Care Coordination Manual Part 1: Overview of UCare Care Coordination

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Introduction to UCare and Care Coordination

UCare developed this Care Coordination Manual to share instructions and guidance by product to care coordinators as they provide services to members. UCare contracts with Counties and Care Systems, hereafter referred to as "delegate," to provide care coordination services and benefits to members enrolled in the four Minnesota Health Care Programs (MHCP) products offered by UCare.

Care coordination supports UCare's mission statement, "to improve the health of our members through innovative services and partnerships across communities."

UCare follows community best practices as well as the requirements set forth by regulators to determine the practice standards and expectations for care coordination. UCare outlines care coordination practice standards and expectations in the UCare Requirements Grids and within this manual. UCare modifies requirements from time to time, as regulatory requirements change and best practices evolve, and notifies care coordinators via:

- Care Coordination Alerts and Updates
- Care Coordination Monthly Newsletter
- All Care Coordination Quarterly Meetings

Key Contacts

- UCare Clinical Liaison Team:
  - MSC_MSHOClinicalLiaison@ucare.org | 612-294-5045
  - SNBCClinicalLiaison@ucare.org | 612-676-6625
- Care Coordination Contact List: UCare County and Care Systems contact information
- UCare Clinical Phone List: UCare Department contact information
- MSC+ and MSHO Numbers to Know
- Connect and Connect + Medicare Numbers to Know

UCare Care Coordination Products

UCare offers two MHCP health plans for people ages 65 and older who are eligible for Medical Assistance (MA).

UCare's Minnesota Senior Health Plan Options (MSHO) Overview: UCare's MSHO is a voluntary Minnesota Health Care Program plan that combines the benefits and services of Medicare and MA with extra UCare benefits*. UCare manages the covered benefits for Medicare A, B & D and MA. Members must actively choose to enroll in UCare's MSHO plan or will be auto-enrolled in the Minnesota Senior Care + plan.

Minnesota Senior Care + (MSC+) Overview: MSC+ is a plan for people who are eligible for MA and may or may not have Medicare coverage. Dual eligible members may elect to keep their MA and Medicare separate, resulting in one Medicare insurance card, one MSC+ secondary insurance card and one Medicare Part D card.

*Reference: MSC+ and MSHO Additional and Supplemental Benefits

UCare's MSHO and MSC+ Service Area: DHS-4840 Health Plan Choices by County

UCare offers two MHCP Special Needs BasicCare (SNBC) health plans for people between the ages of 18 and 64 who are eligible for MA with a certified disability.

UCare Connect + Medicare (CT+MED) Overview: UCare Connect + Medicare is an SNBC health plan that combines benefits for people with a certified disability who qualify for MA and Medicare A and B with extra UCare benefits*. UCare manages the covered benefits for Medicare A, B & D and MA. Members must actively choose to enroll in UCare Connect + Medicare or will be auto-enrolled in the Connect plan.

UCare Connect (CT) Overview: UCare Connect is an SNBC plan for people with a certified disability who qualify for MA and may or may not have Medicare coverage. Dual eligible members may elect to keep their MA and Medicare separate, resulting in one Medicare insurance card, one Connect secondary insurance card and one Medicare Part D card.

*Reference: Connect and Connect + Medicare Additional and Supplemental Benefits

UCare Connect and Connect + Medicare Service Area: DHS-5218 Health Plan Choices by County

The Minnesota Health Care Provider (MHCP) Manual is a primary source for information related to MHCP coverage for all of UCare's care coordination products. Care coordination is a benefit provided to members enrolled in a Managed Care Organization (MCO).

NOTE**:** MSC+ and UCare Connect members with non-integrated Medicare A & B bill covered services to Medicare first; UCare will coordinate benefits for the remaining co-payments for Medicare-covered benefits. Members with Medicare Part D, as well as MSHO and Connect + Medicare, are responsible for medication co-payments.

Care Coordinator Role and Purpose

Care coordinators (CCs) foster ongoing primary and preventative care, create a person-centered support plan, and assist with communication between all members of the interdisciplinary care team. Working alongside members, care coordinators educate, motivate, and encourage to improve health outcomes. Four main components of care coordination include:

1. Education: Care coordinators share information about benefits and offer relevant resources to improve successful health outcomes by:
    a. Completing an annual Health Risk Assessment to learn about what's important to and for the member
    b. Promoting preventative care
    c. Developing a support plan that informs members of UCare benefits, community resources, and connects members to the supports the member requests
    d. Assisting members to navigate health care systems – understanding when and where to receive care
2. Improving quality of life and clinical outcomes: Care coordinators help to support members through ongoing case management to help members understand medical conditions, improve medication adherence and compliance with scheduled appointments, as well as closing gaps in preventative care
3. Increasing access to services: Care coordinators assist members in locating medical providers, including primary care providers, dentists, specialists, medical equipment and Home and Community Based Supports (HCBS)
4. Managing MA costs and health care utilization: Care coordinators manage hospitalizations for all health issues and guide members to the right care at the right time and in the right place.
    a. MSC+ and MSHO care coordinators manage benefits provided by Elderly Waiver (EW) services and Personal Care Assistance (PCA) for members who qualify.

Care Coordinator License and Training Requirements

Care Coordinator Qualifications

All care coordinators (CCs) need to meet UCare's requirements for professional care coordinators or have passed the Minnesota Merit System exam to qualify as a County Social Worker*. Counties may be excused of Merit System qualifications by the Commissioner of Human Services because the county personnel system follows federal standards and has completed all necessary steps in accordance with the Commissioner of Human Services guidance. Counties that are excused maintain a record of the Commissioner of Human Services confirmation letter.

UCare's professional care coordinators include:

- Licensed Social Worker (LSW, LISW, LGSW, LICSW)
- County Social Worker* (CSW)
- Registered Nurse (RN and additional advanced licensure)
- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Public Health Nurse (PHN)
- Physician (MD)
- CT/CT+ Med Only: Independently Licensed Mental Health Professionals (LP, LPCC, LMFT)

*MN licensure is not required

Connect + Medicare: The CC must meet the above qualifications when providing care coordination to Connect+ Medicare members.

Connect: When providing care coordination to Connect only members, and the CC does not meet the above qualifications, unlicensed care coordination staff must have a bachelor's degree in a related field and be supervised by a care coordinator who meets UCare's professional care coordinator definition. Supervising CCs are required to document a review of all completed assessments and support plans in the member record. Unlicensed staff may use BA/BS/BSW or similar when signing documents requiring credentials.

MSC+ and MSHO Certified Assessor*: At a minimum, UCare care coordinators must be professional Care Coordinators as defined above and meet DHS Certified Assessor protocol. All MSC+ and MSHO care coordinators must complete and maintain MnCHOICES Certified Assessor training.

*Certified Assessors maintain responsibility to complete the TrainLink course MnCAT Step 4: MNCH8020 to recertify their status every three years. Failure to complete recertification will result in the inability to complete MnCHOICES Assessments. Certified Assessors can view the effective range for recertification in their MnCHOICES profile.

MnCHOICES Access and Handling Minnesota Information Securely

For access to MnCHOICES and other DHS applications, required training must be up-to-date in TrainLink and Handling MN Information Securely. Care coordinators submit UCare's DHS Systems Access request form to securityliaison@ucare.org to add, change or remove a CCs access to MnCHOICES and other DHS systems.

Handling MN Information Securely

- The seven required trainings display when "County Worker" is selected as the training role in the profile settings
- Users must independently track when annual training is due
  - Failure to complete annual Handling MN Info Securely may result in losing access to the MnCHOICES assessment
- Users must update the profile settings with the employee number (MMIS PW #) and with other relevant changes (i.e.: email address)

Care Coordinator NPI/UMPI

Care coordinators accessing MnCHOICES must complete and sign the DHS 4474 Health Care Case Coordinator-Provider Enrollment Application to obtain a Unique Minnesota Provider Identifier (UMPI) number. Users may alternatively apply using the Minnesota Provider Screening and Enrollment (MPSE) portal. If a delegate is unable to obtain an UMPI through DHS, the delegate may reach out the Clinical Liaisons for assistance.

Model of Care (SNP-MOC) Annual Training

The UCare MOC provides training about the population, demographics, goals, and service elements unique to UCare's Special Needs Plans. Every year, care coordinators and providers are required to complete the Model of Care training and provide an attestation of completion to UCare. Support staff working at delegate agencies are encouraged to review the annual MOC training.

- New employees: Care coordinators complete MOC training within 90 days of employment
  - The Model of Care Training is located on the UCare Care Coordination and Care Management website
    - Attestation: Once completed, submit the electronic attestation
- Annually: Care coordinators are offered MOC training via the Quarterly All Care Coordinator Meeting to meet the annual training requirement. Alternatively, CCs may view the recorded MOC training and provide the electronic attestation.

New Hire Onboarding

UCare provides resources on the Care Coordination and Care Management website to help care coordinators work effectively with members. Additional requirements for training on agency-specific systems, policies, and procedures, as well as observation of skills and demonstration of mastery of assessment/support planning and care coordination responsibilities, are to be provided by the delegate. UCare care coordination training resources include:

- UCare Care Coordination and Care Management Website Overview
- MSC+/MSHO
  - New Hire Training Guide (MSC+/MSHO)
  - MSC+ and MSHO Care Coordination 101 Three-Part Series
  - MSC+/MSHO Assessment Checklist
- Connect (CT) Connect + Medicare (CT+)
  - New Hire Training Guide (CT/CT+ MED)
  - SNBC Care Coordination 101
  - CT/CT + Assessment Checklist
- All
  - Transitions of Care Training

Care Coordination Rules and Requirements

The Federal Government (CMS) and State Government (DHS) provide the regulatory guidance for all MSC+, MSHO, Connect and Connect + Medicare health plans. UCare care coordination requirements are located on the Care Coordination and Care Management website. The Requirements Grids are UCare's official policies and procedures for care coordination responsibilities. The Requirements Grids are typically updated twice yearly (January/July) or if significant DHS/CMS regulatory changes occur.

Care Coordination Requirements Grids

- MSC+/MSHO Care Coordination Requirements Grid
- MSC+/MSHO Institutionalized Care Coordination Requirements Grid
- Connect/Connect + Medicare Care Coordination Requirements Grid

As a supplement to the Requirements Grids, the Care Coordination and Care Management website also houses many resources and tools that provide guidance on specific care coordination tasks. Job aids are developed based on feedback from care coordinators and are designed to elaborate on care coordination requirements. Included in, but not limited to are:

- Assessment Timelines
- Assessment Checklist
- Behavioral Health Home
- Housing Stabilization
- Member Engagement Strategies
- Letters Guide
- New Hire Training Guide
- SMART Goals
- Transportation - Medical
- Transition of Care Scenarios

Caseload Size and Caseload Management

UCare delegate partners establish the caseload sizes based on the agency specific roles and responsibilities. Caseload sizes may be adjusted for Full-Time Equivalent (FTE) status if staff hold additional duties outside of the care coordination job description and other contributing considerations.

Recommendation for Caseload per Care Coordinator

When determining caseload ratios, delegates should consider:

- CC experience and agency tenure
- CCs ability to provide quality service as evidenced by member engagement and compliance with CC tasks
- CCs additional responsibilities
- Use of support staff to assist with unlicensed tasks
- CCs management of multiple MCO care coordination programs
- CCs management of Elderly Waiver vs non-Waiver/SNF members
- Members with completed assessments vs. unable to reach or refusing care coordination
- Member demographics
    - Driving distance
    - Language proficiency
    - Complexity of case mix/member situation
    - Members receiving CDCS, PCA or Non-Waiver Institutional status

UCare requires delegates to determine the size of care coordinator caseloads based on their unique situation and attest to the delegate's estimated caseload target size. At a minimum, care coordinators must be able to complete the UCare care coordination requirements that support member needs within the required timelines.

Caseload Management

UCare delegates establish systems to track ongoing member requirements to ensure compliance with regulatory timelines. Tracking systems may be within the delegate's electronic health records, applications, or spreadsheets that work best for the delegate. Delegates needing assistance with tracking systems may contact the Clinical Liaison team for suggested tools and instructions.

Delegated Activities

Certain care coordination tasks may be shared with support staff, while a care coordinator must complete other tasks. The table below indicates examples of activities or functions that may be delegated to support staff.

Activity/Task	CC Only Task	Support Staff
Verifying member eligibility in MN-ITS		Yes
MnCHOICES Location/Assignment		Yes
Mailing Letters with assigned CC Name/Contact (Welcome Letter/CC Change Letter)		Yes
Member outreach attempts (phone or letters) to schedule visits (assessments/6 mo./TOC/ visits/other)		Yes
MnCHOICES Assessment/HRA-MCO	Yes	
THRA	Required by CC: Review HRA/Support Plan complete THRA w/ Member	Prep documents

MMIS Entry		Yes
TOC Log	Partial: All member contacts and related activities	Partial: Notify PCP, verify admission, prep documents
Completing the MnCHOICES Support Plan	Yes	
Mailing Support Plan		Yes
Support Plan revisions	Yes	
UTR/Refusal Support Plan	CC required to review /sign	Prep documents
Referrals	Assessing the need for referrals	Submit referrals
Documentation of task/activities/member interactions		Yes
Monthly Activity Log		Yes

Recreating documents

Any delegate who would like to recreate a UCare document within an agency-specific electronic health record (EHR) must have written approval from UCare to ensure consistency of all required elements in the documents. UCare notifies delegates of updated documents via the monthly Care Coordination Newsletter and Alerts/Updates. Delegates are required to update internal documents in a timely manner to ensure staff are using the most recently updated forms and tools. When creating new UCare documents within agency specific EHR, the delegate is required to notify the Clinical Liaison Team to review, track and approve.

Alternative Decision Makers

When alerted of legal/authorized decision-makers, care coordinators are to request copies of legal documents to keep in the member's record and determine the validity and scope of the legal decision-maker. Because each member's situation is unique, the scope of legal authority should be reviewed from the shared document to ensure the proper people are involved in the member's assessment and support planning.

To speak with a UCare representative as an alternative decision maker, supporting legal documentation must be sent to UCare by:

Mail: UCare Attn: Enrollment PO Box 52 Minneapolis, MN 55440-0052,
Fax: 612-676-6501
Secure email: CLSScanReqInq@ucare.org

*Guardian: A person(s) appointed by the court to make the **personal decisions** for the person subject to guardianship. The guardian has the authority to make decisions on behalf of the person subject to guardianship about where to live, medical decisions, training and education, etc. If a member has a verified legal guardian, they must be contacted and invited to attend the assessment. It should be documented if the guardian refuses to participate in the assessment. Private and public guardians are the signature providers of support plans and release of information documents.

*Conservator: A person(s) appointed by the court to make **financial decisions** for the person subject to conservatorship. The conservator typically has the power to enter into contracts, pay bills, invest assets, and perform other financial functions for the person subject to conservatorship.

*Power of Attorney (POA): A written document that allows someone to act on behalf of another person regarding **financial and property matters**. A POA with the proper paperwork on file with UCare may speak on behalf of the members regarding UCare insurance matters. POAs do not sign on behalf of members. A POA ceases when a person becomes incapacitated.

*Durable POA: Holds the same power as POA regarding **financial and property matters** but maintains the power through incapacities and terminates upon the member's death.

Health Care Agent: A designated person who may or may not make **health care decisions** on behalf of a person when the person has the capacity to speak on their own behalf, as noted in a person's Health Care Directive (HCD). A health care agent may sign an ROI only if the person is unable to sign for themselves unless explicitly directed in the HCD.

Representative Payee: A representative payee is a person or entity appointed by Social Security to **manage Social Security benefit payments** for someone unable to do so on their own — for example, a minor child, a severely disabled person or a retiree suffering from advanced dementia.

Authorized Rep (A-Rep): A person or organization authorized by an applicant or enrollee to apply for an MHCP and to perform the duties required to establish and maintain eligibility. This type of representative is **exclusive to financial eligibility, such as MA eligibility** and MHCP Eligibility.

Responsible Party (RP): A person who is at least 18 years old and capable of providing the support necessary to help the person receiving PCA services to live in the community when the person is assessed as unable to direct their own care. This type of representative is **exclusive to PCA**. The designated RP is not permitted to act as the PCA.

* Indicates a type of alternative decision maker that may receive Protected Health Information (PHI) about the member from a UCare representative.

Release of Information

At times, some entities may have more restrictive privacy practices or may not be a covered entity under HIPAA, and written consent is requested to share member information. UCare provides a care coordination specific Release of Information (ROI)* form located on the UCare Care Coordination and Care Management website to obtain member consent to disclose protected health information. UCare's ROI is valid through the date or condition indicated on the signed ROI form.

An ROI is not needed for continuity of care purposes, including but not limited to sharing information with medical providers for the purposes of TOC, requesting orders or assisting in scheduling appointments, when transferring member cases between care coordination delegates, with county financial workers and waiver case managers, BHH providers, and legal representatives as indicated above. Anytime written records are requested by the CC, an ROI will be needed. If you are running into barriers working with medical providers on the above, contact the clinical liaisons for guidance.

NOTE: Members with a substance use disorder (SUD) diagnosis must provide explicit written consent to release any information related to SUD, including to the member's PCP. Support plans and other communication must redact SUD information if an ROI is not documented.

*UCare's standard ROI is available in a variety of languages. When needed, see the UCare Member Plan Documents.

Fraud, Waste and Abuse

Through their daily work, care coordinators may become aware of potential Fraud, Waste, or Abuse (FWA). UCare defines Fraud, Waste and Abuse as:

Fraud: When someone makes a false statement, false claim or false representation to UCare where the person knows or should reasonably know the statement, claim or representation is false; and where the false statement, claim or representation could result in an unauthorized benefit to the person or some other person.

Waste: Any over-utilization of services and misuse of resources that is not caused by fraud or abuse.

NOTE: Care coordinators have a responsibility to ensure members are using the most cost-effective means and avoid duplication of services and supports to reduce the misuse of resources. Medical assistance is the payor of last resort. When other payors, such as other insurance or supplemental benefits can meet the member's needs, these should be utilized first.

Abuse: A pattern of practice that is inconsistent with sound fiscal, business or medical practices and either directly or indirectly results in unnecessary costs to UCare or that fails to meet professionally recognized standards for health care; enrollee practices that result in unnecessary cost to UCare; substantial failure to provide medically necessary items and services that are required to be provided to an enrollee if the failure has adversely affected or has a substantial likelihood of adversely affecting the health of the enrollee.

To report FWA, care coordinators may contact UCare via:


1-877-826-6847


UCare
Special Investigation Unit
PO Box 52
Minneapolis, MN 55440-0052


compliance@ucare.org

Reference: UCare Fraud, Waste and Abuse

Vulnerable Adult Reporting

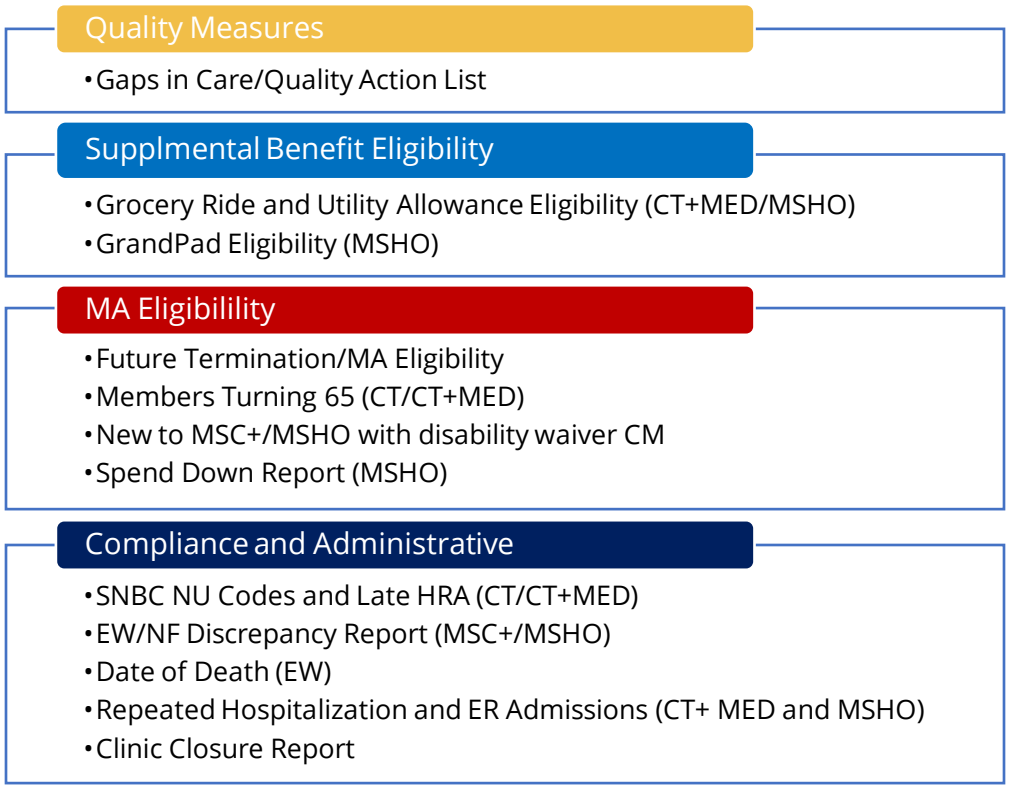
DHS notes that mandated reporters include law enforcement, educators, nurses, social workers and other licensed professionals. DHS provides online training related to vulnerable adult reporting. See the link below.

Care coordinators are mandated reporters, and as such, when a CC has witnessed or knows of a member who has been the victim of physical or mental abuse, neglect, financial exploitation, or unexplained injuries, the CC is to immediately act to file a complaint or report an incident. Reports can be made using the Minnesota Abuse Reporting Center (MAARC) or by calling 1-844-880-1574. In the event of an emergency or immediate jeopardy, call 911.

Reference: DHS Vulnerable Adult Mandated Training | Making Mandated Reports

Reports

Delegates receive several reports from UCare to aid in care coordination. Some reports require timely action on the part of the care coordinator, while others are a resource to use when working with members. Reports are submitted via the Sec FTP or secure email. Delegates are asked to review the reports and disseminate information to the assigned care coordinators as appropriate. Most reports are provided on a monthly basis, others are dependent upon DHS disseminating information. Reports may apply only to one or more plans and include but are not limited to:



Audits

Self-Audits

UCare maintains that all delegates are responsible for creating an internal system to oversee staff performance related to compliance. This may include a routine review of care coordination member engagement, supports, and interventions as well as the DHS/CMS requirements for timely and complete assessments, support plans, transition of care tasks and documentation.

Annual Compliance Audit

Frequency: Annual or bi-annual for MSHO, MSC+, Connect, and Connect + Medicare. Delegates who reach "high performer" status as set forth by DHS will be exempt from the annual audit for one year. High-performing delegates are those who have met all audit protocols and requirements for two consecutive years and can bypass the next year's audit cycle. Delegates can maintain high performer status, being audited every other year, if all protocols and requirements continue to be met.

Corrective Action Plans Apply: Yes

Summary: UCare conducts an annual compliance/oversight audit of all delegates using audit tools designed to assess the performance of the delegate based on the delegation agreement and required regulations. UCare makes an effort to inform delegates of the expectations by disseminating the content of the audit tool and audit process to delegates, as well as conducting compliance education for delegates.

Quality Review

Frequency: Annual for MSHO, MSC+, Connect, Connect + Medicare. Quality Reviews are optional for delegates who have High Performer status and are in their by-annual compliance audit exempt year.

Corrective Action Plans Apply: No

Summary: The Quality Review is complementary to annual DHS compliance audits completed by UCare's Compliance department. Quality Reviews are conducted annually and geared towards improving member experience and highlighting strengths of the care coordination process. It is designed to review and provide feedback on current care coordination requirements and practices in real time. The outcomes do not result in corrective action plans but instead provide the delegate with an opportunity to provide training and education to care coordinators and improve processes in preparation for the compliance audit.

The Quality Review uses a tool that identifies areas of success in care coordination requirements and opportunities for improvement. After a review is completed, a summary of the findings is provided to the delegate. The summary highlights review elements, supporting comments, resources and scoring.
Contact QualityReviewTeam@UCare.org to learn more.

TOC Audit tasks)

Corrective Action Plans Apply: No

Summary: The Transition of Care (TOC) audit is conducted annually on randomly selected transitions of care from the previous year and the required care coordination tasks. For MSHO and Connect + Medicare, the TOC Logs are audited. If the transition notification occurs 15 days or more after the member is discharged to home, the TOC log is not required, but case notes will be audited to show that follow-up tasks occurred. For MSC+ and Connect member transitions, case notes showing required follow-up tasks are audited. All transitions within a series are audited. A transition series is defined as all of the transitions that take place from the time of the initial admission until the member returns to their usual setting.

HEDIS

Frequency: Annual

Corrective Action Plans Apply: No

Summary: All health plans submitting HEDIS data to NCQA must undergo a HEDIS Compliance Audit, which may only be performed by licensed organizations and certified auditors. The HEDIS Compliance Audit helps ensure accurate, reliable data that can be used by employers, consumers and government to compare health plans. It has two parts: evaluating a plan's overall information systems capabilities (the "IS standards") and evaluating a plan's ability to comply with HEDIS specifications (the "HD standards").

MDH Audit

Frequency: Every three years for MSHO and MSC+

Corrective Action Plans Apply: Yes

Summary: The Minnesota Department of Health (MDH) licenses all managed care organizations (MCOs) in the state. As part of that licensing review, MDH may audit plans once every three years. Regulation ensures that health plans follow applicable laws, standards and rules governing financial solvency, quality of care, access to services, complaints, appeals and other consumer rights in compliance. MDH reviews managed care contracts to ensure MCOs are in compliance with the contract with DHS, as well as to ensure they meet federal standards.

CMS Audit

Frequency: Varies for MSHO and Connect +

Corrective Action Plans Apply: Yes

Summary: The Centers for Medicare & Medicaid Services (CMS) is responsible for creating and administering the audit strategy to oversee the Part C and Part D programs. These program audits measure an organization's compliance with the terms of its contract with CMS, particularly the requirements associated with access to medical services, drugs, and other enrollee protections required by Medicare. For MCOs, this includes auditing alignment to the current Model of Care.

Part C Validation Audit

Frequency: Annual for MSHO and Connect + Medicare

Corrective Action Plans Apply: No

Summary: The Centers for Medicare & Medicaid Services (CMS) requires that sponsoring organizations (SOs) contracted to offer Medicare Part C and/or Part D benefits be subject to an independent yearly audit to validate certain data reported to CMS to determine its reliability, validity, completeness, and comparability in accordance with specifications developed by CMS. Audited areas include grievances, reconsiderations, and the care management documentation for Special Needs Plans.

Secure Communications

Secure File Transfer Portal (Sec FTP)

The Sec FTP is a secure website that ensures a safe and HIPAA compliant method to temporarily transfer member information. Once viewed, Sec FTP authorized users are to download and remove information from the portal. Sec FTP is not intended to store information. Authorized users are able to access the care coordination Enrollment Rosters, Daily Authorization Reports (DAR), and Gaps in Care (GIC) reports, among other reports.

To add or remove access to the Sec FTP, care coordination staff utilize the Sec FTP Request Form located on the Care Coordination and Care Management homepage.

Provider Portal

The Provider Portal allows delegates access to:

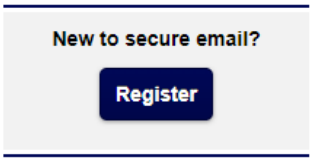
- Explanation of payments (monthly remit statements that show payment for care coordination per member per month fees)
- View claim status
- Complete the online Provider Claim Reconsideration Form
- Look up member eligibility
- Check authorization on medical service status
- Send a secure message to the Provider Assistance Center

Delegates establish a primary Provider Admin to access the Provider Portal. The primary Provider Admin can assign other users. See the Admin User Guide.

NOTE: The Provider Portal should only be used for care coordination remit reports. The Provider Portal should not otherwise be used for care coordination purposes. The primary source of truth for member information is the Care Coordination Enrollment Roster.

UCare Secure Email Message Center

Delegates must use secure messaging when communicating a member's protected health information to UCare affiliates. If the delegate does not have a secure messaging system or if UCare cannot open the third-party messaging system, the delegate may use the UCare Secure Email Message Center. To create a personal mailbox, register by opening the message center and clicking "New to secure email?" Messages in the message center are automatically removed after approximately ten days.



Member Complaints and Grievances and Appeals

For additional information on complaints, grievances, and appeals, refer to the member handbook for the member's specific health plan.

Complaints and Grievances

A complaint or grievance can be a written or spoken statement saying the member has a problem or concern about covered services or care. This includes any concerns about the quality of service, quality of care, UCare network providers, or UCare network pharmacies. The formal name for "making a complaint" is "filing a grievance". Care coordinators may assist members in submitting complaints; however, they may not submit complaints on behalf of members. If a complaint is made about a specific care coordinator or delegate, UCare will contact the CC/delegate to inquire and gather more information. UCare encourages delegates to honor member requests to change care coordinators.

To make a complaint, members or authorized representative may contact UCare's Customer Service via:

Phone: 612-676-3310 or 1-855-260-9707, TTY 612-676-6810 or 1-800-688-2534,
Email: cag@ucare.org or
Mail: UCare PO Box 52 Minneapolis, MN 55440-0052

Appeals

An appeal is a way for members to challenge UCare's coverage decision related to UCare benefits and services. Members can ask UCare to change a coverage decision by filing an appeal. MSC+ and MSHO care coordinators issue a denial, termination or reduction (DTR) of elderly waiver services to notify UCare to provide members the appeal rights (also known by DHS as a Notice of Action). Connect and Connect + Medicare care coordinators do not issue DTRs. UCare provides all other denial notifications per DHS and CMS guidelines.

Care Coordination by Product

To learn more about care coordination responsibilities by product, see:

- Care Coordination Manual Part 2: MSC+ and MSHO Care Coordination
- Care Coordination Manual Part 3: Connect and Connect+ Medicare Care Coordination