2017 Elderly Waiver Provider Signature Requirement for Health Plans

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December 7, 2017

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SOUTH COUNTRY HEALTH ALLIANCE
Bringing Wellness Home

PrimeWest HEALTH

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DEPARTMENT OF HUMAN SERVICES

IMCare

BlueCross BlueShield Minnesota

Agenda

- Welcome
- Background Information
- Requirements
- Framework for discussion with member
- Care Plan Updates
- New Letters
- Updates to the Support Plan
- Resources

MCO Collaborative Presenters

- South Country Health Alliance

  Heather Goodwin, Senior Manager – Health Services

- Blue Plus

  Katie Gumtow, Manager Partner Relations

- Medica

  Sheila Heskin, Clinical Improvement Lead

- PrimeWest Health

  Leah Roell, RN Care Coordinator

- Health Partners

  Florence Okoampa, Supervisor

- UCare

  Dee-Ana Farness, Supervisor – MSHO/MSC+ Care Management

MN Department of Human Services Partners

- Aron Buchanan, Program Administrator, Aging and Adult Services Division
- Sue Kvendru, Special Needs Purchasing

Why is this being required?

- Center for Medicare and Medicaid (CMS) – Required involvement of providers in the member care plan, signature verifies their engagement
- Department of Human Services (DHS) – Implementation was January 2017 for HCBS Waiver services

A Year in the Making

Effective date of change

January 1, 2018

- Health Plans – Implementation to come into compliance with DHS/CMS rules.
- For initial, annual and changes to existing care plans completed on or after January 1, 2018

Scope of impact

Initial and reassessments:

- For the health plans, this requirement is applicable for providers when they are providing Elderly Waiver (EW) services.
- Also applicable for PCA providers when open to EW.
- Member can choose how information is shared or, choose not to share care plan information.

Scope of impact (continued)

- Signature must be obtained from each EW and PCA provider, if applicable, acknowledging their agreement to provide services and supports as outlined in the plan.
- All care plans developed on or after January 1, 2018 will need to be sent to the EW provider

Note: These requirements do not change the DTR process

Scope of impact (continued)

On-going updates to the care plan:

- Changes to the care plan that affect how the Elderly Waiver service is provided
  - changes in hours/units, or
  - change in provider, or
  - addition of a new provider.

Not in scope

This requirement does **not** apply to the following:

- Community Well persons who have PCA and not open to Elderly Waiver
- MA plan services are NOT included in requirement (Home Health Aide and Skilled Nursing Visit)
- Approval-option: purchased-item services (formerly Tier 3)
  - Specialized Supplies and Equipment
  - Personal Emergency Response System

Not in scope (continued)

- Consumer Directed Community Supports (CDCS)
- Residential Services (RS) Tool and Individual Community Living Services (ICLS) Planning Form
  - The CC can send the RS tool or ICLS planning form (DHS-3751) to the provider in lieu of the entire care plan if the member makes an informed choice to do so. Both the RS tool and ICLS planning form include a provider signature field. *Exception: Prime West*

Conversation with the Member

Value of sending the care plan

- Member centered
- Informs provider of care delivery
- Reduces confusion
- Ensures consistency
- Accountability

Choice

- Informed consent (consider MI/CD content in care plan)
- Method of sharing care plan information
- Encourage collaboration between member and provider

Conversation with the Member

- During your assessment, discuss with member or representative the CMS requirement of sharing their pertinent care plan information and support instructions with EW and PCA (if applicable) providers to help them deliver their services in a person-centered manner.

- Explain that these providers must sign to indicate their acknowledgement of the services and supports in the plan and their agreement to deliver them as outlined.

Conversation with the Member

Explain the following choices:

1. Inform the member that their care plan information may be shared in either of the following formats:
   - Complete Care Plan
   - Care Plan Summary Letter
   - Residential Services Tool
   - ICSP Planning sheet
2. Share care plan information only with selected EW providers.
3. Inform the member they may also decide to share no care plan information with EW providers.
4. The member indicates their choices on the signature page and signs.

What are your tools?

Care Plan

- Collaborative Care Plan
- Instructions for the Collaborative Care Plan
- Health Partners Care Plan
- PrimeWest Health Care Plan

Letters

- Provider Care Plan Cover Letter
- Provider Care Plan summary Letter
- Member Service Change Letter
- PrimeWest: Member EW Service Change Letter and Provider EW Services Summary Letter

Care Plan Tools

Changes were made to assist the care coordinator in documenting the member's choice and mode of sharing care plan information.

Updates were made to these tools:

- Instructions for the Collaborative Care Plan
- Collaborative Care Plan
  - Signature sheet
  - Budget worksheet

Changes to the Collaborative Care Plan Instructions

- Collaborative Care Plan training document—handout
- All changes reviewed today are highlighted in yellow

Changes Includes:

- Requirements for annual discussions about sharing care plan information with EW providers and PCA providers if applicable
- Member's choices related to their decision to share care plan information
- Member's choice about how that information will be shared
- Requirements related to discussion of updates to the support plan and sharing the updated care plan information with EW providers
  - Document updates in case notes

Collaborative Care Plan - Signature Page

Member's choices must be documented:

- Choose format of sharing the care plan information: Complete Care Plan; Care Plan Summary Letter
- Choose to share care plan information only with selected EW providers/PCA, if applicable
- Choose not to share any care plan information with any EW providers

- The member checks the box corresponding with their choice
- List all providers if the member chooses to share Care Plan information with some or all providers.

Collaborative Care Plan – new section on the signature page

Document member's choices at initial and annual assessment

☐ I CHOOSE TO SHARE CARE PLAN INFORMATION WITH THE FOLLOWING EW PROVIDERS

Provider 1	☐ Complete Care Plan	☐ Care Plan Summary Letter	☐ None
Provider 2	☐ Complete Care Plan	☐ Care Plan Summary Letter	☐ None
Provider 3	☐ Complete Care Plan	☐ Care Plan Summary Letter	☐ None
Provider 4	☐ Complete Care Plan	☐ Care Plan Summary Letter	☐ None
Provider 5	☐ Complete Care Plan	☐ Care Plan Summary Letter	☐ None

☐ I CHOOSE NOT TO SHARE MY CARE PLAN WITH ANY ELDERLY WAIVER SERVICE PROVIDERS

Collaborative Care Plan - Budget Worksheet

- Updated to be more user friendly for the Care Coordinator.
- More readable for the member.
- Reduced from four pages to one.
- Menu of services offered to the member is at the top—CC should check all the services offered to member.
- New drop-down list added to the Formal/Paid Services section—CC should select the service authorized and complete the remainder of the columns related to it.
- Informal/Non-paid community supports or resources is listed at the bottom.

Letters

Guidelines for sending letters

- Send applicable Care Plan Information to selected providers within 30 days of the care plan completion date.
- Follow-up attempt for provider signatures not received must be done and documented within 60 days of the care plan completion date
- Use with the initial notification of services to the provider or when there are changes.
- Letters:
  - Provider Care Plan Cover Letter
  - Provider Care Plan Summary Letter
  - Member Service Change Letter

Option one: Send entire care plan with Provider Care Plan Cover Letter

- Fillable
- Support Instructions
  - Should be included if member has specific requests that are not documented in the care plan, i.e. requesting female staff, has a pet, no calls or visits before 10am
- Information should match care plan
- Letter may be sent via: secure email, mail or fax
- Area for provider signature
- Keep a copy of this letter in the case file
- Document the follow up attempt in the case notes.

Option #1 Send entire care plan w/Provider Care Plan Cover Letter—Case Scenario

- Member receives 5 EW services
- Member requests the care plan be sent to 3 providers

- Responsibilities:
  - Create and send out 3 separate provider care plan cover letters (1 for each provider) that include support instructions, if applicable
    - Case note that information was sent to provider (within 30 days of assessment)
  - Second attempt is required within 60 days of the first notification – can be reminder call
    - Case note the second attempt

Option #1 - Signature page

☒ I CHOOSE TO SHARE CARE PLAN INFORMATION WITH THE FOLLOWING EW PROVIDERS
Provider 1 ABC Services (HMKR) ☒ Complete Care Plan ☐ Care Plan Summary Letter ☐ None
Provider 2 DEF Services (HHA) ☒ Complete Care Plan ☐ Care Plan Summary Letter ☐ None
Provider 3 Sky Meals (HDM) ☐ Complete Care Plan ☐ Care Plan Summary Letter ☒ None
Provider 4 Gabby Services (Companion) ☐ Complete Care Plan ☐ Care Plan Summary Letter ☒ None
Provider 5 Daily 5 (ADC) ☒ Complete Care Plan ☐ Care Plan Summary Letter ☐ None
☐ I CHOOSE NOT TO SHARE MY CARE PLAN WITH ANY ELDERLY WAIVER SERVICE PROVIDERS

Option #1 - Provider Care Plan Cover Letter

December 7, 2017

ABC Services
1234 Provider Way
Mpls, MN 55123

Re: Ann Doe
Health Plan I.D. Number: 000000009

Dear ABC Services,

Please find a copy of the care plan for the member listed above.

Support instructions, if applicable:
In addition to the written care plan, Ann has requested female staff persons, has two cats and would prefer to begin receiving home care after 10am.

The services delivered by your agency will be reviewed and monitored by the Care Coordinator and the member as indicated below.

- ☐ Once a month
- ☐ Every 3 months
- ☒ Every 6 months
- ☐ Other

Please sign that you have reviewed the plan, acknowledge and agree to provide the services and supports as outlined. Please sign and return within 15 days of the date of this letter. Keep a copy of this letter for your records.

_____

Provider Signature Date

Sincerely,

Betty White, LSW
UCare
612-555-1234
Fax: 612-555-1235
Email: bettywhite@goldengirls.org

Option #2:
Sharing a summary of the care plan

Complete the Provider Care Plan Summary Letter for each of the selected EW Providers. The Care Coordinator must enter:

- support instructions,
- implications,
- and member's goals related to the service
- timeline for monitoring.

In addition, there are instructions for the provider to sign and a timeframe for return when reviewed. Send to the selected provider within 30 days of the date the care plan was completed.

Case Scenario—Option #2

In this scenario the member is receiving PCA services and home delivered meals. In the conversation with the member, they have chosen to share only a summary of the care plan with the providers.

- For the PCA and the home delivered meals provides you will need to generate a Provider Summary letter for each provider identifying the service, unit and frequency.
- You will also include the corresponding goal that is driving the EW service and how you will be monitoring the service with the member/consumer.

Option #2 - Signature page

- Screenshot showing signature page with decision to share cp summary?

Option #2 Provider Care Plan Summary Letter

Peaceful Home Care
1234 Peace Street
Peace, MN 123456

Re: John Smith
Health Plan I.D. Number: 123456789

Dear Peaceful Home Care,

Your agency has been approved for providing the following:

Services to be provided: PCA and PCA Supervision

Frequency/Schedule: 8 units a day for the PCA service and 8 units a Month for the PCA Supervision

Goals related to service provided/support instructions/implications:
John would like to remain in his home with the assistance of the PCA services. He would prefer to have assistance with shopping on a Monday and Thursday.

The services delivered by your agency will be reviewed and monitored by the Care Coordinator and the member as indicated below.

- ☐ Once a month
- ☑ Every 3 months
- ☐ Every 6 months
- ☐ Other

Please sign that you have reviewed the plan, acknowledge and agree to provide the services and supports as outlined. Please sign and return within 15 days of the date of this letter. Keep a copy of this letter for your records.

_____

Provider Signature Date

Sincerely,

Option three: Sharing no care plan information with provider

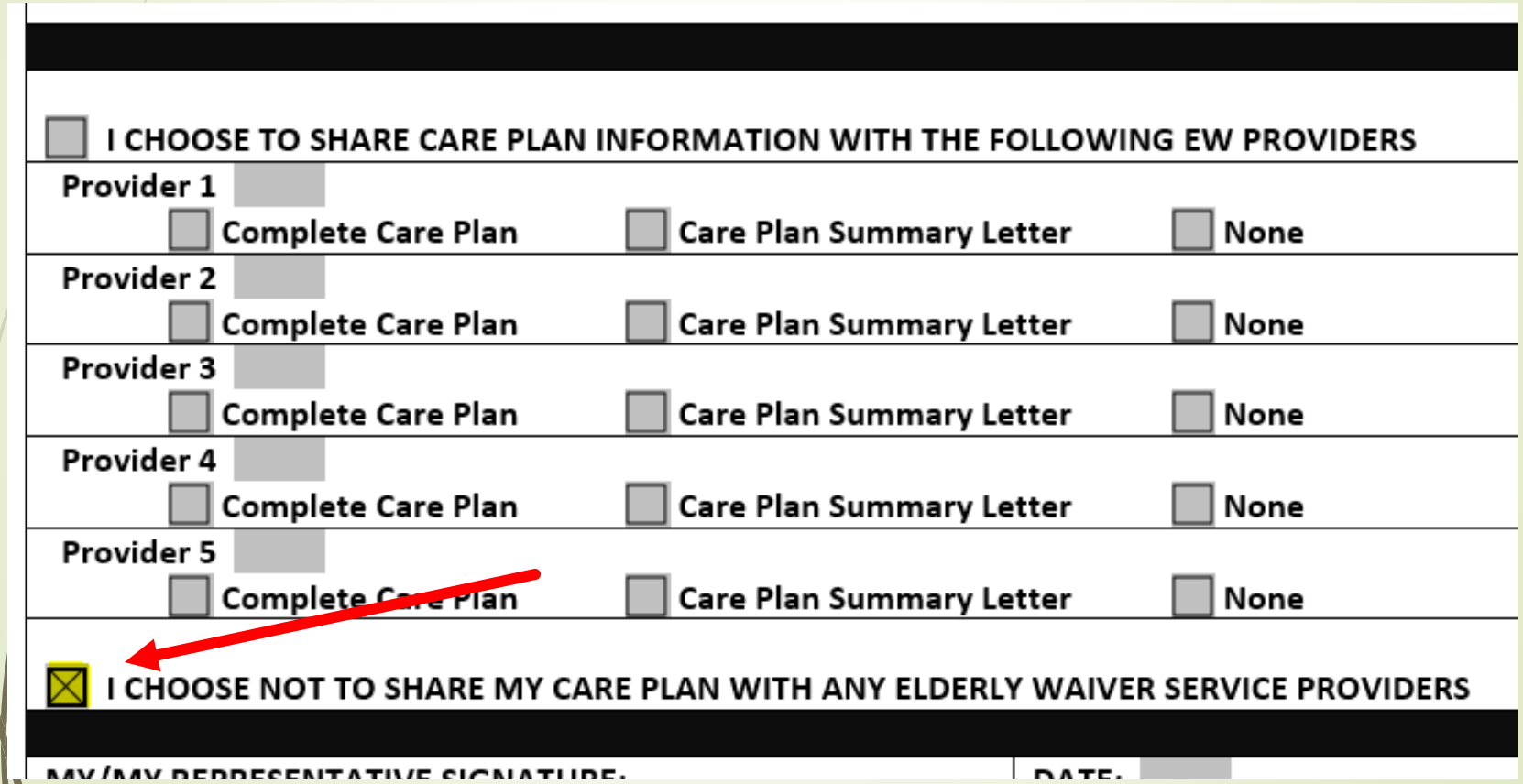
- Ultimately it is the decision of the member whether to send the full care plan, the care plan summary letter, or nothing to each applicable EW provider

- The Care Coordinator must have a conversation with the member and document the member's decision about what they want to share or not with each provider. If the member gives the Care Coordinator a reason, document the reason.

Case Scenario – Option #3

- Member is currently unhappy with her service providers. Member decides that she is moving to a new facility.
- Care Coordinator meets with member and updates care plan
- Member chooses not to share her care plan or any other documents with her providers
- Document member discussion and that she chooses to send no documents to her current EW provider for signature

Option #3 - Signature page



☐ I CHOOSE TO SHARE CARE PLAN INFORMATION WITH THE FOLLOWING EW PROVIDERS

Provider 1	☐ Complete Care Plan	☐ Care Plan Summary Letter	☐ None
Provider 2	☐ Complete Care Plan	☐ Care Plan Summary Letter	☐ None
Provider 3	☐ Complete Care Plan	☐ Care Plan Summary Letter	☐ None
Provider 4	☐ Complete Care Plan	☐ Care Plan Summary Letter	☐ None
Provider 5	☐ Complete Care Plan	☐ Care Plan Summary Letter	☐ None

☒ I CHOOSE NOT TO SHARE MY CARE PLAN WITH ANY ELDERLY WAIVER SERVICE PROVIDERS

ME/MY REPRESENTATIVE SIGNATURE: DATE:

Updates to the support plan

Updates to the Care Plan

If Elderly Waiver or PCA services change, an updated signature by member and the provider are required. Their signatures denote their agreement to the changes of their plan.

- Changes to EW service frequency
- Addition of a new or change of provider
- Updates to the tasks assigned to the provider

Changes to EW Service Plan

- Discuss the service change with the Member
- Member to decide how or if they want their updated Care Plan information shared with their EW provider as follows:
  - Copy of the updated Care Plan **(or)**
  - Care Plan Summary Letter **(or)**
  - Nothing
- Send Member Service Change Letter for their signature with their choice of:
  - Copy of updated Care Plan **(or)**
  - Copy of the updated Budget Worksheet

Changes to EW Service Plan (continued)

- CC sends documents as discussed with member
- Document members discussion, choice of sharing care plan information and dates each letter is sent in case notes
- Keep a copy of all letters in the case file

Case Scenario

Eunice is an 82 year old MSHO member who lives alone in her apartment. She likes to remain as independent as she can and at the point of her annual LTCC in February, she was receiving MOM's meals, Lifeline and 2 hours/week of Homemaking Services.

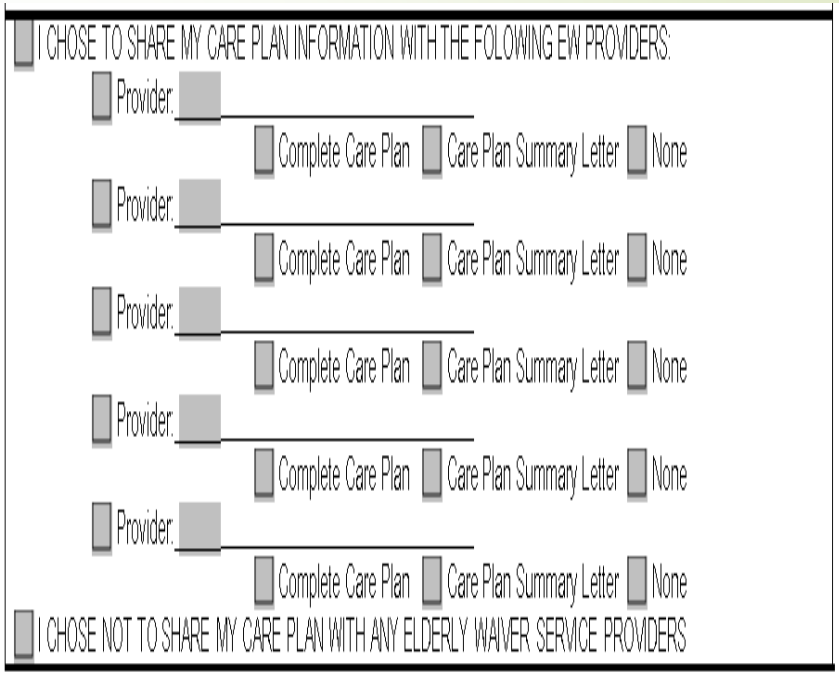
In June, Eunice tripped on a curb, and broke her foot. She called her Care Coordinator from the hospital to talk about what she will need when she gets home and asked if she could get an increase in her Homemaking Services as she will need more help with things that require she be on her feet like: laundry, vacuuming, dishes, etc. After discussion of her needs (and completion of the TOC log), the decision is made to increase her Homemaking Services from 2 hours to 5 hours/week during her recovery.

Case Note Documentation for Changes

	Change in (type) Service (be clear about what the service is)
Discussion with member	Include detail about what the change in service is and what changes are made to the member's Care Plan. ▪ Document members choice of sending a copy of the updated budget worksheet or the full care plan to them for their signature and returned to CC **(AND)** ▪ Document members decision to share care plan information with this EW provider and which format (copy of care plan, care plan summary). **(OR)** ▪ If the member does not want care plan information sent to this EW provider, document that clearly.
Document date sent to member	Include what was sent and how it was sent. I.e.: CC mailed cover letter and updated budget worksheet to member for their signature and instructions for returning signature page to CC for member file.
Document date sent to provider	Include what was sent and how it was sent I.e.: CC faxed Care plan Summary letter with service change details to provider for signature and instructions for returning signature page to CC for member file.
Document 2nd provider attempt (if needed)	Include documentation of a phone call *or* letter resent to the provider in the attempt to collect their signature.

HealthPartners

- MSHO Delegated Model (Bluestone)
  - Follow Collaborative Care Plan process
- MSHO Internal Care Coordination Model
  - Some similarities
  - Letters align
    - Full Care Plan letter
    - Partial Care Plan letter
    - Change(s) to Care Plan letter
- Signature requirements


I CHOSE TO SHARE MY CARE PLAN INFORMATION WITH THE FOLOWING EW PROVIDERS:

Provider: _____

Complete Care Plan Care Plan Summary Letter None

Provider: _____

Complete Care Plan Care Plan Summary Letter None

Provider: _____

Complete Care Plan Care Plan Summary Letter None

Provider: _____

Complete Care Plan Care Plan Summary Letter None

Provider: _____

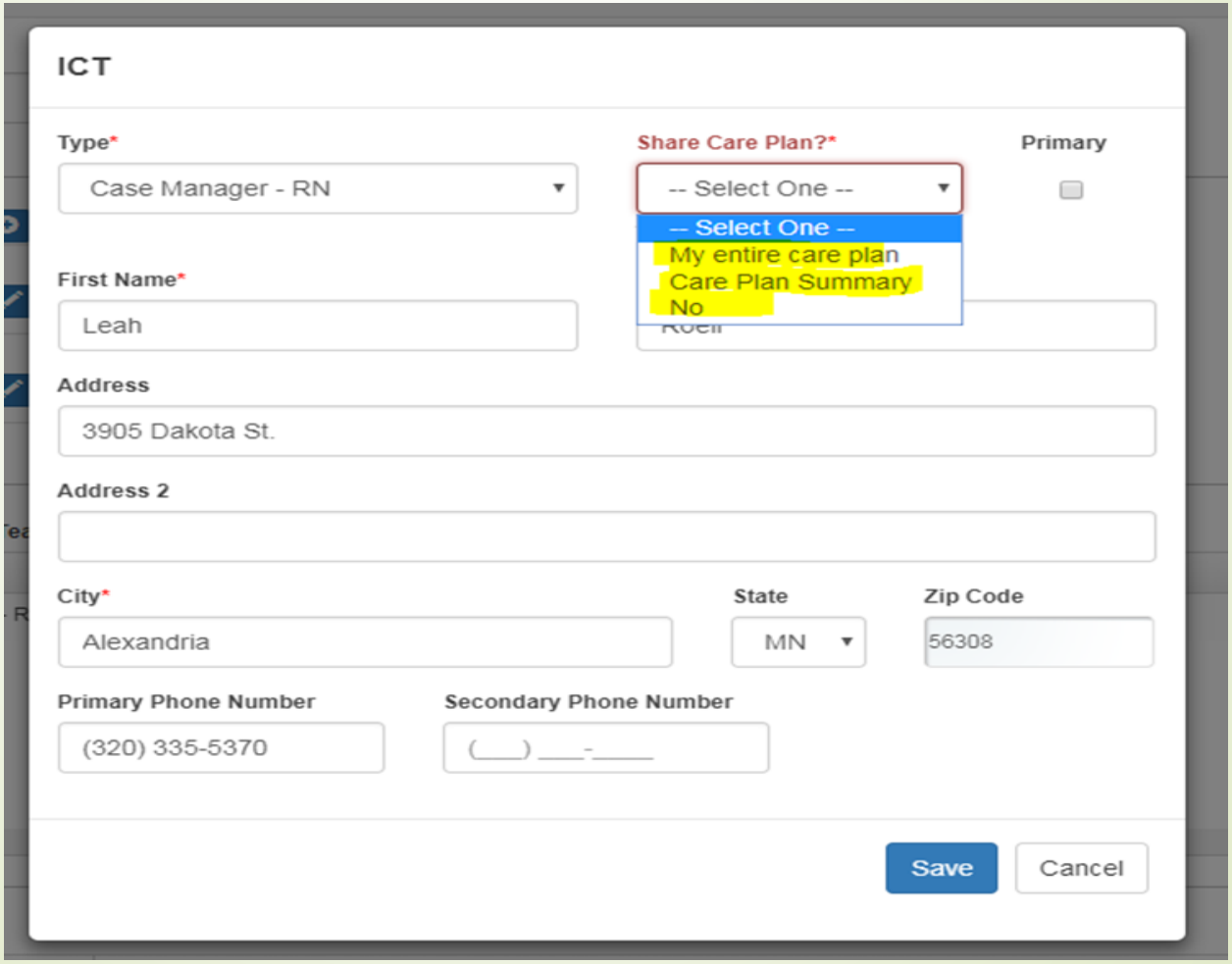
Complete Care Plan Care Plan Summary Letter None

I CHOSE NOT TO SHARE MY CARE PLAN WITH ANY ELDERLY WAIVER SERVICE PROVIDERS

PrimeWest Health

- Member and CCM will discuss requirements about sharing care plan information with EW providers and PCA providers, if applicable.
  - Share entire care plan
  - Share care plan summary
  - Choose not to share any portion of care plan
- Member's choice about how their information will be shared with providers will be reflected on the care plan.
  - Noted in the ICT section of the electronic care plan
- CCM will document in their case notes any discussion of updates to the support plan, and sharing the updated care plan information with EW providers.

PrimeWest Health Care Plan
ICT section: Member's choice for sharing care plan



PrimeWest Health times for notification

Member

- Initial and Annual
  - Care Plan Signature Page
- When services change
  - Member—EW Services Change Letter
  - Send updated care plan

Provider

- Initial, Annual, and Change
  - EW services summary letter may be sent alone or along with:
    - Completed care plan
    - Residential Services Tool or Individual Community Living Supports Planning Forms may be sent to providers for signature in lieu of this requirement if the member has made an informed choice to do so.

PrimeWest Health – Member letter

PrimeWest HEALTH

<Date>

<Mbr FName> <Mbr LName>
<Mbr Address1>
<Mbr Address2>
<Mbr City>, <Mbr State> <Mbr Zip>

Member number: <PMI>

Dear <Member FName>,

During our recent conversation, you said that you would like to choose an item. Your documents have been updated to reflect this change. Along with this letter, you will find an updated copy of your care plan that reflects this change.

We discussed the reason you should share your care plan information and support instructions with your provider. Per our discussion you have chosen to choose an item

Please sign this letter on the line below to show that you agree with the changes.

_____ _____
Member Signature Date

Once you have signed above, please mail the letter back to me at the address below. If you have questions, please call me at <phone number>.

Sincerely,

<County Case Manager Name>, <Title>
<County Agency Name>
<Address 1>
<Address 2>
<City>, <State> <Zip>

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PrimeWest Health – Member letter

PrimeWest HEALTH

<Date>

<Mbr FName> <Mbr LName>
<Mbr Address1>
<Mbr Address2>
<Mbr City>, <Mbr State> <Mbr Zip>

Member number: <PMI>

Dear <Member FName>,

During our recent conversation, you said that you would like to choose an item. Your documents have been updated to reflect t… …pdated copy of your care plan that reflects thi…

choose an item
change your units/hours
change your service provider and your units/hours
change your service provder

We discussed the reason you … …t instructions with your provider. Per our di…

Please sign this letter on the line below to show that you agree with the changes.

_____ _____
Member Signature Date

Once you have signed above, please mail the letter back to me at the address below. If you have questions, please call me at <phone number>.

Sincerely,

<County Case Manager Name>, <Title>
<County Agency Name>
<Address 1>
<Address 2>
<City>, <State> <Zip>

PW_08-17_293
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PrimeWest Health – Member letter

PrimeWest HEALTH

<Date>

<Mbr FName> <Mbr LName>
<Mbr Address1>
<Mbr Address2>
<Mbr City>, <Mbr State> <Mbr Zip>

Member number: <PMI>

Dear <Member FName>,

During our recent conversation, you said that you would like to choose an item. Your documents have been updated to reflect this change. Along with this letter, you will find an updated copy of your care plan that reflects this change.

We discussed the reason you should share your care plan information and support instructions with your provider. Per our discussion you have chosen to choose an item

- choose an item
- share a copy of your updated care plan summary
- send no care plan information to your provider
- share a copy of your updated care plan

Please sign this letter on **changes.**

Member Signature Date

Once you have signed above, please mail the letter back to me at the address below. If you have questions, please call me at <phone number>.

Sincerely,

<County Case Manager Name>, <Title>
<County Agency Name>
<Address 1>
<Address 2>
<City>, <State> <Zip>

PW_08-17_293
DHS_Approved_09/14/2017

PrimeWest Health – Provider letter

PrimeWest HEALTH

Click here to enter a date.

<Provider Name>
<Address 1>
<City>, <State> <Zip>

Re: <Member Name>
Member Number: <Member Number>

Dear <Provider Name>,

Your agency has been approved to provide the following for the above-named member:

- Service: Select EW Services Approved
- Frequency/Schedule: <Enter frequency>
- Additional support instructions: <Enter additional instructions>

The service delivered by your agency will be reviewed and monitored by the county case manager and the member <enter frequency>.

Please sign this letter on the line below to acknowledge that you have reviewed the plan and agree to provide the services and supports as outlined.

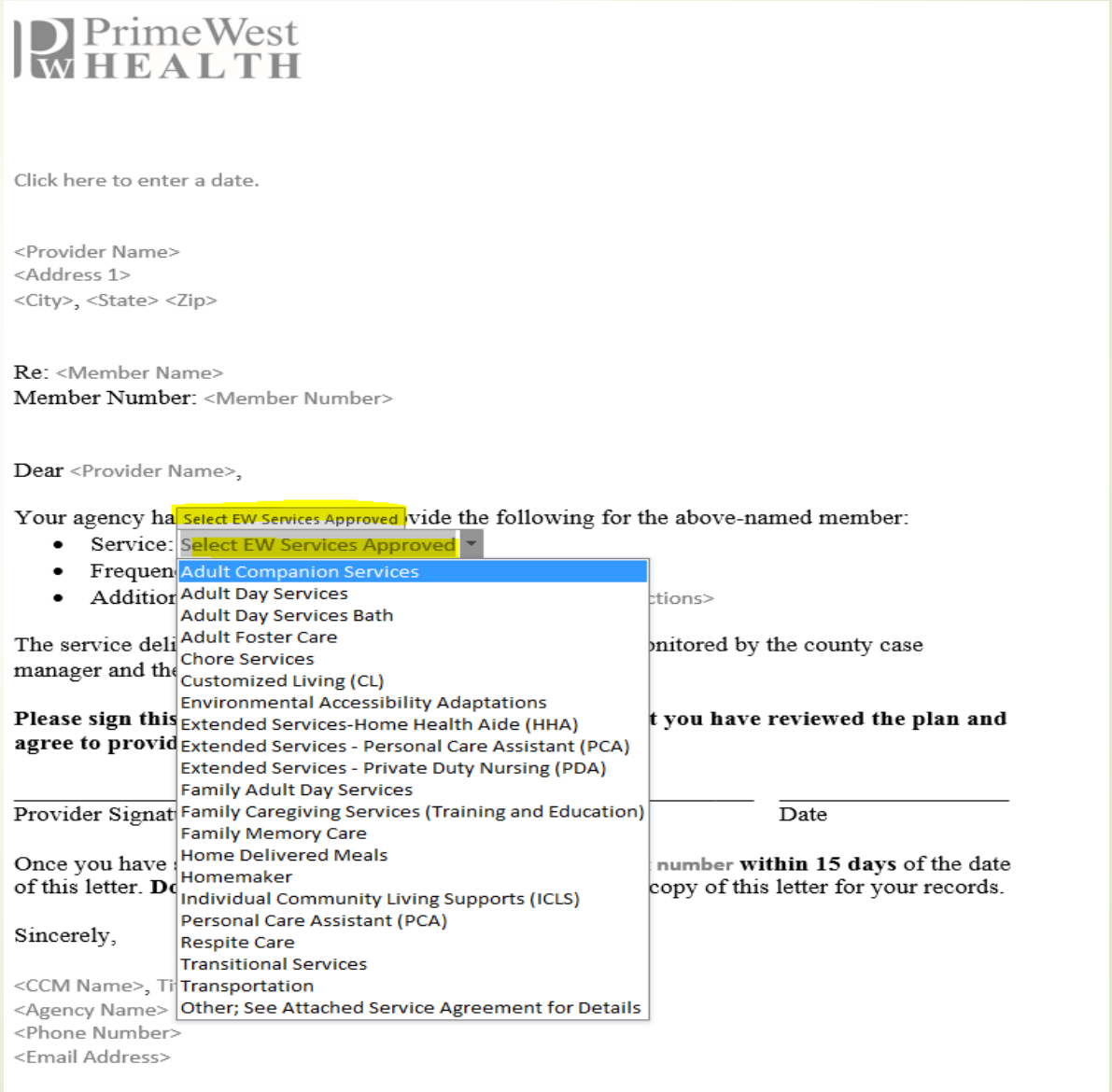
_____ _____
Provider Signature Date

Once you have signed above, please **fax this to me at CCM fax number within 15 days** of the date of this letter. **Do not return it to PrimeWest Health.** Keep a copy of this letter for your records.

Sincerely,

<CCM Name>, Title
<Agency Name>
<Phone Number>
<Email Address>

PrimeWest Health – Provider letter



PrimeWest HEALTH

Click here to enter a date.

<Provider Name>
<Address 1>
<City>, <State> <Zip>

Re: <Member Name>
Member Number: <Member Number>

Dear <Provider Name>,

Your agency ha Select EW Services Approved vide the following for the above-named member:

- Service: Select EW Services Approved
- Frequen
- Additior

Adult Companion Services
Adult Day Services
Adult Day Services Bath
Adult Foster Care
Chore Services
Customized Living (CL)
Environmental Accessibility Adaptations
Extended Services-Home Health Aide (HHA)
Extended Services - Personal Care Assistant (PCA)
Extended Services - Private Duty Nursing (PDA)
Family Adult Day Services
Family Caregiving Services (Training and Education)
Family Memory Care
Home Delivered Meals
Homemaker
Individual Community Living Supports (ICLS)
Personal Care Assistant (PCA)
Respite Care
Transitional Services
Transportation
Other; See Attached Service Agreement for Details

ctions>

The service deli nitored by the county case manager and the

Please sign this t you have reviewed the plan and agree to provid

Provider Signat Date

Once you have number **within 15 days** of the date of this letter. **Do** copy of this letter for your records.

Sincerely,

<CCM Name>, Ti
<Agency Name>
<Phone Number>
<Email Address>

Will this requirement be audited?

- Yes, for care plans generated and updated after January 1, 2018
- During the 2019 audit using Minnesota Department of Human Services Managed Care (MSHO and MSC+) Elderly Waiver Care Planning Audit Protocol
  - Audit element #15 *Communication of Care Plan Summary – Enrollee and Providers*.

We realize this creates additional work

But we hope that when providers better understand our expectations, they will serve our members better!

MCO EW Provider Signature Workgroup

- Kim Flom-Brooks, Blue Plus
- Melissa Rakow-Pare, Blue Plus
- Jennifer Hipp, UCare
- Katie Gumtow, Blue Plus
- Florence Okoampa, Health Partners
- Sheila Heskin, Medica
- Kathy Albrecht, Medica
- Dee-Ana Farness, UCare
- Heather Goodwin, South Country Health Alliance
- Leah Roell, PrimeWest
- Alexis Martire, IMCare

Resources

- **DHS e-list announcement link:**

  http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-292108

- **Provider-signature requirements for HCBS support plans:**

  http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs-294567#

- **FAQ:**

  http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs-292109#

- **Waiver/AC service provider overview (Tier 1, 2, 3 services):**

  http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_181656#

Questions or Comments?

Thank you for all you do!