HealthPartners

HealthPartners

Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+)

Elderly Waiver and Non-Elderly Waiver Services

Delegate Care Coordinator Requirements Guide

March 2026

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INTRODUCTION

Introduction

HealthPartners (HP) offers two health plans to Minnesota residents age 65 and older. The two plans are Minnesota Senior Health Options (MSHO), for resident eligible for Medical Assistance (MA) and Medicare, and Minnesota Senior Care Plus (MSC+), for resident eligible for Medical Assistance. With either plan, enrolled members may receive Elderly Waiver or Non-Elderly Waiver services approved by MN Department of Human Services (DHS). HealthPartners is considered a Managed Care Organization (MCO) since it offers these plans to members.

This guide is written specifically for Bluestone Physician Services, an HP delegate contracted to provide care coordination services for select MSHO and MSC+ members.

When using the guide, please understand the following:

- Days are considered calendar days unless the days are specified as business days.
- Member refers to the member or the member's authorized representative.
- The term "decline" and "refusal" are synonymous.
- Documentation sources include MnCHOICES, the delegate's electronic health records and Medicaid Management Information System (MMIS).

In addition to this guide, care coordination resources can be found on the HP Care Coordination web page at: MSHO/MSC+ Care Coordination

Abbreviations/Acronyms

BHH	Behavioral Health Home
CC	Care Coordinator
CDCS	Consumer Directed Community Supports
CFSS	Community First Services and Support
CS	Community Support
DHS	Minnesota Department of Human Services
DTR	Denial, Termination or Reduction of Services
EW	Elderly Waiver
FFS	Fee For Service
FNU	Functional Need Update
HP	HealthPartners
HRA	Health Risk Assessment
ICLS	Individualized Community Living Supports

ICT	Interdisciplinary Care Team
MA	Medical Assistance
MCO	Managed Care Organization
MHM	Moving Home Minnesota
MMIS	Medicaid Management Information System
MnCHOICES	MnCHOICES
MSC+	Minnesota Senior Care Plus
MSHO	Minnesota Senior Health Options
Non-EW	Non-Elderly Waiver
PCA	Personal Care Attendant
PERS	Personal Emergency Response System
PHI	Personal Health Information
TFNU	Transfer Functional Needs Update
THRA	Transitional Health Risk Assessment
TOC	Transition of Care
UM	Utilization Management

ENROLLMENT / ELIGIBILITY

Initial Assignment

Overview: Initial assignment is the first day the member is assigned to HealthPartners.

- HP receives its monthly enrollment roster from DHS each month and sends the monthly enrollment roster to the delegate.
- Members are enrolled on the first of every month.
- CC has 10 business days to notify the member of the CC's assignment from the initial assignment, the date of enrollment.

CC Responsibilities: The CC is required to:

- Provide the member with the name and phone number of the CC within 10 business days of initial assignment, the date of the member's enrollment.
- Mail the MSC+ or MSHO CC Introduction letter to the member, postmarked within 10 business days of initial assignment.
- Save documentation in the member's record.
- Contact the member within 30 days of enrollment, if the member is newly enrolled, to complete an initial assessment or complete the tasks required for an unable to reach or refusal member. (See Initial Assessment, Unable To Reach and Refusals sections in this guide.)

Gap in Enrollment

Overview: A gap in enrollment occurs when the members Medical Assistance eligibility is discontinued (lost) for more than 90 days.

- Members that experience a gap in coverage (lose of MA eligibility beyond the 90-day grace period) are considered new members upon re-enrollment.

CC Responsibilities: The CC is required to:

- Assist members in renewing the MA eligibility in a timely manner to avoid loss of eligibility. (See Medical Assistance Eligibility Renewal section within this guide.)
- Complete an initial assessment within 30 days of re-enrollment if there is no previous assessment within the last 365 days. (See Initial Assessment section in this guide.)
- Complete a THRA/FNU within 30 days of re-enrollment if there is a previous assessment within the last 355 days. (See THRA and FNU sections in this guide.)
- Complete the Unable to Reach or Refusal requirements within 30 days of re-enrollment if the member is unable to reach or refusal. (See Unable to Reach or Refusals sections in this guide.)

Medical Assistance Eligibility Renewal

Overview: Members need to renew their MA eligibility in a timely manner to avoid loss of eligibility.

CC Responsibilities: The CC is required to:

- Remind the member that the renew process needs to be completed and provide support as needed.
- Track the status of the renewal and, if eligibility is lost, assist in the reinstatement of MA and complete any required documentation needed for the renewal.
- Continue to provide all care coordination services to MSHO member during the initial 90-day grace period following loss of eligibility.
- Complete an assessment if the MSC+ B member is due for reassessment within 90 days of MA term.
- Document the effort to renew the eligibility in the member's record.

Product Change

Overview: A product change occurs when an existing member moves from MSC+ to MSHO or from MSHO to MSC+.

- At the time of the product change, a THRA/FNU occurs.

- For a member who was previously unable to be reached or refusal, and continues to be unable to reach or refusal, the next annual assessment is due within 365 days of the product change date.

CC Responsibilities: The CC is required to:

- Complete the THRA/FNU within 30 days of the product change if the member is reached. Use the Health Risk Assessment-MCO form or FNU in MnCHOICES.
- Complete the Unable to Reach or Refusal requirements within 30 days if the member is unable to reach or refusal. (See Unable to Reach or Refusals sections in this guide.)

ASSESSMENT - INITIAL

Initial Assessment

Overview: A member is considered new when newly enrolled with HP and has not had a MSHO/MSC+ assessment within the last 365 days.

- Members are enrolled on the first of every month. Initial enrollment is the date the member was enrolled in the HP plan.
- The initial assessment needs to be face-to-face.
- A member aging into MSHO/MSC+ is considered a new member and needs an assessment unless the assessment reflects determination for opening to Elderly Waiver. Opening to Elderly Waiver due to the member's 65th birthday requires a full MnCHOICES Assessment.
- Members with previous coverage that experience a gap in coverage (lose of Medical Assistance eligibility beyond the 90-day grace period) are considered new members upon re-enrollment. If the member had an assessment with the last 365 days, a THRA/FNU is acceptable. (See Gap in Enrollment, FNU and Transitional HRA sections in this guide.)
- If the member is an FFS transfer and has an existing CFSS/PCA assessment (DHS 6893A) and did not have a MnCHOICES assessment, a new assessment is required and the current CFSS/PCA authorization will remain in effect and will not change the reassessment due date for the authorization.

CC Responsibilities: The CC is required to:

- Provide the member with the CC's name and phone number within 10 business days of the member's enrollment by sending a letter. CC may complete a phone call, but the letter must be sent. (See the letter template MSC+ or MSHO Care Coordinator Introduction on HP CC Webpage.)

- Complete the MnCHOICES assessment within 30 calendar days of initial enrollment. Ensure all MnCHOICES assessment questions and sections are completed or noted as not applicable.
- Complete the CFSS (formerly PCA) if requested. (See CFSS section in this guide.)
- Complete Unable to Reach or Refusal requirements if member unable to be reached or refuses/declines assessment. (See Unable to Reach or Refusal sections in this guide.)
- Completing documentation in the members' record and in MnCHOICES.

Member Requested Assessment

Overview: A member or their authorized representative may request an assessment at any time to determine EW eligibility.
CC Responsibilities: The CC is required to:

- Complete the requested assessment to determine EW eligibility within 20 business days of the request. (See Reassessment section in this guide.)

Transitional Assessment - Member Transfer To HealthPartners

Overview: Members can be transferred to or from an FFS or MCO. Transfers include members who are transferring from FFS, a different MCO or have a gap in coverage (over 90 days between enrollment and re-enrollment). For a transfer to HP, the transfer process is based on the status of the member's previous assessment.

- Member receives a THRA if the member had a previous assessment within the previous 365 days and documentation includes the MnCHOICES assessment, support plan, and signature page.
- To complete a THRA/FNU, the CC reviews with the member the previous assessment and support plan and updates are made as appropriate. THRA/FNU may be face-to-face or verbal (telephonic, video call).
- Members receive an initial assessment, and are considered a new member, if the member was previously UTR or Refusal.
- Members receive a Transfer FNU in lieu of a THRA, if the member is EW and has completed a MnCHOICES assessment in the last 365 day. The Transfer FNU does not replace a reassessment and does not reset or extend the waiver eligibility span. Members may request an assessment to reset the waiver eligibility span.
- Members receive a new MnCHOICES assessment if the member is a transfer from FFS and has an existing CFSS/PCA assessment without a MnCHOICES assessment. The CFSS/PCA authorization remains in effect and is not reset

when there is no change or a decrease in services. The CFSS/PCA authorization is reset if there is an increase in services.

- The first full assessment after a transfer from an FFS or MCO is considered the initial assessment for documentation purposes and reassessment requirements.

CC Responsibilities: The CC is required to:

- Provide the member with name and phone number of the new CC within 10 business days of the transfer and follow the responsibilities stated in Initial Assignment. (See Initial Assignment section in this guide.)
- Review the transfer documentation and obtain any missing information from the member, if necessary.
- Complete a THRA/FNU within 30 days of enrollment . (See the form titled Transitional Health Risk Assessment Form on the HP CC Webpage or use MnCHOICES FNU assessment in MnCHOICES and see FNU section in this guide.)
- Obtain the member signature sheet if the member signature sheet was not received previously. If not received, the CC should make at least one attempt to obtain the members signature. (See Support Plan Signature Sheet section in this guide.)
- Complete the outreach process to initiate a transitional assessment if the transfer documentation includes an assessment within the last 365 days of continuous enrollment, Support Plan and signed Signature Page. Complete a THRA/FNU with the member within 30 days of enrollment.
- Complete the outreach process to document the unable to be reached or declining members if the member is unable to be reached or refuses an assessment within 30 days of the assessment. (See UTR or Refusal sections in this guide.)
- Complete an UTR/Refusal Support Plan and save in the member's record. Send the UTR/Refusal Support plan to the member. (See Unable to Reach or Refusal sections in this guide.)
- Complete an initial assessment and consider whether the member to be a new member if the member was previously UTR or Refusal and is now reachable within 30 days of enrollment. (See Initial Assessment in this guide.)
- Complete a Transfer FNU if the member is EW and has a previous MnCHOICES assessment within 30 days of enrollment. (See Functional Needs Update in this guide.)
- Enter the change of CC information in MMIS if the member is EW.
- Complete documentation in the member's record and MnCHOICES.

Transitional Assessment - Member Transfer From HealthPartners

Overview: Members can be transferred to or from an FFS or an MCO. For a transfer from HP:

- The member is confirmed to be enrolled with another MCO or confirmed the member Medical Assistance but without an assigned MCO.
- The transfer from HP includes members with an assessment as well as members unable to be reached or decline occurrences.

CC Responsibilities: The CC is required to:

- Complete the Transfer Form (DHS 6037) and send securely to the new (receiving) CC plus send documents not available in MnCHOICES. If the sending CC completed an assessment and is notified of a member transfer, the sending CC must complete all documentation prior to transfer including the support plan and EW documentation.
- Ensure MnCHOICES forms are left in complete status within MnCHOICES and ensure all attachment available in MnCHOICES.
- Collaborate with the member and receiving CC to ensure a smooth transfer process.
- Discontinue providing care coordination once enrollment transfer has been confirmed via MN-ITS or by HP.

ASSESSMENT - REASSESSMENT

Reassessment

Overview: Reassessments need to be completed. Specifics include:

- A reassessment needs to be completed within 365 days of the previous assessment if there is a previous assessment.
- A reassessment needs to be completed within 365 days of the members enrollment date if the member is a new member and was unable to be reached or a refusal at the time of initial assessment. Subsequent reassessments are due within 365 days of the enrollment date and each 365 days thereafter.
- Reassessments need to be face-to-face.

CC Responsibilities: The CC is required to:

- Complete a reassessment within 365 days of an assessment if there is a previous assessment.
- Complete a reassessment within 365 days of the member's enrollment date if the member was unable to be reached or a refusal at the time of initial assessment.

- Complete the CFSS at the same time as the reassessment if the member requests PCA/CFSS services. (See CFSS section in this guide.)
- Send a copy of the MnCHOICES assessment summary and support plan to the member within 30 days of the assessment.
- Conduct Safe Disposal of Medication conversation with the member at the time of the reassessment. (See Safe Disposal of Medication section in this guide.)
- Complete OBRA Level I screening at time of reassessment for member on waiver. (See OBRA section in this guide.)
- Submit the screening document into MMIS prior to the first capitation date.
- Complete Unable to Reach or Refusal requirements if member unable to be reached or refuses/declines assessment. (See Unable to Reach or Refusal sections in this guide.)

ASSESSMENT – ADDITIONAL / OTHER

Community First Services and Supports (CFSS)

Overview: CFSS provides members with flexible options to meet a members' unique needs to allow for greater independence.

- CFSS replaced PCA effective Oct 1, 2024. PCA is phased out as member transition to CFSS.
- Members with PCA transition to CFSS through a required CRSS Service Delivery Plan (DHS-6893P).
- Members who do not have PCA must meet with a CS Provider and have an approved CFSS Service Delivery Plan for CFSS service to begin.

CC Responsibilities: The CC is required to:

- Respond to member request for CFSS services, often identified during an assessment.
- Complete an in-person assessment for CFSS, the MnCHOICES Comprehensive Assessment, to determine the CFSS units for which member is eligible.
- Educate the member about CFSS and provide the member with CFSS information including the assessment summary and list of service providers within 10 days of the assessment.
- Include CFSS service in the MnCHOICES support plan. Ensure dates align with member's waiver span/1year span. Include the CS Provider in the support plan or document CS Provider is pending.
- Review and approve the service plan and include the service plan in MnCHOICES.

- Send the final copy of approved service plan to the member within 10 days of the assessment completion date.
- If the member chooses the CFFS agency model, submit the HP CFSS UM Communication form to medicalpolicy@healthpartners.com along with the assessment summary, supplemental summary, support plan and DHS 6893W form. (See the HP CFSS UM Communication form on the HP CC webpage.)
- If the member chooses the budget model, submit the HP Service Authorization form by email stated on the form.(See the HP Service Authorization form on the HP CC webpage.)
- Obtain HP authorization, by submitting the HP Service Authorization form by email stated on the form, for all goods and services, PERS and/or consultation service providers. (See the HP Service Authorization form on the HP CC webpage.)

CFSS Services Requiring Temporary Start

Overview: Member who are new to CFSS may need urgent support and a temporary start to services can be obtained.

- The temporary start to services can only occur using the Agency Model. The member may choose the Budget Model for their ongoing services once the Service Delivery Plan is completed.
- The CC can request a temporary start of services prior to completing the MnCHOICES assessment.
- Services cannot start before the HP UM team has processed the authorization.

CC Responsibilities: The CC is required to:

- Conduct a telephone assessment and complete the DHS-6893A CFSS. Assess to determine the member's ADL/IADL needs.
- Upload the DHS-6893A CFSS Assessment Form in MnCHOICES.
- Submit, within 10 days of the CFSS assessment (DHS 6893A) and the HP CFSS UM Communication form to medicalpolicy@healthpartners.com. (See the HP CFSS UM Communication form on the HP CC webpage.)
- Collaborate with the member to complete a CFSS assessment, meet with Consultation Service Provider, and approve the Service Delivery Plan before the end of the 45 days.

CFSS Services Requiring Temporary Increase

Overview: Members may request a temporary increase in CFSS services in the CFSS Agency Model Services.

- A member may request a temporary 45-day increase in CFSS services related to a change in condition. Examples of a change in condition include new ADL dependencies, change in complex care needs, and meaningful change in behaviors.

CC Responsibilities: The CC is required to:

- Conduct a telephone assessment and complete the DHS-6893M form. Assess to determine the needed change in the member's unit of services.
- Upload the DHS-6893M CFSS Assessment Form in MnCHOICES.
- Submit, within 10 days of the CFSS assessment (DHS 6893M) and the HP CFSS UM Communication form to medicalpolicy@healthpartners.com. (See the HP CFSS UM Communication form on the HP CC webpage.)
- Collaborate with the member to complete a CFSS assessment and approve the Service Delivery Plan before the end of the 45 days.

Caregiver Questionnaire

Overview: A caregiver is a non-paid person that assists the member in the member's care. If a caregiver is identified:

- A caregiver questionnaire should be completed at the time of the member's assessment or shortly thereafter unless the caregiver declines the caregiver assessment.
- Caregiver needs, if identified, are included in the member's support plan.

CC Responsibilities: The CC is required to:

- Complete a caregiver questionnaire if a caregiver is identified during the member assessment and the caregiver agrees to a caregiver assessment. (See the DHS 691H Caregiver Questionnaire on the HP CC webpage.)
- Document the caregivers refusal to a caregiver assessment, if applicable.
- Include the caregivers needs in the support plan.

Functional Needs Update (Primary and Secondary Use)

Overview (Primary Use): The FNU is a remote assessment used by lead agencies to document a change to a member's assessed need(s) anytime during the service agreement year for members on Elderly Waiver. The certified assessor is typically the member's care coordinator.

- The certified assessor conducts the FNU. DHS recommends the certified assessor who completed the assessment for the service plan also completes the functional needs update whenever possible.
- The certified assessor uses professional judgment to determine when an in-person reassessment is needed. The FNU does not replace an annual

reassessment and does not reset or extend a program eligibility span or service agreement span. A person may choose to receive a reassessment instead of an FNU.

- A Functional Needs Update cannot be used to change CFSS-related assessed needs (e.g., ADL dependencies or CFSS units). If the member has a change in condition, a new full MnCHOICES assessment is required.

CC Responsibilities (Primary Use): The CC is required to:

- Contact the member, after receiving the request for an assessment, to determine the type of assessment needed and function as the certified assessor to determine if an FNU is appropriate. If appropriate, the assessor will:
- Conduct a remote interview with the member.
- Complete an FNU in MnCHOICES and make any adjustments to the assessment based on the member's changes in need.
- Create the assessment summary and distribute it to the appropriate parties. (Refer to the CBSM – Support Planning for LTSS on the MN DHS website).
- Communicate changes in the support plan to relevant service providers.
- Enter an MMIS contact update with the name of the case manager if different from the certified assessor.
- Enter the functional needs update long-term care (LTC) screening document into MMIS.

Overview (Secondary Use): DHS has approved the FNU as a replacement for the THRA in certain circumstances.

- The FNU is used for new enrollees, internal program changes for Rate Cell B or Rate Cell A with CFSS, and mid-year changes.
- The FNU is used for members who already have a MnCHOICES Comprehensive Assessment, completed within the past 364 days (before the member's reassessment due date).
- For members receiving Community First Services and Supports (CFSS), ADL dependencies and CFSS units cannot be changed via an FNU. If the member has a change in condition, a new full assessment is needed.
- The FNU is completed in conjunction with the requirements for new enrollees or program changes. (See the Initial Assignment and/or Initial Assessment sections in this guide.)

CC Responsibilities (Secondary Use): The CC is required to:

- Complete the FNU within 30 days of enrollment or program change. Use the MnCHOICES FNU assessment in MnCHOICES.
- Follow CC requirements outlined in the Transitional Assessment-Member Transfer to HealthPartners section in this guide. (See Transitonal Assessment-Member Transfer to HP section in this guide.)
- Follow CC requirements outlined in the Initial Assignment and Initial Assessment sections in this guide. (See Initial Assignment and Initial Assessment sections in this guide.)

In Lieu of Services

Overview: In Lieu of Services may be implemented to meet the needs of a member with replacement service that would not normally be covered within the member's benefits.

- Common In Lieu of Services include homemaker assistance with personal care, homemaker cleaning, respite, and home delivered meals. Another common example of In Lieu of Services is a waivered DME item provided to a non-waivered member.
- If the member has needs that make the member eligible for the waiver, the member should be opened to the waiver.

CC Responsibilities: The CC is required to:

- Complete the HP process. (See the form titled HP Service Authorization Request Form on the HP CC Webpage.)
- Monitor the implementation of the services.
- Document the services in MnCHOICES.

My Move, Moving Home Minnesota

Overview: Moving Home Minnesota is a federal grant consisting of short-term transitional services.

- MHM occurs when a member request relocation from a nursing home facility to the community.
- The purpose of MHM is to eliminate or reduce barriers to receiving long-term care services in the home and community settings rather than institutional settings.

CC Responsibilities: The CC is required to:

- Respond to members request to move to a community setting and determine if member meets basic eligibility requirements for MHM. Complete the Comprehensive MnCHOICES Assessment.
- Continue to provide care coordination, even if the member is not eligible, using relocation, EW benefits, and other resources to assist the member to move into the community.
- Enroll the member, if eligible, by completing the DHS process including the appropriate forms including Intake form (DHS 5032), Transition Worksheet (DHS 6759G), Communication Form (DHS 6795H), Consent (DHS 6759I), and Transition Planning Tool (DHS 6759).
- Collaborate with the member to develop and implement the transition plan.
- Include the MHM services in the member's support plan

- Monitor the MHM services and submit a DTR when MHM service is ending. (See DTR section in this guide.)

OBRA Level 1 Screening

Overview: OBRA Level 1 Screenings are required for all members at the time of the MnCHOICES comprehensive assessment.
CC Responsibilities: The CC is required to:

- Complete an OBRA Level 1 screening for all members at the time of the MnCHOICES assessment.
- Include the OBRA Level 1 screening documentation in MnCHOICES.

Relocation Services Coordination

Overview: Members may request a transition from a nursing home setting to the community.

- The assessment must be completed within 20 days of the request and only delayed upon the member's request to delay.
- The assessment is valid for 60 days. If the member is still in the nursing facility after 60 days and still working towards community placement, If a member has access to a waiver in the past then a new face to face assessment needs to be completed. If member has not access waiver in the past, complete an Initial Assessment Review within 20days of being ready to discharge. If member reaches day 364/365, they will need a new in person assessment.
- A support plan must be created and approved within 30 days of the assessment and mailed to member.
- If the member has been in long-term care for 30 days or longer, a request for Long Term Care Payment form (DHS-3543) is not required.

CC Responsibilities: The CC is required to:

- Complete a face-to-face assessment within 20 days (or delayed upon member request).
- Complete and mail a support plan within 30 days of the assessment to the member .
- Document the results of the assessment and maintain the assessment in the members records, whether the member is appropriate to move or decides not to move.
- Initiate relocation planning after determining whether the member can live in a community setting.
- Investigate and facilitate the selection of the housing and/or assisted living options with the member and family. Assist with the housing application and agreement process.

- Facilitate the relocation in collaboration with member, family, nursing facility social worker, housing program and other as needed. Assist in identifying and obtaining appropriate furnishings. Determine if the member qualifies and needs a hospital bed.
- Address the financial details. Submit a Long-Term Care Payment form (DHS-3543) if the member has not resided in the nursing facility for more than 30 days.
- Access Moving Home Minnesota (MHM) and Metropolitan Center for Independent Living and use Independent Living services resources as appropriate. (See MHM section in this guide.)
- Submit the county communication form (DHS 5181) with appropriate supporting documentation.
- Document relocation activities in the member record.

UNABLE TO REACH OR REFUSAL

Unable to Reach

Overview: For a member due for their initial, mid-year support plan review, or reassessment, the member outreach needs to be completed.

- Outreach includes three telephone attempts on different days and different times plus the mailing of an UTR letter. (See the letter templates titled MSC+ Unable to Reach and MSHO Unable to Reach on the HP CC Webpage.)
- For initial assessment, outreach must be completed within 30 days of enrollment.
- For reassessments, outreach must be completed within 365 days of prior assessment. If there is no prior assessment, outreach needs to be completed within 365 days of the initial enrollment and every subsequent 365 days.
- For mid-year support plan reviews, outreach must also be completed within 5 to 7 months of the preceding assessment (or enrollment if no assessment).
- Documentation is required of all outreach.

CC Responsibilities: The CC is required to:

- Complete the outreach within required time periods for initial assessments, mid-year support plan reviews and reassessments. Send the UTR letter to the member if the member is unable to be reached. (See the letter templates titled MSC+ Unable to Reach and MSHO Unable to Reach on the HP CC Webpage.)
- Complete the Health Risk Assessment – MCO) form indicating assessment results as “Person not located for health risk assessment” in MnCHOICES.
- Close or terminate Elderly Waiver or waivered services.

- Complete UTR/Refusal support plan for MSHO members and send it to the member. (See the letter template titled MSHO UTR/Decline Support Plan to Member on the HP CC Webpage.)

Refusal

Overview: For a member due for their initial, mid-year support plan review, or reassessment, the member outreach needs to be completed.

- Outreach includes three telephone attempts on different days and different times plus the mailing of an UTR letter prior to the members refusal. (See the letter templates titled MSC+ Unable to Reach and MSHO Unable to Reach on the HP CC Webpage.)
- For initial assessment, outreach must be completed within 30 days of enrollment.
- For reassessments, outreach must be completed within 365 days of prior assessment. If there is no prior assessment, outreach needs to be completed within 365 days of the initial enrollment and every subsequent 365 days.
- For mid-year support plan reviews, outreach must also be completed within 5 to 7 months of the preceding assessment (or enrollment if no assessment).

CC Responsibilities: The CC is required to:

- Complete the outreach within required time periods for initial assessments, mid-year support plan reviews, and reassessments.
- Complete the Health Risk Assessment – MCO) form indicating assessment results as "Person declines health risk assessment" if the member declines the assessment in MnCHOICES.
- Close or terminate Elderly Waiver or waivered services.
- Complete UTR/Refusal support plan for MSHO members and send it to the member. (See the letter template titled MSHO UTR/Decline Support Plan to Member on the HP CC Webpage.)

SUPPORT PLAN

Support Plan

Overview: A support plan is a written summary of the identified supports and services a member needs and the describes the goals and next steps to address the member's needs.

- Support plans are created and sent, within 30 days of an assessment, to the member, primary provider, and EW providers as appropriate. Day 1 is the date of the assessment. (See Provider Support Plan (MSHO Only) for EW provider section in this guide.)
- Support plans should be updated at time of initial assessment and annually thereafter and updated throughout the year based on member request or member's change of condition.
- The support plan needs at least one "High Priority" goal.

CC Responsibilities: The CC is required to:

- Complete the support plan with the member within 30 days of an assessment.
- Complete a support plan without the member, for MSHO members only, when the member is unable to be reached or declines an assessment. Complete all sections of the support plan including members of the Interdisciplinary Care Team (ICT), goals, interventions, and previous goals.
- Develop person-entered goals based on members needs which are prioritized (high, medium, low) and written as SMART goals (Specific, Measurable, Attainable, Relevant and Time-bound).
- Develop goals for identified chronic conditions that are not well managed and document that no goals are needed for well managed chronic conditions.
- Review previous goals, if applicable, and indicate whether the goal was achieved, remain in progress or can be discontinued
- Send the support plan with the member, primary provider, and Elderly waiver Providers as applicable, within 30 calendar days of the assessments and document. (See the MSC+ or MSHO letter templates titled Support Plan to Member, Support plan to Member Other, Care Plan to MD or Care Team and/or MSHO UTR/Decline Support Plan to Member on the HP CC Webpage.)
- Document the completed support plan in MnCHOICES and ensure the support plan is in "Plan approved" status.

Support Plan Signature

Overview: The member signature on the Support Plan Signature Sheet shows that the CC discussed the support plan with the member, and the member agrees with the discussed support plan.

- Member signatures are required or the attempt to acquire is documented.

CC Responsibilities: The CC is required to:

- Obtain an e-signature on the Support Plan Signature Sheet from the member using the e-signature feature within MnCHOICES if able.
- Obtain a handwritten signature on the Support Plan Signature Sheet from the member by printing the signature sheet and mailing the signature sheet to the member with instructions to return the signed sheet in the return envelope. (See

the MSC+ or MSHO letter templates titled Support Plan to Member, Support plan to Member Other, and Care Plan to MD or Care Team on the HP CC Webpage.)
- Document all attempts and efforts to obtain the member signature.
- Document and save the signature sheet in MnCHOICES.

Six Month Support Plan Review

Overview: The member and care coordinator need to review the support plan six months from date of the last assessment to ensure contact occurs and updates occur to reflect the changing needs of the member.

- The six-month support plan review needs to occur between 5 to 7 months from the date of the last assessment.
- The date of the assessment is the date the assessment was completed.
- If there was no prior assessment but a support plan was created, the six-month review should occur between 5 to 7 months from the completion date of the last support plan.

CC Responsibilities: The CC is required to:

- Contact the member approximately six months from last assessment to discuss progress and changes. Contact may be by phone, video, or in-person. Contact should occur between 5 to 7 months from the last assessment date.
- Document all attempts to reach the member. (See Unable to Reach and Refusal sections in this guide.)
- Discuss the members progress to meet each goal stated in the support plan.
- Document the member's progress to meet each goal within MnCHOICES.
- Complete an update to EW Services and/or Providers if the services or providers have changes. (See Elderly Waiver sections in this guide.)
- Send any updated support plan to the member. (See Support Plan sections in this guide.)

Provider Signature (EW only)

Overview: Home and Community Based Service providers are required to provide a signature indicating receipt of the member's support plan and the member has a choice to send the full support plan, a portion of the support plan, or not to send the support plan to each of their service providers.

- Service provider signatures acknowledging receipt of the support plan, or the attempt to obtain the signature, are required. One signature per service provider is needed regardless of the number or types of services provided by that services provider.

- The first attempt is made within 30 calendar days of the date the support plan was completed. If the provider signature is not obtained during the first attempt, a second attempt must occur within 60 days of the date the support plan was completed.
- A service provider affected by this requirement are DHS Enrollment Required Services (formerly called Tier 1) and Approval Options; Direct Delivery Services (formerly called Tier 2) providers, and PCA providers only if the member is open to the waiver. These services CDCS, ICLS, and delivery of purchased items are not included in the EW provider signature requirement.

CC Responsibilities: The CC is required to:

- Offer the member the choice to send support plan to their service providers at the time of the member's assessment. Indicated the members choice/designation on the support plan for each service under each service.
- Make two attempts to obtain signatures from the providers. Use the letter templates and mail it to the provider with each attempt. (See the letter templates titled MSHO/MSC+ Provider Support Plan Cover Letter and MSHO/MSC+ Provider Support Plan Summary Letter on the HP CC Webpage.)
- Document all attempts to obtain the service provider signature. Include the letters as attachments in MnCHOICES.
- Save the provider signature, if obtained, in MnCHOICES.

TRANSITION OF CARE

Transition of Care

Overview: Members transition from one case setting to another based on changes in the member's health status.

- Transitions occur between care settings include the member's home, hospital, skilled nursing facility, or others, whether planned or unplanned.

CC Responsibilities: The CC is required to:

- Monitor the admission report sent from HP to Bluestone daily.
- Contact and assist the member with their planned or unplanned transition from one care setting to another.
- Share CC contact information and support plan/services with receiving setting within one business day of notification of transition.
- Notify the Primary provider, the PCP of the transition with one business day of notification of transition. Notification can occur by fax, phone, EMR or secure email.

- Complete the TOC documentation including reason for admission and relevant information about the transition in the TOC log. (See the form titled Transitional Health Risk Assessment on the HP CC Webpage.)
- Make attempts within one to three days of notification of transition to reach the member. Communicate with the member when the member is discharged to the usual care setting, including education about the discharge summary, transition process, follow-up appointments, medications, warning signs, and other information as needed.
- Conduct a function needs update if appropriate. (a FNU is not applicable for EW members who use PCA/CFSS services.)
- Update the Support Plan if the TOC results in a change in the member's services, goals and/or needs and distribute to the member, PCP, and/or service providers. (See Support Plan, Support Plan Signature, Provider Signature sections in this guide. See the letter templates titled MSC+ Member Services Support Plan Change on the HP CC Webpage.)

Admission Over 30 Days

Overview: Communication and adjustment in services is needed for members who are admitted to a nursing facility for 30 days or more.
CC Responsibilities: The CC is required to:

- Complete and send the DHS 5181 Communication Form to the county financial worker and indicate the date the member was admitted to the nursing facility.
- Temporarily exit the member from the waiver using the date of the hospital admission if the member is on Elderly Waiver and the plans to return to the home setting.
- Complete the DTR for each waivers services the member is receiving.
- Complete additional action/communication for members that return to their home setting and/or remain in an institutional setting.

ADDITIONAL REQUIREMENTS

Authorization to Disclose Personal Health Information

Overview: The member must authorize the release of the PHI for HealthPartners and its delegates, to share PHI.

- PHI includes member demographics, health information including diagnosis and support plan, claims, and health insurance coverage.

- The authorization is valid for one year from the date the member signed the authorization.

CC Responsibilities: The CC is required to:

- Complete the release of authorization form with the member. (See the forms titled HP Authorization to Disclose PHI MSC+ and HP Authorization to Disclose PHI MSHO on the HP CC web page.)
- Save the documentation in the member's record.

Behavioral Health Home

Overview: Minnesota provides BHH benefits to eligible MA enrollee for the coordination of care. BHH is a model of care which integrates primary care, mental health services, social services, and support for members with mental illness diagnose.

CC Responsibilities: The CC is required to:

- Contact the BHH provider within 30 days of notification that the member is receiving BHH. Provide the CC's contact information, share related information regarding the member's support plan and establish contact frequency and method of communication.
- Include BHH service on the members support plan and as a provider as the ICT.
- Notify BHSs provider of know emergency visit, hospitalizations and/or transition of care and share the post discharge plan.
- Document all contact in member's record.

Benefit Exception

Overview: The CC may request an item or service be provided to the member that is outside the member's regular benefit set or case mix budget.

CC Responsibilities: The CC is required to:

- Consider all other appropriate benefits include the members MSHO supplemental benefits, informal and/or quasi form support before requesting an exception.
- Ensure the need for the item or services outside of regulator benefits is based on assessed need and related a goal or goals, included in the support plan and documentation demonstrates the necessity of the item or service.
- Complete the exception of Benefit form and submit it to HP. (See the forms titled HP Benefit Exception Inquiry Form and Instructions on the HP CC webpage.)
- Document the request and approval/denial in the member's records.

Care Coordinator Change

Overview: Members are to be notified of a change in care coordinator within 10 business days of the change in assignment.
CC Responsibilities: The CC is required to:

- Contact the member to notify the member of the change. The contact can be by phone in addition to a letter. A letter must be sent to the member. The letter must include the new care coordinator name and telephone number. (See the letter templates titled MSC+ Care Coordinator Change and MSHO Care Coordinator Change on the HP CC Webpage.)
- Complete the transfer staff assignment documentation in MnCHOICES and enter change of CC in MMIS.
- Save the letter in member's record.

Denial Termination Reduction

Overview: Members have a right to be notified when a service is being denied, terminated, or reduced and be given their appeal rights.

- A change in the services a member receives requires appropriate actions to ensure the change is managed appropriately according to applicable regulations, requirements and administrative steps including the limited 14 calendar time frame to complete the entire process.
- The limited 14 calendar time frame is based on the date requested. The definition of this date includes three options which are Date of Assessment, Date when all pertinent assessment information is gathered, or Date member ask between assessment periods for EW service and care coordinator have the information to determine if the service is appropriate.

CC Responsibilities: The CC is required to:

- Complete and submit to HP within 5 calendar days of the date requested the appropriate DTR form for the specific change in services for each service. Follow the HP process and use the form. (See the forms titled HP Denial Termination/Reduction (DTR) Form and HP Denial Termination/Reduction Instructions on the HP CC web page.)

Interpretive Services

Overview: HP provides contracted interpreter services for in-person visits, the Language Line for telephonic communication and the TTY line for members who are deaf or hard of hearing.
CC Responsibilities: The CC is required to:

- Identify when the member needs interpretive services and coordinate those services.
- Use HP approved services/resources. (See Language and Interpreter Services resource on the HP CC web page.)

Member Complaints, Grievances and Appeals

Overview: Member complaints, grievances and appeals need to be addressed in an appropriate and timely manner.

- 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.
- Grievances are verbal or written expressions of dissatisfaction about any matter, including but not limited to, the quality of care or services provided or failure to respect the member's rights.

CC Responsibilities: The CC is required to:

- Respond immediately to a member complaint, grievance or appeal and direct the member appropriately. (See the document titled Letter Attachment – Appeal Rights MSHO and MSC+ on the HP CC webpage.)
- Reach out to your Bluestone leader and have the Bluestone leader contact the HP MSHO liaison. If the issue is related to a DTR, then follow the process outlined in the Appeal Rights letter attachment. (See the Letter Attachment - Appeal Rights MSHO and MSC+ with the Delegate Oversite section on the HP CC webpage.)
- Assist the member in initiating the contact, either verbal or written.
- Share the information as outlined in the Appeal Rights letter attachment. (See the document titled Letter Attachment – Appeal Rights MSHO and MSC+ on the HP CC webpage.)
- Document the concern and action taken in the member's record.

Restricted Recipient (for MSC+ only)

Overview: The Restricted Recipient Program (RRP) program goals are to improve patient safety, coordination of care and member management of chronic pain issues. Care coordination services ensure continuity of care.

- The member's provider network is restricted to one pharmacy, hospital, primary clinic, and urgent care location.
- Each member enrolled in RRP is assigned to a case manager who is a nurse or behavioral health specialist at HP. The member is given the HP Case manager's first name only and phone number.
- The RRP Case manager is considered part of the interdisciplinary care teams.

CC Responsibilities: The CC is required to:

- Understand the provider restrictions in place for a member in the RRP program. Provider restrictions are in MN-ITS for members in the program.
- Locate a member's HP RRP Case Manager by calling 952-883-6983 or 800-255-1886.
- Record the RRP case manager as part of the interdisciplinary care team in the member's record.
- Communicate with the HP RRP Case Manager regarding the member's support plan.

Safe Disposal of Medications

Overview: At the time of initial assessment and reassessment, discussion about the safe disposal of medications needs to occur for those members taking medications.
CC Responsibilities: The CC is required to:

- Discuss the disposal of medication with the member. (See the Safe Disposal of Medication resource found on the HP CC webpage.)
- Complete the form and provide it to the member.
- Document the discussion with the member and save the form in member's record.

Transportation

Overview: Members have coverage for transportation through HP Ride Care for medical and related needs based on their plan coverage.

- HP Ride Care provides transportation for medical, dental, and behavioral health appointments plus inpatient hospitalization, prescription and durable medical equipment pickup, fitness/wellness classes, and other related needs.
- HP Ride Care may use common transportation or specialized transportation based on the member's needs.
- Request for transportation usually require three days' notice.

CC Responsibilities: The CC is required to:

- Contact HealthPartners Ride Care services to determine if transportation is covered for the need. (See the Ride Care information found on the HP CC webpage.)
- Assist the member in obtaining transportation services and coordinating those services.
- Document the information in the member's records.

OTHER – REPORTING REQUIREMENTS

HP Member Registry Reports

Overview: HP provides registry reports to assist the CC in managing their assigned members.

- Reports include inpatient admission, HRA log, census changes, Medicaid reinstatements, and EW/PCA Authorizations.

CC Responsibility: CC is required to:

- Monitor the HP registry reports and leverage the information about their assignment member to trigger earlier contact than indicated in the member's support plan.
- Offer support, intervention and care coordination as triggered by the registry reports
- Amend the members support plan as needed following contact,

MMIS Reporting

Overview: MMIS data entry is needed to meet state and federal requirements and ensure proper medical assistance payments for services rendered.

Responsibilities: CC is required to:

- Maintain their access to log on to the DHS MMIS.
- Enter data in a timely manner.
- Enter screening documents for Elderly Waiver (EW) renewals by the DHS capitation deadline for those members with expirations.