:

    - CC must follow the instructions located on the DTR Reference Guide for Hospital or Nursing Home Stays or vacation/temporarily out of service area guide.
    - CC must notify any home care or EW services providers as soon as the Care Coordinator is notified.
    - Waiver and service agreement closure must match the facility admission date. Do not use the date provided by UM.

Member loses Nursing Facility (NF) Level of Care (which allows EW eligibility) the NFLOC statute requires a minimum of 30 days advance notice for termination of services.

1. The Care Coordinator must fax the Request for DTR form to Blue Plus UM.
2. UM will process the request and send the Care Coordinator a copy of the Denial Termination Reduction letter which will include the effective date (which is 30 days from the date of processing). This effective date will be used as the date of EW closure and the last date services are covered.
3. The Care Coordinator will duplicate the effective date given by UM to:

Notify the member and service Provider within 24 hours of the determination explaining that the date given on the letter they will receive from Blue Plus is the appeal window. If the provider chooses to continue services during this appeal window and they do not appeal or the DTR is upheld on appeal, any claims paid during the appeal window will be adjusted and recouped.

4. Send DHS 5181 to the Member's Financial Worker.
5. Enter a screening document to exit elderly waiver into MMIS.
6. Close the service agreement in Bridgeview with the effective date provided by Blue Plus UM.

Transitions of Care (TOC)

The Blue Plus Care Coordinator is key to supporting the members' 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 tasks are required for emergency room visits. See Notification of Outpatient Procedures/DME/ER Visits and Observation Stays

- **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, TOC log tasks are not required.
- **Outpatient procedures:** See Notification of Outpatient Procedures/DME/ER Visits and Observation Stays 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.

Notification of Inpatient Stays/Skilled Nursing Facility

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 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 each 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 that setting, leave this date field blank and must 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 each transition. Enter the date the Care Coordinator notified member's PCP or the date the Care Coordinator confirmed the member's PCP was already aware of transition.

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.) Don't forget to enter the date you confirmed in the date completed field.
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 and note in the comments.
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.

Notification of Outpatient Surgical Procedures, ER Visits, 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 outpatient surgical procedures, ER visits, hospital or ER observation stays, DME, and non-surgical treatments through our daily Inpatient/Outpatient notification reports.

Type of notification	Outreach to member	Documentation
Inpatient hospitalizations	Yes—TOC process	TOC log
Nursing Home/TCU	Yes—TOC process	TOC log
Transition back home after IP/SNF	Yes—TOC process	TOC log
Hospital or ER Observation Stays	Yes	Case Note
ER visits	Yes	Case Note
Outpatient surgical procedures	Yes	Case Note
Non-surgical Outpatient treatments	CCs professional judgement	
DME	CCs professional judgement	

Care Coordinators must reach out to the member when made aware of:

- Outpatient Surgical Procedures: procedures performed in a surgical setting, typically requiring anesthesia or sedation (i.e. orthopedic surgery, cataract surgery).
- Emergency Room (ER) Visits (when made aware through notifications or other sources)

- Hospital or ER Observation Stays: observation status refers to a temporary, outpatient designation for patients who require hospital-level care for a limited time (usually less than 48 hours) while doctors decide if inpatient admission is necessary.

Outreach requirements:

- Contact member to discuss their current health status.
- Identify the need for any services or support planning updates.
- Provide education and support for aftercare if applicable.

Documentation:

- Document outreach in case notes.
- A Transitions of Care (TOC) log is not required.

Notification of Non-surgical Outpatient Treatments, Durable Medical Equipment (DME)

Care Coordinators should use their professional judgment to determine outreach when made aware of:

- Durable Medical Equipment (DME) that was not ordered by the Care Coordinator and may indicate a change in member needs
    - Examples: Wheelchair, Scooter, wound therapy pumps.
- Non-surgical Outpatient Treatments: interventions such as imaging, chemotherapy, radiology, or infusion treatments.

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 MA covered Home Care or EW services	No	Yes, on day 31 or within 24	Yes, on day 31 or within 24 hours of notification

		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 Minnesota Aging Pathways (formerly the Senior LinkAge Line) at 1-800-333-2433. Minnesota Aging Pathways 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 Minnesota Aging Pathways, Relocation Services Coordination, and Care Coordination as well as receiving a DTR submitted by the Care Coordinator to Blue Plus.

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

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

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

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

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

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

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

Transfers

The term "transfer" refers to 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 a Blue Plus enrollee who has disenrolled and is now moving to another health plan or back to County 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.

Refer to the following Care Coordinator Resources:

- MSHO & MSC+ Care Coordinator Checklist Grids.
- MnCHOICES Smart Guide: Assignments, transfers and discharges in MnCHOICES Help Center as applicable.

Transfers of Care Coordination to Another Blue Plus Delegate

When a Care Coordinator becomes aware that a member is moving or changes their PCC results in change to another delegate, 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 Transfer documents:

    a. Send the ***Blue Plus Transfer in Care Coordination Delegation form*** and all transfer documents (assessments and Support Plans etc.) directly to the new Delegate. **Optional:** complete *Aging & Disability Services: MnCHOICES Lead Agency Transfer and Communication Form DHS 6037* OR

    b. After confirmation of new Delegate, the CC can transfer member in MnCHOICES using Smart Guide: Assignments, transfers and discharges in Help Center as applicable.

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.

****Important:** If at the time of transfer, it is known the member's MA is terming and will not be reinstated, do **not** transfer the case. The current Care Coordinator must continue to follow the member until the member's coverage terminates.

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

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

    - Bluestone Physicians
    - Essentia Health
    - Genevive
    - Genevive

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. After confirmation of new Delegate, CC can reassign new delegate in MnCHOICES using Smart Guide: Assignments, transfers and discharges in MnCHOICES Help Center as applicable.

4. 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 the ***Blue Plus Transfer in Care Coordination Delegation form*** and all transfer documents directly to the new Delegate.

   Optional: complete *Aging & Disability Services: MnCHOICES Lead Agency Transfer and Communication Form DHS-6037*

2. The **transferring** Care Coordinator is required, at a minimum, to ensure the current assessent and Support Plan are in their final status in MnCHOICES and includes all required attachments, as applicable.

3. The **transferring** Care Coordinator must communicate the following to the member's financial worker:

   - Address change
   - EW eligibility

4. If in MnCHOICES, refer to the Smart Guide_Assignments_Transfers_Discharges resource found in the Help Center located in the MnCHOICES application.

5. If the member is open to EW, the **transferring** Care Coordinator must:

   - Keep the waiver span open in MMIS if the member remains eligible for EW
   - Keep all active service agreement(s) in Bridgeview open, if services will continue with the same provider. Be sure to share this information with the new delegate.
   - Close service agreement(s) that are no longer applicable.
   - If a member enters an inpatient setting such as a hospital, Residential Treatment Center, etc. outside of the county the member resides in, the Care Coordination responsibility continues with the current Care Coordinator. Once it is determined the member will not be returning to the original county, the **transferring** Care Coordinator must proceed with the transfer process outlined here and change the PCC (if applicable).
   - 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 the ***Blue Plus 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. Completion of a new assessment/support plan (and Bridgeview entry) is not required for a transfer unless the receiving Delegate does not obtain a copy of the assessment and support plan from the previous Delegate.
    - Do not complete a Transitional HRA.
2. Assignment of Care Coordinator:
    - In Bridgeview: Assign the new 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.
    - In MnCHOICES: End the previous CC assignment and assign new CC as both the Care Coordinator MSHO/MSC+ and Certified Assessor effective the date of the transfer.
3. The Care Coordinator must follow the same timelines as previous CC for next mid-year outreach and next reassessment as applicable. If the date of the previous assessment is not available on the transfer form, CC can view the date of the previous assessment/refusal/UTR in Bridgeview or MnCHOICES, if needed.
4. Enter the name of the assigned Care Coordinator in Bridgeview following the process outlined in the Bridgeview Care Coordination User Guide.
5. After confirmation of new Delegate, CC can reassign new delegate in MnCHOICES using Smart Guide: Assignments, transfers and discharges in MnCHOICES Help Center as applicable.
6. Update the Screening Document to reflect the change in Care Coordinator
7. Notify the financial worker of the assigned Care Coordinator's name.
8. Notify the 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. Confirm the PCC is correct in Bridgeview. If not, please update following the process outlined in the *Primary Care Clinic (PCC) Change* section of these Guidelines.
9. The Care Coordinator is now responsible for the content of the transferred assessment and Support Plan. The CC must review the assessment and Support Plan received from the previous Delegate. If applicable, document any updates and complete any areas that are not complete.

10. Keep copies of all forms and letters related to the transfer for your records.

Optional: Either Delegate may update the address and County of Residence in Bridgeview. This will be done automatically after the Financial Worker makes their changes; however, those changes may take up to a month to reach Bridgeview. Follow the process outlined in the Bridgeview Care Coordination User Guide to make these manual changes.

Note: Manual changes made to the member information except the PCC in Bridgeview are saved for only 90 days. You must notify the financial worker to permanently change the member's information.

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

If there is a change in Care Coordinator within the Delegate agency, the Delegate agency must:

1. Inform member of the name, number, and availability of new Care Coordinator within 10 calendar days (new CC may use CM Change Intro letter)
2. Update the Care Coordinator assigned in Bridgeview
3. Update the Care Coordinator assigned in MnCHOICES using the Smart Guide: Assignments, transfers and discharges in Help Center as applicable.
4. Enter a Screening Document into MMIS if on Elderly Waiver.
5. Notify the financial worker of the change in Care Coordinator.
6. Notify the 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. See *Summary of Requirements & Timelines*.

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 *Aging & Disability Services: MnCHOICES Lead Agency Transfer and Communication Form DHS 6037* to the new health plan or county. This should be attached the member's record in MnCHOICES.
3. Refer to MnCHOICES Smart Guide: Assignments, transfers and discharges in MnCHOICES Help Center for steps on what to do in MnCHOICES.
4. Send any applicable paper documents directly to the new health plan or County.
5. If on EW, **do not** close waiver span in MMIS.

6. Close service agreements in Bridgeview.

Case Closure Care Coordination Responsibilities

Activities required when closing a member's case depends on the reason for the termination. If you have any questions, always contact your Partner Relations Consultant. Care Coordinators should be referring to the *DTRs—Coordination of Potential Denials, Terminations, and Reductions of Services* section to determine if a DTR is needed. Here are some common "termination" scenarios (not all inclusive):

Term due to Medicaid eligibility ending

See 90 Day Monitoring after Medicaid becomes inactive (includes MSHO grace period and MSC+ guidance)

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/CFSS " by the 23rd of each month.
3. After entering DOD into Bridgeview, all EW service agreements will be auto-closed as of the date of death, including the LTCC/Case Mix span. CC must verify the SA's were closed and must modify and update the units accordingly.
4. Close member to EW in MMIS (EW only)
5. It is not required to revise the member's Support Plan in MnCHOICES upon term.
6. If the member just had a reassessment or is new to the plan, the CC must ensure the support plan is completed to the point where CC can authorize the services received before the date of death.
    a. For example: if a member was residing in an assisted living, the support plan must be completed to provide the CL rate for the authorization, and case note must reflect why there is no member signature.

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

1. Notify Financial Worker via DHS 5181

a. Care Coordination activities must continue until member officially terms off enrollment

2. Once officially termed on enrollment, Care Coordinator must:
    a. Close member to EW in MMIS (EW only)
    b. Close service agreements in Bridgeview (EW only).

Term due MA closing and will not reopen

1. Close member to EW in MMIS (EW only)
2. Close service agreements in Bridgeview (EW only)
3. Refer member to Minnesota Aging Pathways (formerly the Senior LinkAge Line) at 1-800-333-2433 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 *Aging & Disability Services: MnCHOICES Lead Agency Transfer and Communication Form DHS 6037* to the new health plan or county. This may be uploaded as an attachment to a person's record in MnCHOICES.
3. Send any applicable paper documents directly to the new health plan or County.
4. If on EW, do not close waiver span in MMIS
5. Close service agreements in Bridgeview.

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

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

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

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

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

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

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

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

**Only the above criteria will result in a member receiving the targeted outreach from our vendor. However, all SecureBlue members can participate by calling 1-844-226-8218 (TTY 711),

7 a.m. to 7 p.m., Central Time, Monday – Friday and 8 a.m. to 4:30 p.m., Central Time Saturday or they can visit schedule.signifyhealth.com.

PHI & Validation of Decision Makers

Personal Health Information (PHI)

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

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

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

- Written
    - The authorization must clearly state what information may be released, and to whom.
    - Under MN State law, authorization cannot be effective more than one year from signature date and may have a shorter duration noted by the member.
- Verbal
    - Verbal authorizations are valid only during the phone call/e-visit/on-site visit during which the authorization is made.
    - The member making the verbal authorization must have their identity validated, and must state what information may be released, and to whom.
    - Verbal authorization needs to be documented in case notes.

Authorized Representatives & Decision Makers

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

The different types of authorized decision makers include:

- Authorized Representative Designation appendix on MN MA Application
    - When someone applies for Medicaid in the State of MN using DHS form 3876 – they can choose to designate someone to act on their behalf as an authorized representative. The application has an appendix where the applicant can name their authorized representative including a signature from both parties. Care

Coordinators may request this information from a financial worker if validation is ever needed.

- Financial Power of Attorney (POA)
    - A Short Form/Financial POA does not allow for release of specific medical information to the person named but would allow for the release of information including benefits, eligibility, or financial matters.
- Health Care Power of Attorney (POA)
    - A Health Care POA or Health Care Directive specifically allows for the release of medical information and may also designate someone to make medical decisions (health care agent).
    - A Health Care POA may be conditional, based on member's medical condition. It does not become effective until conditions are met.

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

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

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

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

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

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

Behavioral Health Homes (BHH)

As part of our contract with DHS, when Blue Plus receives a DHS-4797-ENG Notification of Eligibility for Behavioral Health Home (BHH) Services, we are required to provide this information to our Care Coordinators. The Care Coordinator assigned must:

- Contact the BHH provider within 30 days of receipt of DHS 4797 to initiate communication and create a plan for ongoing communication and check-ins.
- Include this provider as a part of the members ICT team.
- Notify this provider of any Inpatient Hospitalizations in a timely manner and share post discharge plans as applicable.
- Notify this provider in a timely manner if made aware of any ER visits.

Resources:

- Behavioral Health Home (BHH) Services Providers and Managed Care Organizations (MCOs) Collaboration: Roles and Responsibilities
- Behavioral Health Home Services

BlueRide Transportation

All SecureBlue MSHO and Blue Advantage MSC+ members have coverage for transportation to medical appointments through BlueRide. See the Resources page on the Care Coordination website for information and forms.

Common Carrier:

- Common Carrier transportation is for members who can physically and mentally ride independently in a bus, taxi, or volunteer driver vehicle.

Special Transportation (STS):

- Special Transportation is for members who have a physical or mental impairment where Common Carrier transportation is not an option for them (i.e. wheelchair, severe cognitive impairment, etc.).

Call BlueRide when transportation is needed for:

- Medical, dental, and behavioral health appointments
- Prescription pick-up at your pharmacy
- Durable Medical Equipment (DME) supply pick-up

- Discharge from the hospital or nursing home
- SilverSneakers' facilities up to one round trip per day
- Juniper Health and Wellness Classes 4 round trips per month (exception in place for increased transportation to Tai Ji Quan and Stay Active Classes)
- Transportation to Alcoholics Anonymous (AA), Narcotics Anonymous maximum 4 round trip rides per benefit per month

Scheduling Rides:

- Request a ride at least 3 business days prior to the appointment (if a ride is needed with less than 3 days-notice, the CC or member must call BlueRide directly).
- Will allow same day rides based on need or circumstances.
- For bus passes, please call at least 10 business days before an appointment to receive the pass.
- If the appointment changes, call BlueRide at least 4 hours before the pickup time to change or cancel your ride.
- Transportation to a Primary Care Clinic is up to 30 miles, and Specialty Care Clinic is 60 miles, one way. Call BlueRide or complete the BlueRide 30/60 Form for an exception as needed.

Hours of Operation:

To schedule, change or cancel a ride, call: 651-662-8648 or toll free 1-866-340-8648 (TTY: 711), Monday through Friday 7:00 am to 5:00 pm.

Interpreter Services

The Blue Plus contract with the Minnesota Department of Human Services requires that persons with limited English proficiency receive language assistance, as necessary. If a Blue Plus member does not speak English as their primary language and has a limited ability to read, speak, write or understand English, the Care Coordinator may initiate the use of an interpreter to assist in assessment, 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 MSHO Part D benefits. See the Pharmacy section on the Resources page of our website for access to:

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

Self-administration of medications and vaccine coverage

MSHO members may be billed for some Medicare Part D vaccinations received in a clinic setting or over the counter medications self-administered in a hospital or emergency room setting.

- Part D covered vaccinations (examples are Zostavax for shingles or Tdap for tetanus) can be administered in a clinic setting. The clinic can bill Part B benefits for the administration of the vaccine but since they are not a pharmacy, clinics cannot bill Part D benefits for the vaccine itself.

- Members may be billed for medications that are self-administered while in the hospital during an observation stay or while in the Emergency Room. Medicare considers certain prescription and over-the-counter medications normally taken on your own as self-administered and are not generally covered by Medicare benefits during an outpatient, observation, or ER stay. (Examples include Ibuprofen and insulin, etc.).

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

- Members receiving bills can do one of the following:
    - Pay the bill and submit for the form for reimbursement or
    - Not pay the bill and submit invoice for reimbursement.
    - Form can be mailed to address on the form or faxed to 1-800-693-6703.
    - Must include copy of paid receipt or unpaid invoice.

Ask your PR Consultant if you have any questions.

Pharmacy programs for members

Program	Who qualifies	What to expect	Care Coordinator Role
MTM: Medication Therapy Management program *MTM services are provided telephonically by pharmacists who have advanced training in optimizing medication therapy*. The initial visit is called a Comprehensive Medication Review (CMR).	All **MSHO** members meeting the following criteria are eligible for the MTM program at the beginning of the year and are scheduled to receive a CMR: **Criteria A:** Meeting the CMS criteria for MTM services. Completing a CMR for these members improves our Star measure • at least three of five conditions: CHF, COPD, hypertension, osteoporosis, or	• Telephonic visit scheduled with internal MTM team. • MTM Pharmacist follows standard CMR delivery and documentation process to understand the member's medication experience and review medications and conditions to assess, resolve, and prevent any medication related problems.	• Educate member on benefits of having CMR if contacted. • Care Coordinators should complete the Medication Therapy Management (MTM) Referral form and email to: MTM.Pharmacy@ @bluecrossmn.com

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

Relocation Service Coordination (RSC)

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

It remains the Care Coordinator's responsibility to ensure all activities included in the Care Coordination Guidelines are completed within the required timelines. If a member does not wish to continue to work with their Relocation Targeted Case Manager, the Care Coordinator will provide all necessary relocation services coordination. For more information refer to the following resources: *At a Glance – Relocation Resources (*see *Care Coordinator Resources) and* Relocation Service Coordination -Targeted Case Management section of the MHCP Provider Manual.

Moving Home Minnesota

Moving Home Minnesota (MHM) is a federal demonstration initiative designed to support individuals with chronic conditions and disabilities who currently reside in qualifying institutional settings. The program's goal is to facilitate their transition back to an integrated community environment.

Since transitional services are covered under the Elderly Waiver, Blue Plus reserves participation in MHM for members who either:

- Lack a community residence to return to, or
- Require substantial assistance in locating a new, qualifying community residence.

Before referring a member to the Department of Human Services (DHS) under MHM, Care Coordinators must first consult with the Senior Housing Services Team at senior.housing.services@bluecrossmn.com

Note: When a service is available through both Medical Assistance (MA) and waiver programs, as well as MHM, MA and waiver-funded options must be used first.

For more information, refer to the following resources:

- At a Glance – Relocation Resources (see Care Coordinator Resources),
- MHM section of the MHCP Provider Manual

- MHM Lead Agency Responsibilities.

The BCBS website's Care Coordination page provides MHM and BCBS processes and additional tools.

Out-of-Home Respite Care—Community Emergency or Disaster

In the event of a community emergency or disaster that requires an emergency need to relocate a member, and a currently licensed out-of-home respite provider is not available, out-of-home respite services may be provided in an unlicensed facility/home. Contrary to normal out-of-home respite practice, a caregiver may reside in the same temporary location as the member. The primary caregiver may not be paid to provide respite services. Requests for out-of-home respite services in these rare circumstances must be approved by Blue Plus.

To request out-of-home respite care for a member because of a community disaster:

1. Care Coordinator contacts their Partner Relations Consultant to discuss the specific situation of any member(s).
2. Partner Relations Consultant works with DHS staff to present situation and request the necessary approvals.
3. Partner Relations Consultant communicates decision to Care Coordinator.

Note: The DHS Commissioner must approve all requests as a necessary expenditure related to the emergency or disaster. The DHS Commissioner may waive other limitations on this service to ensure that necessary expenditures related to protecting the health and safety of members are reimbursed. In the event of an emergency involving the relocation of waiver participants, the Commissioner may approve the provision of respite services by unlicensed providers on a short-term, temporary basis.

Other Care Coordination Responsibilities

1. **QIPs**—The Care Coordinator will participate in the on-going performance improvement projects that are designed to achieve significant favorable health outcomes for members. These projects incorporate standards and guidelines outlined by the Centers for Medicare and Medicaid (CMS) with input by the Minnesota Department of Human Services (DHS).
2. **Vulnerable Persons Reporting.** It is the duty of mandated reporters to report suspected maltreatment of a vulnerable adult or child. Minnesota has a new central system for reporting suspected maltreatment of vulnerable adults. Call 844-880-1574 or go to the MAARC Mandated Reporter Form online.

Vulnerable Adults Mandated Training Web-based training is available at no cost to all mandated reporters here.

3. **Documentation**—The Care Coordinator shall document all activities in the member's contact notes.
4. The Care Coordinator shall comply with any applicable Federal and State laws that pertain to member rights including **HIPAA laws** and the **Minnesota Data Privacy Act** and **your organization's confidentiality policy**.
5. The Care Coordinator should be coordinating with local agency case managers (mental health, developmental disabilities, adult protection, etc), financial workers and other staff as necessary to meet the member's needs. This includes using the Case Manager/Financial Worker Communication Form (DHS # 5181) when:
    - A member requests waiver service
    - A member receiving waiver services has a change in circumstances (exits waiver, moves to SNF, expires, etc.)
6. Americans with Disabilities Act (ADA)--Please contact your Partner Relations Consultant if you need assistance with addressing member ADA needs.

Compliance and Fraud Waste and Abuse (FWA)

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

Compliance and FWA training can be completed in two ways:

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

Retain attestation at your agency.

Appeals and Grievances

Definitions

Grievance

Grievances are verbal or written expressions of dissatisfaction about any matter other than an Action (see definition below), including but not limited to, the quality of care or services provided or failure to respect the member's rights. Some examples of grievances include: the

quality of home delivered meals (food is cold), transportation providers being late, dislike of a roommate in the nursing home, impolite staff, inability 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.

Member and provider appeals received by Blue Plus are managed by Blue Plus (except BlueRide). 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

If requested by a member to assist with an oral appeal Care Coordinators may assist member in calling Blue Plus Appeals team by calling:

- 651-662-4357
- 888-878-0139 ext 24357

Blue Plus Network

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

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

There is no coverage for urgently needed care or any other non-emergency care received outside of the United States. Refer to the member handbooks on our website.

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

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

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

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

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

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 *Summary of Requirements & Timelines*. The requirements are for Blue Plus to achieve equal to or greater than 90% of 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 assessments that have been entered or are missing in Bridgeview. Delegate should review the report, including any comments, and correct the following for compliance:

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

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

- If the Care Coordinator fields are blank, log into Bridgeview and assign members to individual Care Coordinators.
- If assessment dates are missing:
    - Log into Bridgeview and enter the assessment 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: members 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(s) Process

CDCS Audits

Blue Plus completes an audit on authorization and utilization of Consumer Directed Community Supports (CDCS) under Elderly Waiver. This is done on an annual basis with a randomly selected audit sample list.

Health Risk Assessment Audits (HRA)

HRAs are audited on a regular basis to ensure accuracy of entry into the Bridgeview system. The date entered into Bridgeview must be the date the member assessment was completed or the date the UTR Member Support Plan Letter was sent. HRA information in Bridgeview are compared to the assessment documentation submitted. Delegates are audited on a monthly, quarterly or semi-annual basis. See Bridgeview Care Coordination User Guide for details on the audit process.

Pass-through Audits

Blue Plus is required to complete an audit of Delegate agencies that agreed to contract with Blue Plus in a "Pass Through" capacity for services delivered by non-enrolled Approval-Option service providers. This is done on an annual basis with a randomly selected audit sample list.

Managed Care (MSHO and MSC+) EW and Non-Elderly Waiver Support 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 Support Plan audits for elderly waiver and community well members using the DHS approved MSHO and MSC+ EW Support Planning Audit Protocol and Non-Elderly Waiver Support 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 Support Plan audits for two consecutive years may be considered for Higher Performer status. As a high performer, the Delegate agency will be audited every other year if the agency maintains no CAP status for all products and meets the following criteria:

- Delegate must have a self-monitoring system in place to ensure that audit elements are being met by Care Coordinators in their work.
- Internal audit results will be maintained by the Delegate agency and provided to Blue Plus if requested
- Delegate will continue to participate in Blue Plus trainings and webinars during their gap year to stay informed on process and audit protocol changes that are developed in collaboration with DHS or to remain consistent with the Blue Plus Model of Care.

Elderly Waiver: Review of selected member files using an established statistical process of an 8/30 record review sampling methodology. If any element is missing or not met in the first 8 records, another 22 records will be pulled and reviewed in the areas not met in the initial sample.

Community Well and Nursing Home/ICF:

- Review of a random sampling of 5 records for each living arrangement. If any element is missing or not met in those 5 records, another 5 records will be reviewed in the areas not met in the initial sample.
- For Nursing Home/ICF only Delegates, review of selected member files using an established statistical process of an 8/30 record review sampling methodology will be used. If any element is missing or not met in the first 8 records, another 22 records will be pulled and reviewed in the areas not met in the initial sample.

Audit Action Plan

If a problem or findings are identified during the audit, the Delegate will be required to respond to Blue Plus with an Audit Action Plan meaning a list of actions and an associated timetable for implementation to remedy a specific problem which includes measurable interventions, the person responsible for resolution, and a status summary and date for resolution.

- "Findings" are areas of Non-compliance based on CMS requirements and/or DHS audit protocols.
- "Mandatory Improvements" are required corrections for non-compliance with Care Coordination guidelines and annual Systems Audits.
- "Recommendations" are areas where, although compliant with requirements, Blue Plus identified opportunities for improvement.

An Audit Action Plan may be assigned to resolve Findings or mitigate compliance risks when one or more of the following apply:

- The 95% compliance standard for an element is not met
- Policies and procedures are not documented
- Beneficiary's rights are impacted
- There is a repeat finding from a previous assessment or monitoring
- Compliance issues that are related to a high-risk area, where swift correction of the action is required.

Each Delegate will be required to provide a written response within 1 month of receipt of the written audit results if there are Findings or Mandatory Improvements. Interventions to make corrections for the finding areas, target end dates for completion and correction must be within 3 months of the start date of the described intervention. It is the responsibility of each Delegate to alert Blue Plus with the completion dates of the corrective actions implemented.

Records Retention Policy

The Delegate must have policies and procedures to address record retention in accordance with DHS and Center for Medicare and Medicaid Services rules and regulations. Files, either in electronic or hard copy format, are to be kept for 10 years from the date the files are closed. After 10 years the files may be destroyed.

File information includes patient identification information, provider information, clinical information, and approval notification information.

All documents pertaining to pending litigation or a regulatory matter must be retained despite general disposal policy until Blue Plus advises that such documents may be returned to the general disposal policy.