2025 BLUE PLUS
CARE COORDINATOR FALL TRAINING

Government Markets Partner Relations Team

October 2025

AGENDA

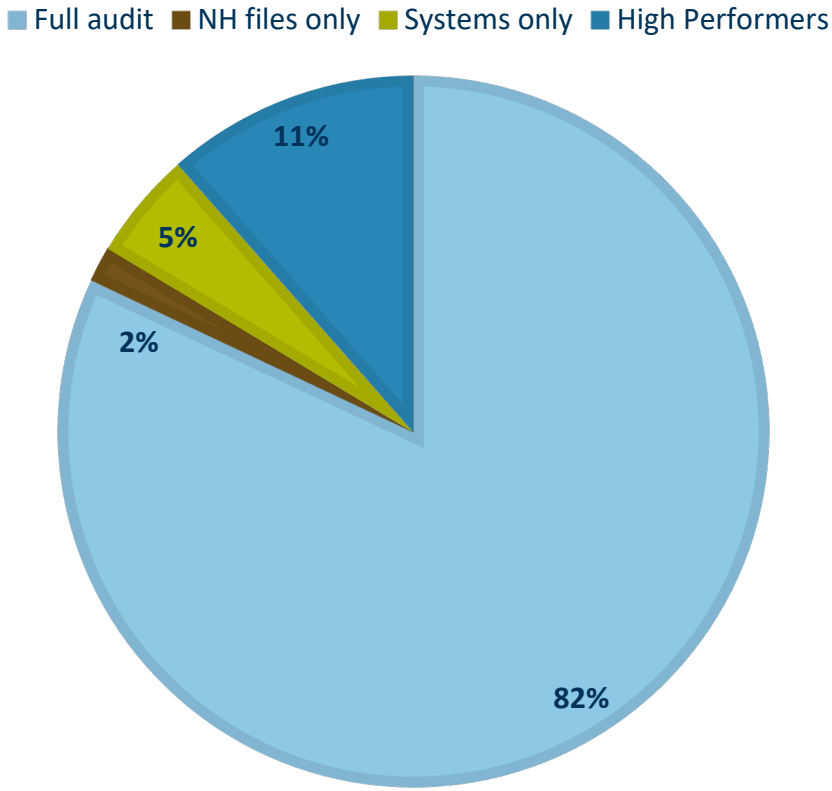
BlueCross BlueShield Minnesota

- Care Coordination Audit Review
- CMS Audit Findings
- Unable to Reach and Refusals
- CFSS Updates
- Model of Care
- 2026 MSHO Supplemental Benefits
- EW Program Sustainability

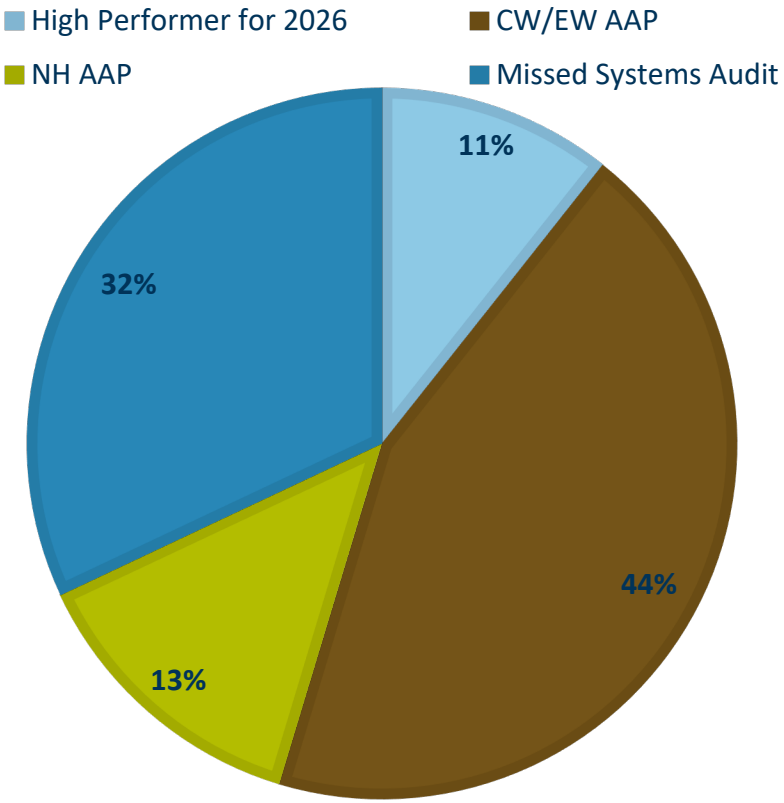
CARE COORDINATION AUDIT REVIEW

AUDIT STATS

70 TOTAL DELEGATE AGENCIES



2025 AUDIT RESULTS



AUDIT RESULTS

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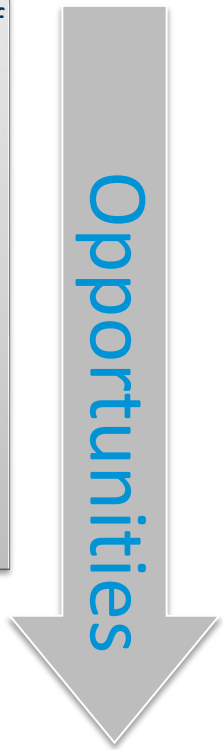
- 100% completion of assessment fields
- Person-centeredness
- Timeliness
- Fewer findings and audit action plans

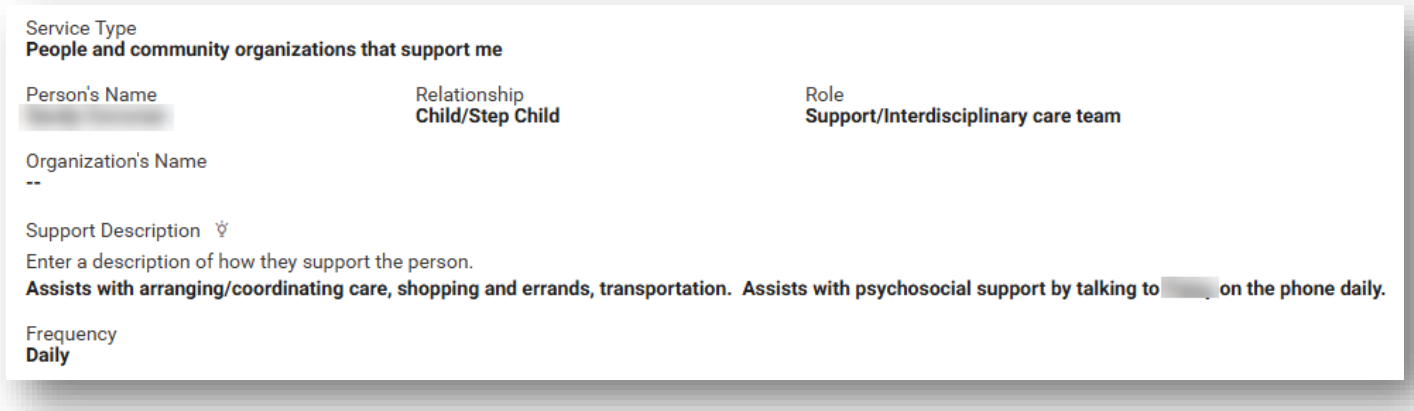
- Informal supports
- Support plan being sent within 30 days of assessment completion
- Documentation of goal monitoring and goal outcomes
- Caregiver Assessments
- Sharing of support plan with PCP
- Choosing correct SP in MnCHOICES
- Documentation of MSHO Supplemental Benefits, MSHO enrollment, & Safe Disposal of Meds



AUDIT AREAS OF OPPORTUNITIES

Informal Supports must be listed in support plan

- Must include informal supports in People & Community Organizations that Support Me.
- Informal supports examples: finances, paperwork, lawn care, drives to appointments, takes shopping, etc.



Service Type
People and community organizations that support me

Person's Name
[redacted]

Relationship
Child/Step Child

Role
Support/Interdisciplinary care team

Organization's Name
--

Support Description

Enter a description of how they support the person.
Assists with arranging/coordinating care, shopping and errands, transportation. Assists with psychosocial support by talking to [redacted] on the phone daily.

Frequency
Daily

*Resource: Community Guidelines section **Support Planning Requirements***

AUDIT AREAS OF OPPORTUNITY

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Timely reassessment within 365 days

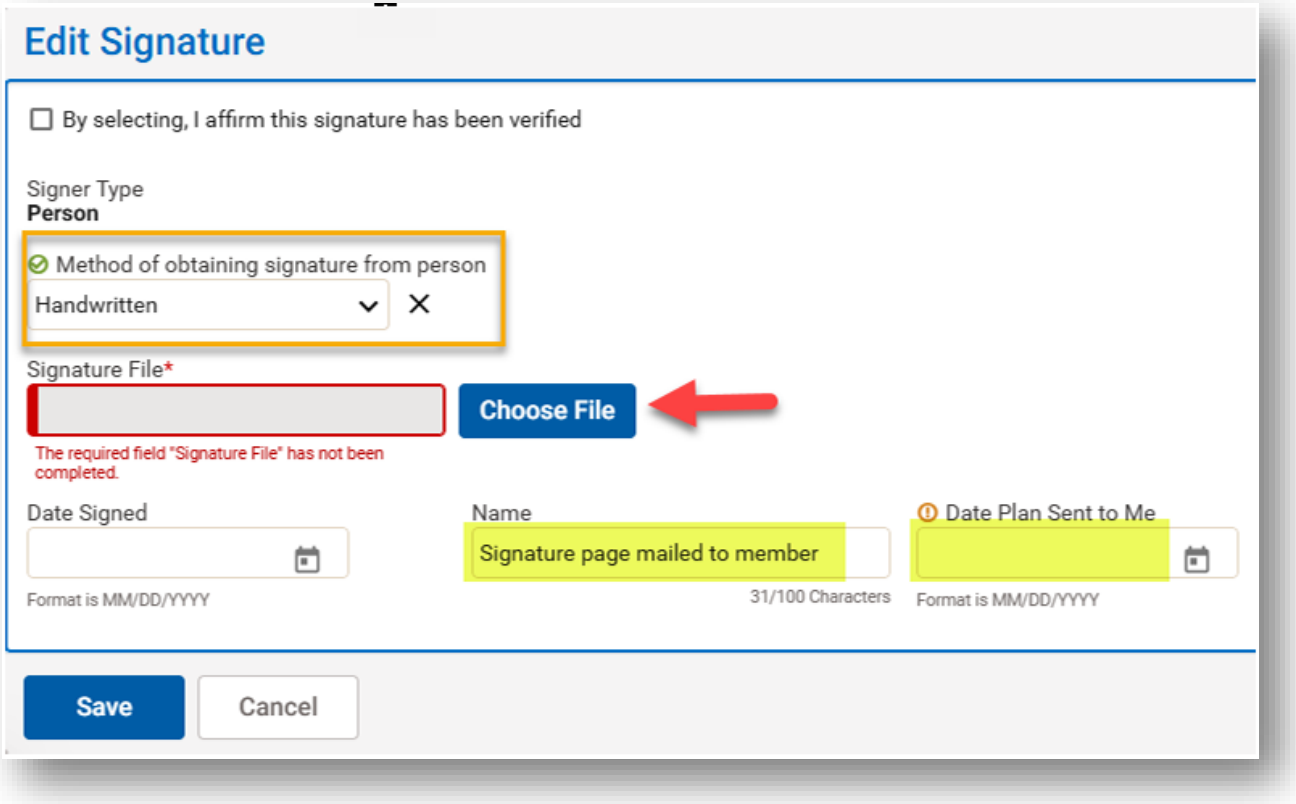
- Timely reassessments missed mostly due to leap year.
- Begin outreach at a minimum of 2 weeks in advance to schedule reassessment.

Support plan must be completed and sent to member within 30 days

- Timeline confusion: 30 days is CMS requirement for health plans while FFS requirement is 60 days.
- OK to close if waiting for information from CL to complete the RS tool. Revise and send later when info from CL is received.
- OK to close SP in MnCH even if waiting for signature

AUDIT AREAS OF OPPORTUNITY

- Do not keep the support plan open while waiting for member signature.



AUDIT AREAS OF OPPORTUNITY

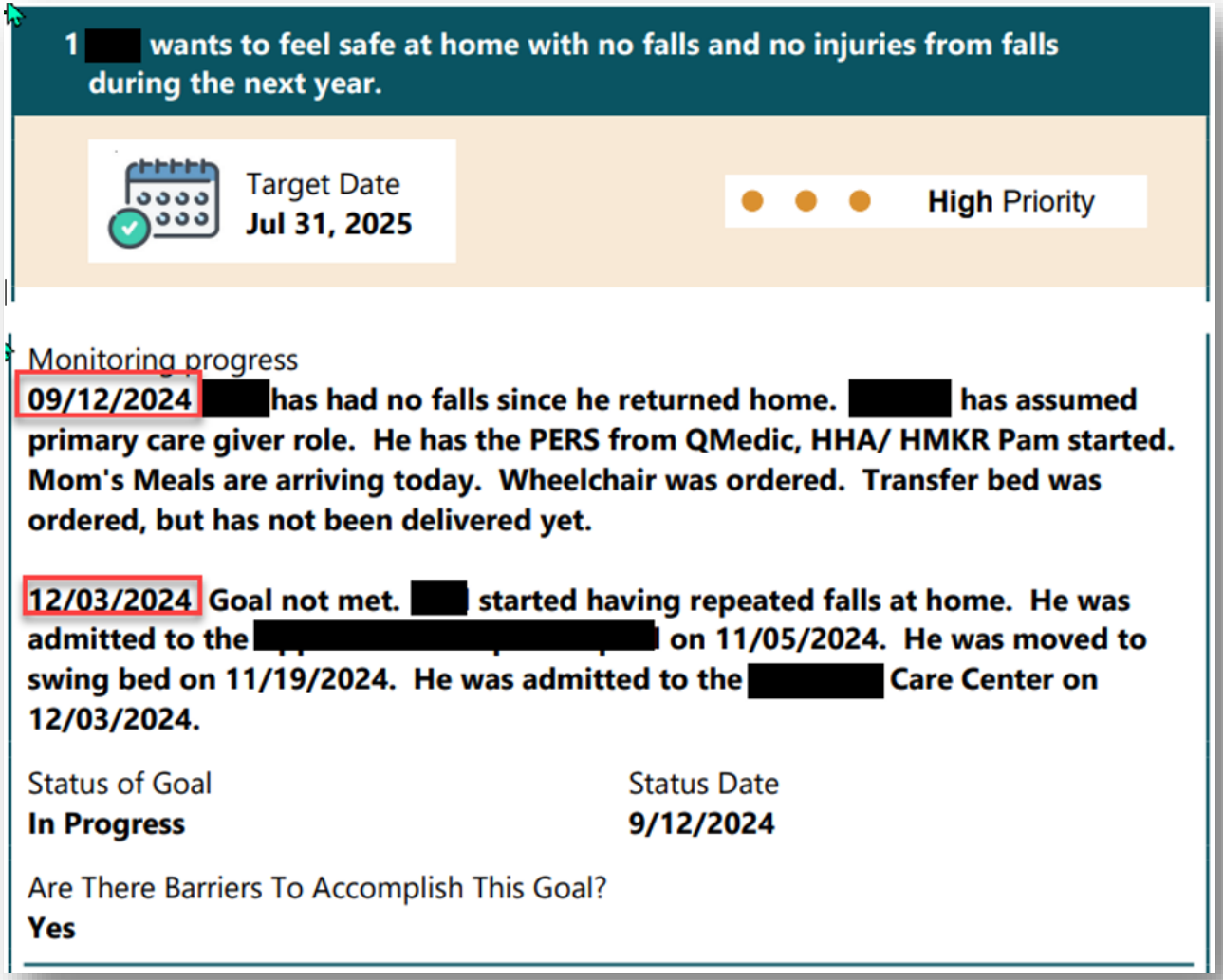
Dated documentation of goal progress at mid-year

- Log into the MnCHOICES application and go to the person record
- Go to Forms tab
- Filter and select “Support Plan” (only support plans in plan approved status will display the revise capability)
- Locate form, click on ellipsis, and select “revise”
- Under Reason for Support Plan Select “Plan Revision”
- Revision Reason enter “Midyear goal monitoring MMDDYY”
- Review existing goals and determine if new goals are necessary and update goal monitoring accordingly

*Resource: Community Care Coordination Guidelines section - **Mid-year Support Plan Review***

AUDIT AREAS OF OPPORTUNITY

Example:



1 [redacted] wants to feel safe at home with no falls and no injuries from falls during the next year.

Target Date
Jul 31, 2025

High Priority

Monitoring progress

09/12/2024 [redacted] **has had no falls since he returned home.** [redacted] **has assumed primary care giver role. He has the PERS from QMedic, HHA/ HMKR Pam started. Mom's Meals are arriving today. Wheelchair was ordered. Transfer bed was ordered, but has not been delivered yet.**

12/03/2024 Goal not met. [redacted] **started having repeated falls at home. He was admitted to the** [redacted] **on 11/05/2024. He was moved to swing bed on 11/19/2024. He was admitted to the** [redacted] **Care Center on 12/03/2024.**

Status of Goal
In Progress

Status Date
9/12/2024

Are There Barriers To Accomplish This Goal?
Yes

AUDIT AREAS OF OPPORTUNITY

Correct documentation of end of year goal outcomes at reassessment

Option 1 – only choose this option if goal outcomes/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.

AUDIT AREAS OF OPPORTUNITY

If an Informal Caregiver is identified during the assessment, CC must offer the DHS 6914 Caregiver Assessment and document offering

- Document offering (i.e.,CG assessment was offered and/or declined, mailed and/or completed.) under Functional Assessment - Community Living> Relationships Informal Supports comment box.
- Reminder: Add the caregivers name under relationship type “Informal Caregiver” in member profile to display in informal caregiver drop-down list.

Resource: *Community Care Coordination Guidelines section -* ***Summary of Requirements and Timelines, MSHO & MSC+ Elderly Waiver*** *and* ***Full MnCHOICES Assessment***

AUDIT AREAS OF OPPORTUNITY

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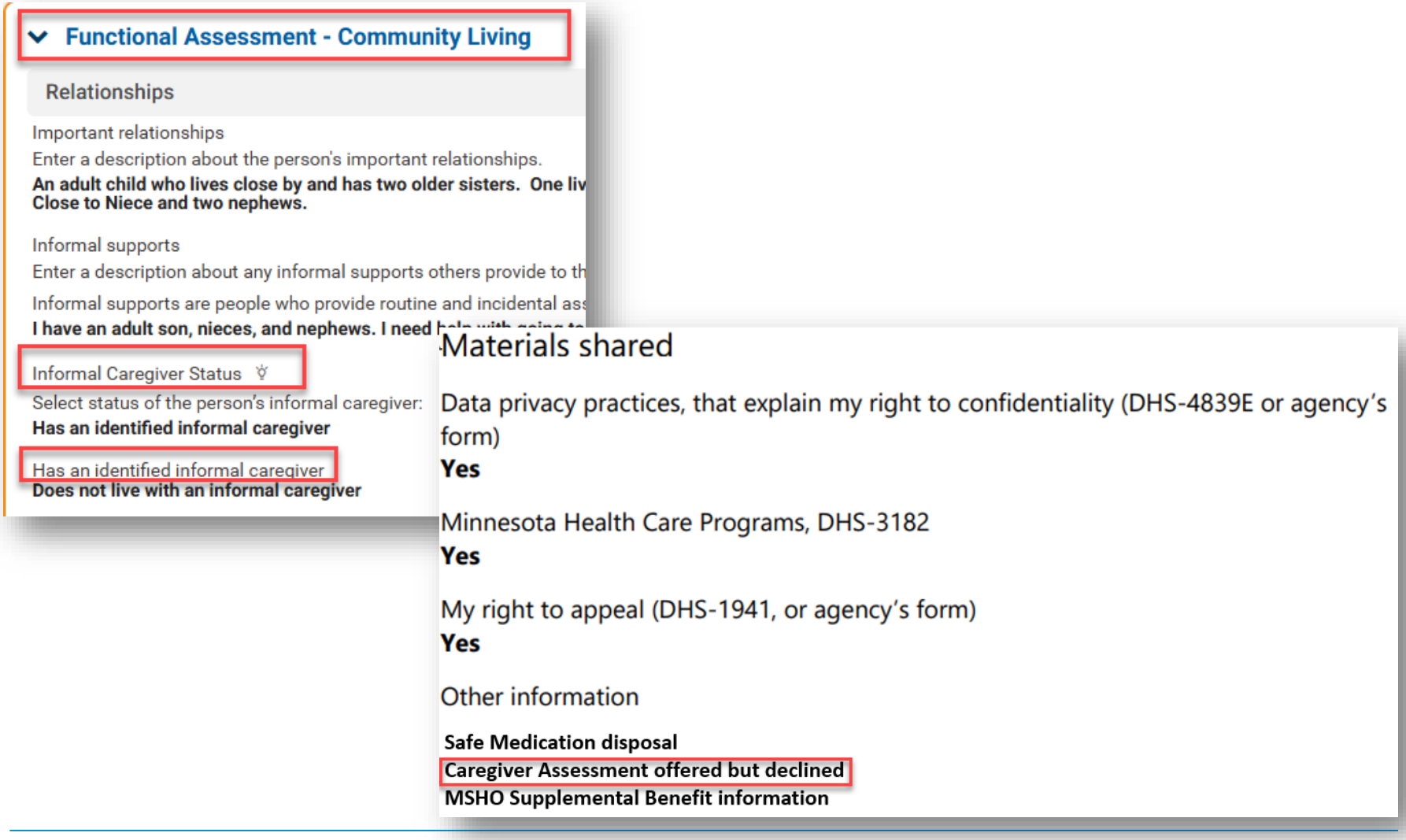
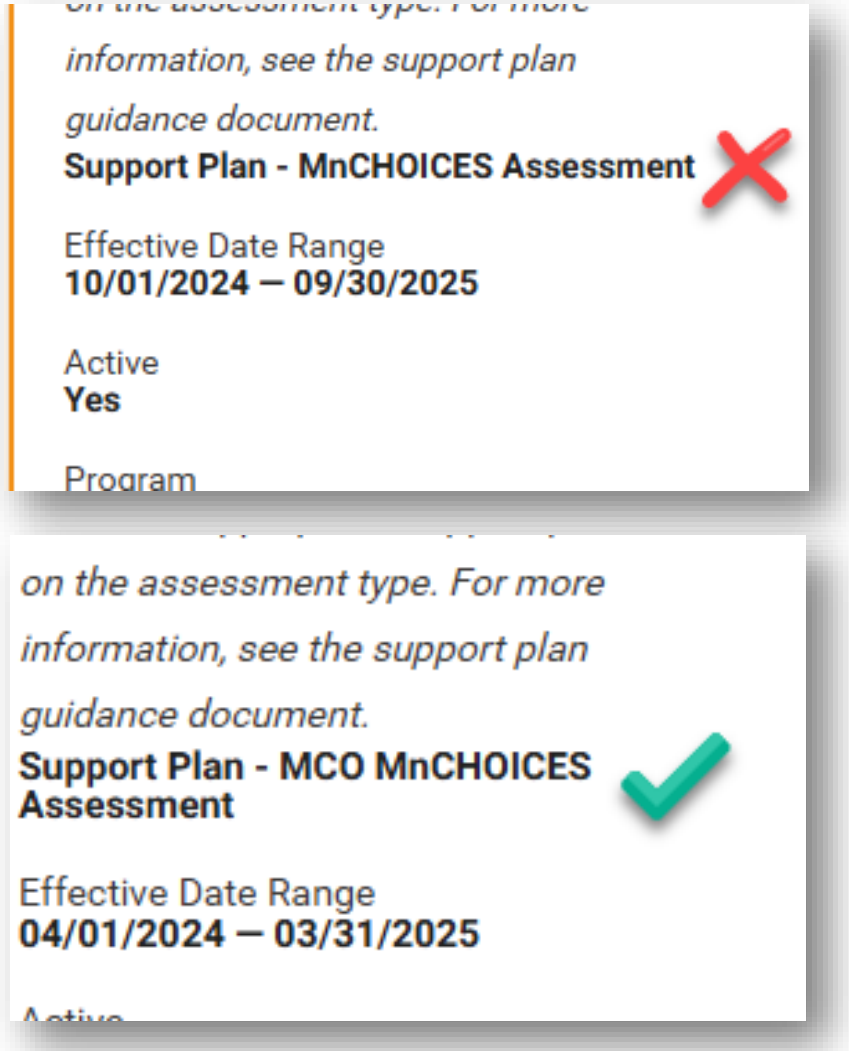


AUDIT AREAS OF OPPORTUNITY

Care Coordinators must choose the correct MCO specific support plan.



AUDIT AREAS OF OPPORTUNITY

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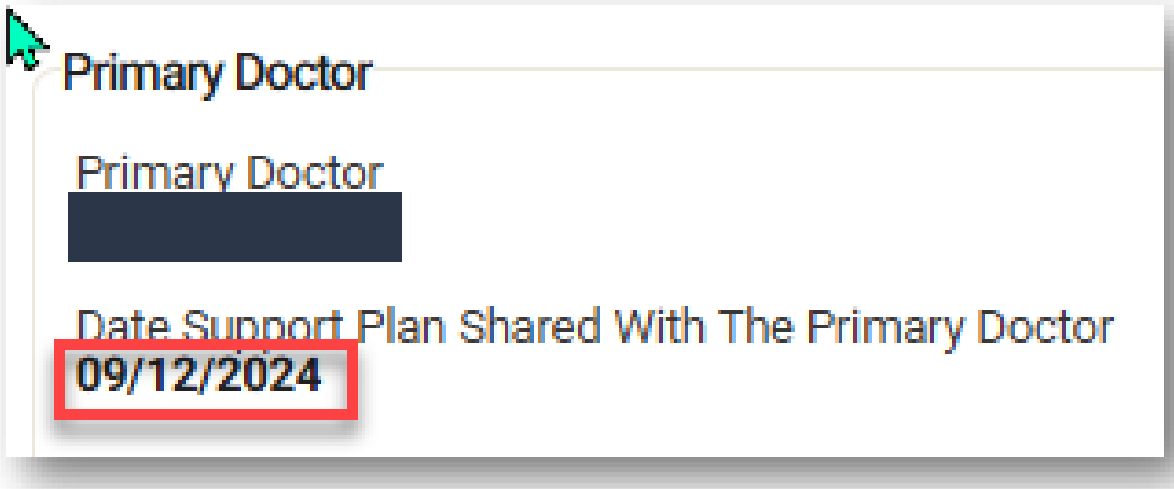
Sharing support plan with Primary Care Provider within 90 days of assessment for initials (including THRA & TFNUs which includes product changes) and annually



Resource: Community Care Coordination Guidelines section ***Summary of Requirements & Timelines***

TRANSITIONS OF CARE LOG

Common errors found on TOC logs:

- Leaving dates blank
- No notification to PCP or if CC “confirmed the member’s PCP was notified”, not including date

Notified PCP of transition - Date completed:

☒ Confirmed the member's PCP was notified **OR** Care Coordinator notified PCP via: ☐ Fax ☐ Phone ☐ EMR ☐ Secure email

- Incomplete return to usual/new usual care setting

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BLUE PLUS TRANSITIONS OF CARE (TOC) LOG

Return to usual or new usual care setting required tasks:

The following tasks are required for ALL members discharging to their usual or new usual care setting within one (1) business day of notification. For situations where the Care Coordinator is notified of the discharge prior to the date of discharge, the Care Coordinator must follow up with the member or designated representative to confirm that discharge occurred and complete the tasks outlined below.

Date completed: 6/3/2024

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

- ☑ Care transition process, including sharing Care Coordinator contact information for additional support.
- ☑ Changes to the member's health status and updates to the member's care plan as applicable.
- ☑ Education about transitions and how to prevent unplanned transitions/readmissions.
- ☑ Four Pillars for Optimal Transition below (these tasks can be confirmed with facility staff for those residing in a residential/facility setting):

Any boxes checked "No", must include an explanation for follow up in comments below.

☑ Yes ☐ No* Does the member have a **follow-up appointment** scheduled with primary care/specialist within 15 days or behavioral health within 7 days?

☑ Yes ☐ No* Can the member **manage their medications** or is there a system in place to manage medications?

☑ Yes ☐ No* Can the member verbalize **warning signs and symptoms to watch for** and how to respond?

☑ Yes ☒ No* Does the member use a **Personal Health Care Record**?
Visit this site for a sample PHR: Sample Personal Health Record

DOCUMENTATION OF OTHER HEALTH PLAN REQUIREMENTS

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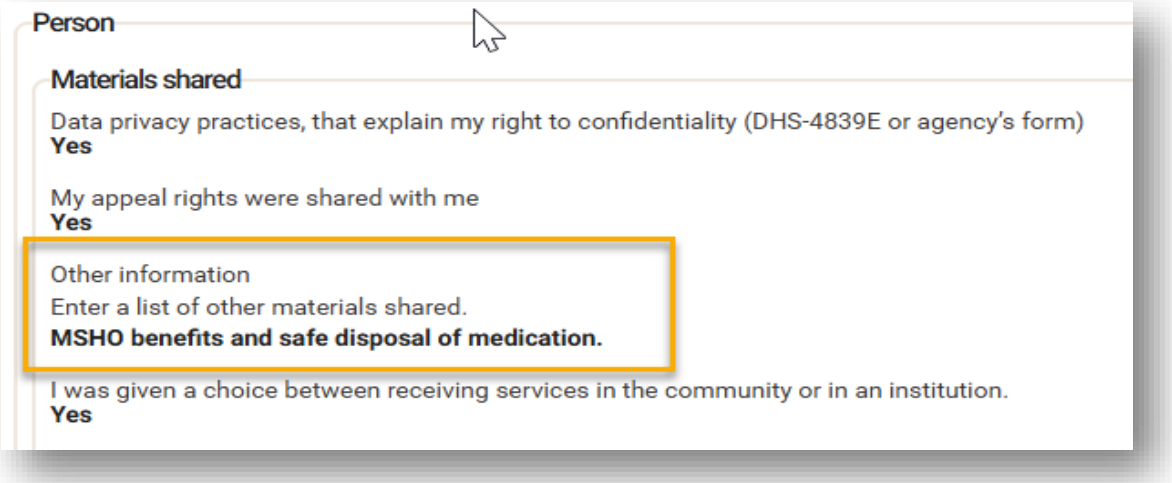
Document discussion of MSHO Supplemental Benefits (MSHO members) or MSHO enrollment (MSC+ members) and Safe Disposal of Meds

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:



CMS (CENTERS FOR MEDICARE & MEDICAID SERVICES) AUDIT

CMS FINDING—BACKGROUND

CMS conducted an initial audit in **July 2024**, followed by a **reaudit in July 2025** to address previously missed elements. Specifically, they reviewed whether **diagnoses (Dx), assessed needs, and health conditions** identified during assessments were appropriately carried over into the support plan either as active goals or documented as declined by the member.

We remain non-compliant in consistently ensuring that all diagnoses, assessed needs, and health conditions from the assessment are reflected in the support plan. This includes:

- Noting when a member **declines a goal** related to a diagnosis, assessed needs, and health conditions.
- Documenting **how each diagnosis, assessed needs, and health condition is being managed**.

Reminders for CW and EW support plans:

- If you inherit a support plan, it is your responsibility to ensure it meets CMS compliance standards.
- Support plans may need to be revised, meaning if a Dx, assessed need, and/or health condition are noted in the assessment, they must be addressed in the support plan.

Nursing Home support plans:

- Continue to obtain and incorporate the Nursing Home Care Plan into the member's Nursing Home – ICF Member Assessment and Support Plan.

REASON FOR NEW REQUIREMENTS

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The support plan is **not just a care coordination tool**—it's a **compliance-critical document** that serves as the central communication point for everyone involved in a member's care, including providers, informal supports, and auditors.

CMS has made it unequivocally clear: **the support plan must reflect all relevant health information and decisions**, even when no assistance is wanted.

✅ What Must Be Included

- **Diagnoses and health conditions** (e.g., diabetes, COPD, broken dentures)
- **Assessed needs** (e.g., mobility support, dental care, transportation)
- **Goal or support for bullet points above**
  - **If no goal or support, rationale for no action** (e.g., member declines goal and assistance, prefers to self-manage diabetes)
- Example: *Member has broken dentures but has declined a goal and assistance from the Care Coordinator at this time.*
  - This brief notation ensures transparency and documents members' choices.

CMS AUDIT IMPLICATIONS FOR HEALTH PLAN

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CMS audits are broad in scope, with serious potential impacts.

CMS evaluates:

- The health plan's systems, processes, and member files.

Findings can lead to:

- Corrective Action Plans (CAPs)
- Financial penalties
- Enrollment freezes
- Contract termination or non-renewal

💡 Bottom Line

- **If it is not in the support plan, it doesn't exist in the eyes of CMS**.
- Copy/pasting relevant data from the assessment into the support plan is acceptable.

CMS REQUIREMENT OVERVIEW

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What Makes a CW or EW Support Plan CMS-Compliant?

- ❑ **The support plan must include all diagnoses, assessed needs, and health conditions** identified in the member's Health Risk Assessment (HRA).
- ❑ **Support plan must document the member's choice** about how they would like to receive support for each diagnosis, assessed need, and/or health condition.

There are two way to do this:

- Create a goal that is explicitly linked to one or multiple diagnoses, assessed needs, and/or health conditions. (Be sure to enter a description of the support the person needs to achieve the goal.)
- Describe any formal or informal supports that is explicitly linked to one or multiple diagnoses, assessed needs, and/or health conditions. You **must** document their choice around not creating a goal. (Can be documented in Support Instructions or narrative sections of the support plan.)

This documentation:

- affirms members' engagement in the person-centered planning process, and
- confirms members' choices within a document that all parties receive a copy of. I.E. Member, AREP, service providers.

WHY THE ASSESSMENT ALONE IS NO LONGER ENOUGH

Historically, it may have been acceptable to document details about the member's diagnoses, assessed needs, and health conditions in the assessment only.

- **CMS requires that this information be present in the support plan**.
- Sending members and providers a copy of the full assessment is not an approved workaround to meet this requirement.

Assessment	Support Plan
Collects detailed information about a person's needs, strengths, risks, and situation.	Uses assessment results to plan services and supports for the person.
Identifies diagnoses, health conditions, and needs impacting the member's service needs.	Provides, in one document, a roadmap for how the member's diagnoses, health conditions, and assessed needs are being addressed, and identifies the member's choices around these elements.

DEFINITIONS: DIAGNOSES VS. HEALTH CONDITIONS

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Term	Definition
Diagnoses	ICD codes/diagnoses from a member's MnCHOICES profile that are pulled into the MnCHOICES assessment. **Bottom line:** All diagnoses pulled into the assessment must be addressed in the support plan. The assessor chooses which diagnoses to pull in. If a diagnosis impacts a member's need for services, it must be pulled from their profile into their assessment.
Health conditions	Any disease, illness, or injury documented anywhere within the MnCHOICES assessment – including narrative sections – impacting a person's physical or mental well-being.
Assessed needs	Refers to areas such as ADLs and IADLs where a member's assessment reveals a need for supports or services to assist the person in living safety and independently within the community.
Please note: For MnCHOICES Health Risk Assessment (HRA)-MCO for Community Well members, diagnoses loaded into the member's profile do not display within the HRA assessment document. Any diagnoses or health conditions mentioned in any section of the HRA must be accounted for in the support plan.	

DISCLAIMER: WATCH RECORDED CMS VIDEO WHICH CORRESPONDS WITH THIS SLIDE

CW MNCHOICES ASSESSMENT INFO
REFER TO MTZ FALL (FIRST NAME) CW2025 TRAINING (LAST NAME)

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DIAGNOSES FROM ASSESSMENT:	GOALS CHOICES	SUPPORT
Sleep apnea	Declined goal	Sees PCP, has CPAP machine
Hypertension	Declined goal	Sees PCP, takes meds as prescribed
Anxiety	Declined goal	Sees therapist monthly, takes meds as prescribed
Depression	Declined goal	Sees therapist monthly, takes meds as prescribed
DIAGNOSES FROM ASSESSMENT:	**GOALS CHOICES**	**SUPPORT**
Pain	Declined goal	Sees PCP, takes meds as prescribed
Chronic constipation	Declined goal	Sees PCP, MiraLAX
Needs new dentures which has caused issues with eating	Declined goal	Does not want help
Needs vision exam	Goal	Requests CC assistance
Smoker	Declined goal	Does not want help
DIAGNOSES FROM ASSESSMENT:	**GOALS CHOICES**	**SUPPORT**
Wants to move to new foster care	Goal	CADI CM/Sister/Guardian helping
Shopping, meal prep, cleaning, transportation, money/paperwork, dressing, grooming, bathing, supervision	Declined goal	Guardian/sister informal support, AFC providers formal support

DISCLAIMER: WATCH RECORDED CMS VIDEO WHICH CORRESPONDS WITH THIS SLIDE

CMS EW-MNCHOICES ASSESSMENT INFO
REFER TO MTZ FALL (FIRST NAME) EW2025 TRAINING (LAST NAME)

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DIAGNOSES FROM ASSESSMENT:	GOALS CHOICES	SUPPORT
E11.9 Type 2 diabetes mellitus without complications – insulin dependent	Requested Goal	Will set up HDM, SNV, Glucerna shakes
M80.08XA Age-related osteoporosis with fracture	Declined goal	PCP, takes meds as prescribed, informal support from family
F03.90 Unspecified dementia w/o behaviors	Declined goal	PCP, informal support from family
HEALTH CONDITIONS FROM ASSESSMENT:	**GOALS CHOICES**	**SUPPORT**
Pain, weakness, sleep disturbance, and experiences some anxiety attributed to losing memory	Declined goal	PCP, takes meds as prescribed, informal support from family
Fall w/facture and falls risk	Declined goal	Will set up PERS
Needs dentist appointment	Declined goal	Requests CC assistance
Arthritis check box in assessment	Declined goal	PCP, takes meds as prescribed, informal support from family
Vision and hearing impairment, foot care	Declined goal	Has glasses and hearing aide, will add foot care to SNV
ASSESSED NEEDS FROM ASSESSMENT:	**GOALS CHOICES**	**SUPPORT**
ADLs	Declined goal	Family support – requested services to supplement while family is out of home
IADLs	Declined goal	Family support – requested services to supplement while family is out of home
Stairlift/EAA	Requested goal	Will set up EAA, in-network providers
Bladder and bowel incontinence	Requested goal	Will set up incontinence supplies through EW

CMS TRAINING VIDEO

CMS TRANSITIONAL HRA AND TRANSFER FNU EXPECTATIONS

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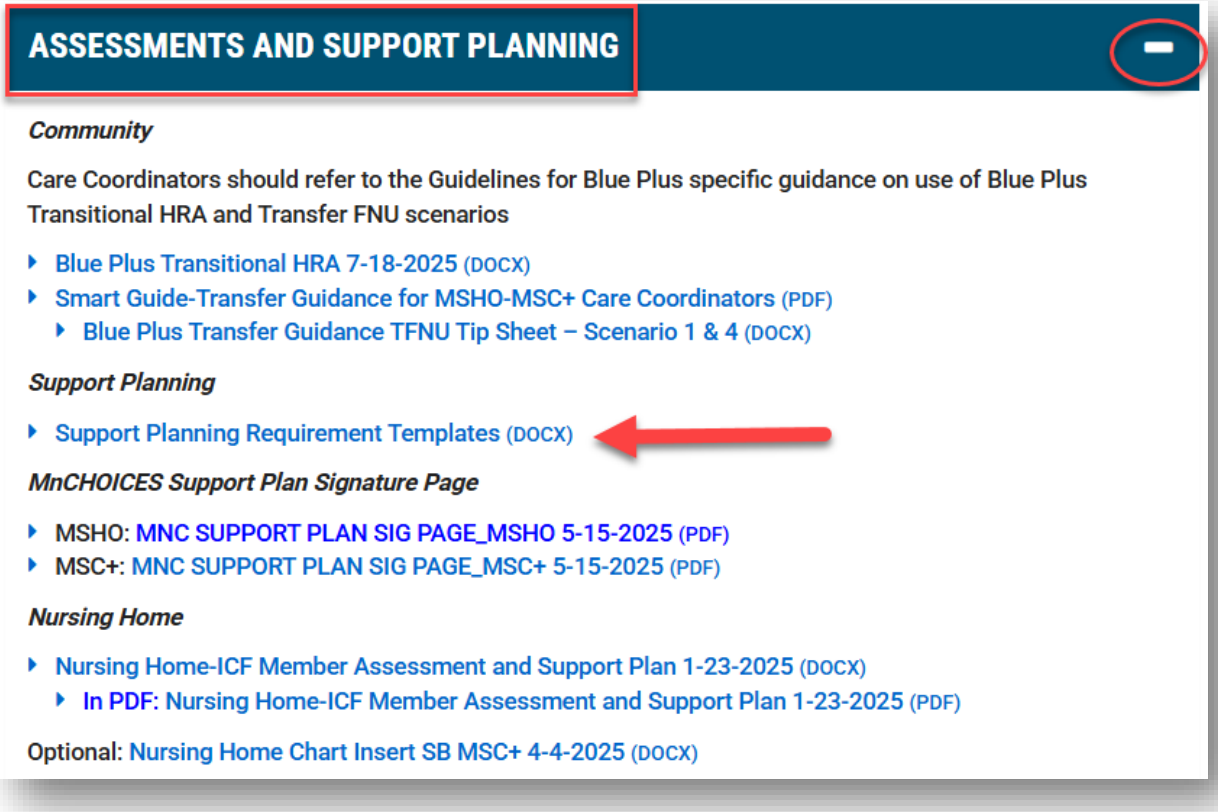
Transitional HRA	Transfer FNU
Review the assessment for diagnoses, health conditions and assessed needs.	Review the assessment and note any diagnoses/health conditions/assessed needs.
Ensure the support plan addresses each item using CMS requirements—including appropriate goals, services, and supports.	Follow the Smart guide: Transfer Guidance for MSHO/MSC+ Care Coordinators. • If a support plan exists, when completing the revision for TFNU, if the plan does not comply with CMS guidance, you will need to update accordingly. This is now a BCBS support plan. • If no support plan exists, when creating, the Care Coordinator is required to ensure the support plan complies with CMS guidance.
If the support plan does not comply with CMS guidance, you will need to revise the plan. This is now a BCBS support plan.	

BCBS RESOURCES FOR CMS REQUIREMENTS

- Care Coordination – Care Coordination
- Support Planning Requirement Templates



UNABLE TO REACH AND REFUSALS

CURRENT STATE OF HRA'S

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To be a 5 Star Plan, we must be >= 89% but we are currently at 80.33%!

Cut Points:	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
	< 46 %	>= 46 % to < 62 %	>= 62 % to < 76 %	>= 76 % to < 89 %	>= 89 %

Most recent Initial HRA results:

March 2025
70.09%

April 2025
71.19%

June 2025
84.11%

July 2025
83.91%

Aug 2025
82.24

REFUSAL AND UTR STARS IMPACT

Our goal is to return to a 5 Star Plan, but we need your help!

Our volume of UTR's and Refusals impacts our Star rating—the more UTR and Refusals we have, the lower our Stars Rating.

- The lower our Stars Rating, the fewer MSHO Supplemental Benefits we can offer.
- In addition to improving our Stars Rating, your ability to reach our members also decreases hospitalizations, ER visits, and improves health outcomes for our members.
- See new "Job Aid UTR-Refusal Tips" resource on the website.

HOW TO IMPACT REFUSALS AND UTRS

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When attempting to impact the number of Refusals and UTRs, keep in mind:

- How soon you reach out—scheduling early enough to allow member to agree or enough time to reach members
- Inform members you are calling from BCBS

When attempting to impact number of Refusals:

- Attempt to discuss MSHO Supplemental Benefits
- Ask open-ended questions, and address any barriers to agreeing to an assessment

When attempting to impact number of UTRs:

- Attempt to reach out via letter rather than all phone calls
- Attempt to validate member contact information via other sources (although this no longer counts as a contact—per CMS)

UNABLE TO REACH—CMS UPDATE

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Updated CMS requirements:

- Make a total of **four** outreach attempts (4th attempt is a support plan letter)
  - The first 3 attempts *must be made on different dates at different times* and documented in case notes.
  - 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, email, or letter to offer an assessment.

This is to ensure that reasonable and diligent efforts have been made to attempt to reach members per CMS.

We are working on updating Bridgeview to include this information.

UNABLE TO REACH—MIDYEAR

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Reminder that UTR attempts have been reduced from 4 to 2 attempts at **Mid-year only** (1x by phone or mail, and 2nd attempt by UTR Support Plan Letter)

PCP support plan letter is not required at mid-year for UTR or Refusal. They continue to be required at initial and annual reassessment.

If the member is unable to be reached at mid-year, the CC must mail the UTR Member Support Plan Letter.

Do not enter mid-year attempts into Bridgeview or MnCHOICES.

CFSS | UPDATES

CFSS | UPDATES

- DHS has approved an extended transition period for people using PCA that allows additional time to transition to CFSS

- Members must transition to CFSS by September 30, 2026

CFSS | RENEWALS—SERVICE DELIVERY PLANS

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Consultation service providers are encouraged to begin working on a draft renewal service delivery plan while they are waiting for the assessment results

Once the assessment is completed, the consultation service provider must finalize the plan and send it to the member for signatures

Once completed and signed, the consultation service provider will upload it into MnCHOICES for approval from the Care Coordinator

The CFSS start date for the new authorization is the date following the end of the current authorization, once the plan is approved

CFSS | CONFLICTS OF INTEREST

Service providers may provide multiple service types; however, they cannot provide multiple services to the same person.

- Consultation Services
- Financial Management Services (FMS)
- CFSS Provider Agency
- Contracted Case Management/Mental Health Case Management

CFSS | BILLABLE TASKS

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Examples of billable tasks include:

- Service delivery plan development
- All communication with the person (phone, text, virtual, email, in-person)
- Administrative tasks (requesting SA's, obtaining signatures, scheduling meetings, reviewing forms, enrollment processes, checking eligibility, data entry, providing technical support to the person, etc.)
- Continuing education
- Renewal plan development
- Quality assurance

MODEL OF CARE

2025 MODEL OF CARE

- The Model of Care (MOC) is required by The Centers for Medicare and Medicaid Services (CMS) for any health plan and must be approved by the National Committee for Quality Assurance (NCQA)

- It is a comprehensive document that outlines how Special Needs Plans (SNP) will address the unique needs of members and how we will address the needs

2025 MODEL OF CARE

BlueCross BlueShield Minnesota

Goals of the MOC:

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

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

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

2025 MODEL OF CARE

BlueCross BlueShield Minnesota

SecureBlue MOC:

- Provides the framework for how Blue Cross identifies and addresses the unique needs of members
- Promotes process around:
  - Quality
  - Care Management
  - Care Coordination
- Incorporates MN DHS elements related to Long-Term Care Services and Support requirements

2025 MODEL OF CARE

BlueCross BlueShield Minnesota

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

Frail and vulnerable:

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

High need for social supports:

40% are eligible for Home and Community Based Services

Poor socioeconomic status:

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

Low health literacy:

23% did not complete high school

Complex medical needs and chronic condition management

Cognitive and sensory impairments

2025 MODEL OF CARE

BlueCross BlueShield Minnesota

As the Care Coordinator, you support members by:

- Conducting Health Risk Assessments
- Closing GAPS in Care
- Supporting members' goals and needs
- Communicating with the ICT
- Individual Support Planning
- Improving Quality of Life
- Facilitating Transitions of Care

2025 MODEL OF CARE

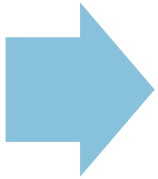
CMS requires all staff working with our MSHO members complete SNP-MOC training upon hire and once per calendar year thereafter:

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

2026 MSHO SUPPLEMENTAL BENEFITS

MSHO SUPPLEMENTAL HISTORY

Medicare Advantage (MA) plans may choose to offer some benefits (item/service that meets CMS criteria) to enrollees in addition to the covered required Medicare Part A and Part B (and Part D, as applicable) benefits.



These benefits are called Supplemental Benefits. MSHO plans in Minnesota are a type of Medicare Advantage plan for dually eligible beneficiaries (people with both Medicare and Medicaid). MSHO Supplemental benefits are provided through rebates received from CMS (based on STAR ratings).

WHAT'S RETURNING IN 2026

Health and Well Being Benefits

- Friendly Helper
- Health & Wellness Classes
- Household Supports**
- Healthy Foods **
- Music Therapy**
- OTC benefit**

***Refer to "What's Changing in 2026"*

Caregiver Supports

- Caregiver Empowerment Program**

Health Services (Medical/Dental/Vision)

- Additional Podiatry Services
- Eyeglass Upgrades

Fitness

- SilverSneakers Fitness Benefit

WHAT'S RETURNING IN 2026

Post-Discharge Services

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

Equipment/Supplies/Safety Items

- $750 Safety Item Benefit
- Medication Dispenser & Reminders (Dose Health)
- Personal Emergency Response System (PERS)

Comfort Item (Baby doll/Animatronic pets)**

Transportation (BlueRide)

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

DISCONTINUED IN 2026

The following items/services will no longer be covered in 2026:

- Blood pressure monitoring system (QMedic)
- Medically tailored meals and food with nutrition education (NourishedRx)
- Caregiver emergency care plan (Lutheran Social Services)
- Additional dental services
- Electric toothbrush/replacement heads (Corner Home Medical)

WHAT'S CHANGING IN 2026

Benefit	2025	2026
Caregiver Empowerment Program (Ceresti)	Caregiver coaching, education and support program is covered for caregivers of members with dementia, cognitive impairment, Parkinson's Disease or stroke. Caregiver program is limited to 6 months per year.	Caregiver coaching, education and support program is covered for caregivers of members with **dementia or cognitive impairment**. Caregiver program is **not** time-limited.
Comfort Item	One animatronic dog, cat or bird is covered for members with cognitive impairment, dementia, or risk of social isolation.	Members with **Alzheimer's disease, cognitive impairment, dementia, depression, intellectual and developmental disabilities, traumatic brain injuries or social isolation** are eligible to receive one comfort item per year. Comfort item options include one **baby doll or one animatronic dog, cat or bird per year.**

WHAT'S CHANGING IN 2026

Benefit	2025	2026
Music Therapy	Members who have dementia, Alzheimer's disease, high risk of isolation, depression, and other mental health-related needs and who live in a nursing home, assisted living facility or foster care are eligible to receive music therapy.	Members with **Alzheimer's disease, cognitive impairment, dementia, depression, intellectual and developmental disabilities, traumatic brain injuries or social isolation** and who live in a nursing home, assisted living facility or foster care are eligible to receive music therapy.
Over-the-Counter	Members receive $150 per quarter allowance for select OTC items. Members must purchase OTC items through a CVS catalog.	Members receive **$75 per quarter allowance for select OTC items**. Members receive a preloaded **Mastercard debit card called myFlexCard to purchase approved OTC items at participating retailers, online or through a catalog.**

WHAT'S CHANGING IN 2026

Benefit	2025	2026
Healthy Foods	Up to 12 weeks of prepared meals, meal kits and grocery boxes with nutrition education for eligible members is covered through NourishedRx. Eligibility for chronic condition meals, food and nutrition education includes members who live in a community setting and have one of the following diagnoses: - COPD - Diabetes - Hypertension	Eligible members who live in the community and have **asthma, cancer, chronic liver disease, chronic renal disease, congestive heart failure, COPD/emphysema, coronary artery disease, diabetes mellitus, peripheral vascular disease, or schizophrenia** receive **$275 per quarter combined allowance** for utilities and rent and plan-approved healthy foods. Members purchase healthy food items at participating retailers using their **myFlexCard**.

WHAT'S CHANGING IN 2026

BlueCross BlueShield Minnesota

Benefit	2025	2026
Household Supports	Eligible members have an allowance of $260 per quarter for rent and approved utilities. Eligibility for the allowance for rent and utilities includes members who live in a community setting and have one of the following diagnoses: - COPD - Diabetes - Hypertension	Eligible members who live in the community and have **asthma, cancer, chronic liver disease, chronic renal disease, congestive heart failure, COPD/emphysema, coronary artery disease, diabetes mellitus, peripheral vascular disease, or schizophrenia** receive **$275 per quarter combined allowance** for utilities and rent and plan-approved healthy foods. Members use their myFlexCard.

CMS PROGRAM INCENTIVE CHANGES

Effective 1/1/2026:

- Copays resume for Part D prescriptions.
- The $50 gift card incentive for completion of a Comprehensive Medication Review (CMR) is no longer available.
  - MSHO members can still get a complete medication review through our Medication Therapy Management (MTM) program. The MSHO MTM referral form is located on the CC Website under the Resources page under the Pharmacy tab.

Image credit: clipartmax.com

* MSHO members open to EW and institutionalized will not have copays for Part D covered medications.

MTM PROGRAM

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

EW PROGRAM SUSTAINABILITY

BlueCross BlueShield Minnesota

APPROPRIATE USE OF EW SERVICES

RIGHT SERVICE, RIGHT NEED

PRINCIPLES OF APPROPRIATE USE & OVERSIGHT OF EW SERVICES

BlueCross BlueShield Minnesota

The Elderly Waiver program is designed with person-centered care in mind and fiscal responsibility:

Needs-Based Services:

- Services must be aligned with members care plan and assessment.
- Are they necessary for the members health, safety and preferences?

EW Budget Limits:

- Services must fit within the member's budget.
- Are costs reasonable and customary?

Avoiding Duplication:

- EW does not cover services already available through other funding sources like Medicare or standard MA benefits.
- Are services duplicated elsewhere?

Community Living Focus:

- Services should promote independence and prevent institutionalization.

SERVICE CONSIDERATIONS

BlueCross BlueShield Minnesota

Examples

- Build Customized Living plans based on member needs - not based on preferred rate
- CDCS services must meet needs - not be designed to maximize budget
- ICLS use - must only support intermittent physical needs during tasks
- Are homemaking hours/tasks individualized for the member and unduplicated and reasonable?
- Are the services prioritizing the member's needs - not what is directed by the provider?
- Is there overlap when member attends adult day 5x/week & also receives CFSS 8-10 hours per day?

FALL TRAINING ATTENDANCE SHEETS

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

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

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

QUESTIONS?
THANK YOU.

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