Care Coordination Manual Part 2: MSC+ and MSHO

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Definitions

Care Coordination: The coordination of services for a member among different health and social service professionals and across settings of care including the provision of all Medicaid and/or Medicare health and long-term care services as determined eligible.

Center for Medicare & Medicaid Services (CMS): Along with DHS, provides the overarching rules for care coordination and Medicare member benefits.

Delegate: Any party directly or indirectly providing or performing any of UCare's core obligations in a manner that requires judgment or interpretation (not just a pass through of data) to our members under individual market member contracts, Medicare or Medicaid contracts, and/or NCQA accreditation standards.

Department of Human Services (DHS): Along with CMS, DHS provides the overarching rules and regulations for care coordination and Medicaid member benefits.

Elderly Waiver (EW): The Home and Community Based Services waiver program authorized by a federal waiver under §1915(c) of the SSA, 42 USC §1396, and Minnesota Statues §256S.

Health Risk Assessment (HRA): An assessment performed to collect health information (including physical, functional, social, and emotional) which provides information from the member/designee that identifies risk factors and interventions needed to promote health and sustain function.

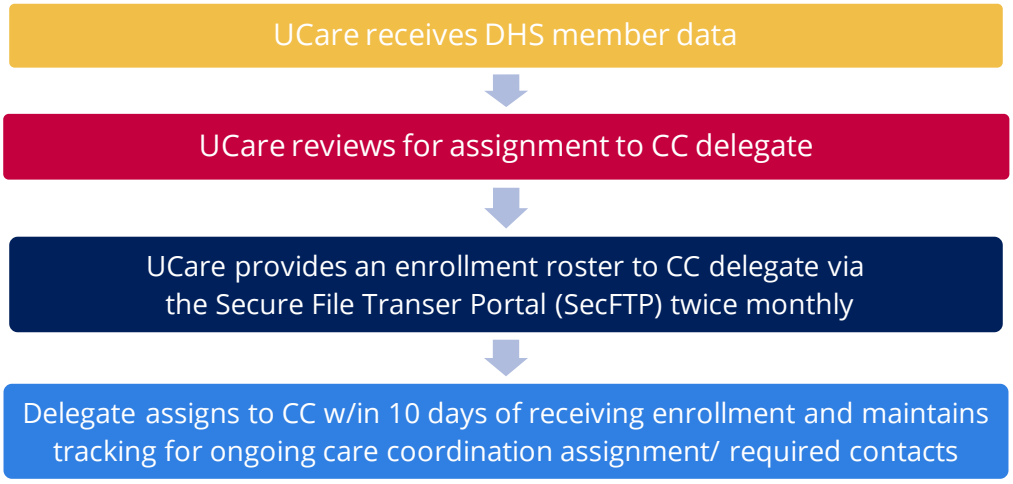
Interdisciplinary Care Team (ICT): A team of individuals that work collaboratively with the member and/or their designee (s) to establish goals, interventions, and a monitoring process that addresses the member needs, wants, and preferences. At a minimum, the ICT is comprised of the Primary Care Provider, the Care Coordinator and the member/designee, and can include other healthcare professionals.

Support Plan: A person-centered document that identifies what is important to the member, what support and care is necessary for the member, and member specific goals and interventions. Information is gathered from consultation with the member, the member's care team, caregivers, and/or member information is used as available including, but not limited to, needs identified by risk and comprehensive assessments and medical records. The Support Plan incorporates an interdisciplinary and preventive care focus including discussion of advance directive planning. The Support Plan is also known as the MnCHOICES Support Plan and previously known as the Care Plan, Plan of Care (POC), Comprehensive Care Plan, Collaborative Care Plan, and Community Support Plan.

Transition: Movement of a member from one care setting to another as the member's health status changes; for example, moving from home to a hospital as the result of an exacerbation of a chronic condition or moving from the hospital to a rehabilitation facility after surgery. Undergoing select outpatient procedures may also be considered a care transition.

Care Coordination Enrollment Overview

The Minnesota Department of Human Services provides UCare with member enrollment updates. UCare reviews enrollment information to determine the delegate that will be assigned for care coordination. MSC+ and MSHO members are assigned to delegates for care coordination based on the member's designated primary care clinic (PCC) and/or geographic location (some exceptions may apply).



Enrollment Rosters

The bi-monthly enrollment rosters provide delegates notification of assigned member status including:

- New Member: Member is new to UCare, or member was reinstated to UCare after a gap in eligibility
- Product Change: Change in UCare product from the prior month (i.e., MSC+ to MSHO)
- Termed Member: Member disenrolled from UCare
- Care Coordinator Change: Change in care coordination entity from the prior month
- Clinic Change: Primary care clinic change
- Rate Cell Change: Living status change (i.e.: community to institutional)

Reconciling the Enrollment Roster

Delegates are responsible for reconciling the enrollment rosters to identify discrepancies or incorrect assignments. Alert CMIntake@ucare.org to research discrepancies, resolve them, and, if applicable, notify the appropriate delegate of a new assignment.

To support care coordination staff, UCare provides training on reconciling the enrollment rosters.

- Navigating the Enrollment Roster using Excel
- Enrollment Roster Reconciliation Job Aid

Primary Care Clinic (PCC) Changes

If a member's primary care provider is verified and requires an update, complete a PCC Change Request Form by the 12th day of the month to reassign to the appropriate delegate.

- Updated PCC and care coordination assignment will be reflected on 2nd roster posting.
- If requested after the 12th day of the month, care coordinators are to continue with all care coordination activities to ensure member contact is completed within the regulated timelines and PCC will be honored effectively the first roster of the next month.

- PCC must be confirmed with the member. Reviewing electronic health records is not sufficient to request a PCC change.

90-Day Grace/Monitoring Period for Medical Assistance

Care coordinators are required to monitor members whose medical assistance becomes inactive for up to 90 days after the date of inactivity. Many times, members are reinstated without a gap in coverage within 90 days. Completing assessments that are due during the 90-day monitoring period ensures compliance with DHS and CMS assessment timeline requirements if the member is reinstated without a gap in coverage.

MSC+: Members are removed from the enrollment roster when MA terms as all UCare medical benefits discontinue upon MA termination.

- Claims are not paid while MSC+/MA is termed
- CCs monitor inactive members for 90 days from the MA termination date and complete reassessments and support plans due within the 90-day monitoring period
- CCs assist members with resolving MA re-enrollment issues. Consider referring to UCare's Keep Your Coverage Team
- When MA is reinstated and backdated ensure any missed contacts are completed
- Medical providers can submit claims retroactively
- CCs enter MMIS assessment activity (as applicable)
- If not reinstated, ensure the MnCHOICES assessment and support plan are in completed or discarded status and remove the location and CC assignment

MSC+ EXCEPTION: If a CC is able to document confirmation from a member or member's Financial Worker that MA will not be reinstated, care coordination may end prior to the conclusion of a 90-day monitoring period. Examples may include a member who moved out of state, is incarcerated, or is no longer financially eligible for MA per FW.

MSHO: Members remain on the enrollment roster because UCare covers all claims covered under the MSHO benefit during the 90-day grace period. During this period, members may appear inactive in MN-ITS. Refer to the enrollment roster future term date or view MN-ITS retro dates to confirm MA eligibility.

- UCare continues to pay claims for eligible members in the 90-day CMS grace period
- CCs continue all care coordination activities while members remain on the enrollment roster

MSHO EXCEPTION: If a member terminates from the enrollment roster prior to the full 90-day grace period, care coordination ends

- Medical providers may contact the Provider Assistance Center at 612-676-3300 to confirm eligibility prior to providing services
- CCs assist with resolving MA re-enrollment issues. Consider referral to UCare's Keep Your Coverage Team
- Upon notification of disenrollment from UCare via the Enrollment Roster, ensure MnCHOICES documents are in completed status and remove the CC location and assignment

IMPORTANT: For **EW Members**, if MA is not reinstated by day 60, CC sends the DHS-6037 to the County.

Medical Spenddowns and Waiver Obligations

The county financial assistance unit is responsible for determining the financial obligation for UCare members. The member receives a notice if they have a waiver obligation or will be responsible for a spenddown.

Spenddown

A spenddown may occur when a person's income/assets are above the criteria to qualify for MA. Similar to an insurance deductible, to get coverage a recipient pays a share of the cost of medical bills before MA begins to pay. Spenddowns may be incurred by:

- People requesting HCBS through a disability waiver (CAC, CADI, DD and BI)
- People requesting HCBS through EW when their income is above the Special Income Standard (SIS) and they do not have a community spouse

MSC+: MSC+ members with a spenddown are not permitted to enroll in an MCO. If a spenddown is incurred while on UCare/MCO, DHS will disenroll the member from the health plan and move to FFS MA.

MSHO and CT/CT+MED: Members who are enrolled in UCare MSHO or Connect/Connect + Medicare (excluding MSC+) and incur a Medical Spenddown may stay enrolled in the UCare plan as long as the member pays the spenddown each month. Members pay spenddowns directly to DHS via monthly invoices from DHS. If a member does not pay the spenddown for three consecutive months, DHS will disenroll the member from UCare.

Designated Providers

Some members may choose to pay monthly spenddown amounts to one provider each month. This is referred to as the Designated Provider Option. MSHO members on EW cannot have a designated provider for a medical spenddown. CT/CT+MED can have a designated provider for a medical spenddown as long as it is for services not covered by UCare. Services covered by fee-for-service that are eligible for payment to a designated provider are Home and Community-Based Services waiver for people with disabilities, CFSS, or home care nursing.

Spenddown report

DHS provides a spenddown report that UCare sends via email to delegates, which includes the delegate's identified recipients with an overdue spenddown. The report informs CCs of the spenddown amount and the number of months the member is overdue and therefore, about to be disenrolled.

MSHO/CT+MED: Members receive 90 days of continued UCare coverage after DHS disenrolls the member due to non-payment of the spenddown. Members will remain on the enrollment roster but will be noted as "No Pre-Paid Health Plan" in MN-ITS. If spenddown payment is not completed, the member will remain on MA fee-for-service with a spenddown. When the UCare coverage ends after 90 days, members must take action to have a new prescription drug coverage plan.

Waiver Obligations

A waiver obligation is a type of payment obligation EW enrollees may have toward the cost of their care. The amount of the waiver obligation is determined by the member's county financial assistance worker based on the amount of income remaining after completing an income calculation.

Waiver Obligation vs Spenddown

- People with incomes equal to or less than the Special Income Standard (SIS) are eligible for EW without an MA spenddown. They must contribute any income over the maintenance needs allowance and other applicable deductions to the cost of services received under EW. This is known as the waiver obligation.

  The waiver obligation is:
  - Deducted from the cost of services received under the Elderly Waiver; the full amount of the waiver obligation does not have to be met each month.
  - The amount the member is responsible for paying towards the services the member used that month, which may be a portion of the waiver obligation or the entire waiver obligation.
  - For members enrolled in MSC+ or MSHO, UCare pays the EW provider minus the waiver obligation and the provider bills the member for the waiver obligation portion.
  - Members cannot use a designated provider for waiver obligations.
- People with incomes greater than the SIS may still be eligible for EW but they will have an MA spenddown.

Reference: DHS MHCP Health Care Programs and Services | DHS-3017 What is a Spenddown | DHS-5525 MSHO and Medical Spenddowns | DHS-5373 SNBC and Spenddowns

Initial Assignment

Upon receiving the enrollment roster from UCare, it is best practice to document the date the enrollment roster was received and the member's original enrollment date (the first day of the month the member was NEW to UCare) in the member record as these are important dates related to required timelines. From the date the enrollment roster is received, care coordinators have 10 business days to contact the member by telephone, letter or verified email address to:

- Introduce themselves to the member
- Provide the assigned care coordinator's name and contact information
- Answer any questions the member has about their plan and/or benefits
- Identify a date/time within 30 days of the member's enrollment to UCare to complete a health risk assessment

Member Contacts

Actionable Attempts

Outreach to members requires communication methods that members can act upon. Examples include a voicemail left at a known working number, a letter mailed to a known address, or a secure email sent to a verified email address.

When mailing Unable to Reach letters, allow at least two days between mailings to allow time for the member to respond.

When calling or secure emailing, the attempts should be made on different dates and at varying times.

Initial contact includes either mailing a "Welcome Letter" or contacting the member by phone to provide the name/contact of the assigned care coordinator within 10 business days of enrollment notification. Mailing the Welcome Letter does not count as one of the four actionable attempts to reach the member to complete the assessment.

Thereafter, contacts completed by care coordinators to complete the assessment, reassessment or mid-year review are ideally, actionable attempts completed by three phone calls and one letter. If phone calls are not actionable (e.g., number unconfirmed/not working), then additional letters are acceptable.

Reference: MSC+/MSHO Letters Guide for the selection and descriptions of UCare letters.
Member Engagement Strategies Job Aid for tips on locating and communicating with members.

Using Interpreters

UCare provides interpreter services for American Sign Language and spoken language/limited English proficiency for members of Minnesota Senior Care Plus (MSC+), UCare Connect, UCare Connect + Medicare and UCare's Minnesota Senior Health Options (MSHO) plans for the purpose of completing assessments and ongoing care coordination (i.e., transition of care, mid-year review and other member/care coordination) communication needs.

Arranging Interpreter Services

Telephone Interpreters: Care coordinators may use telephonic translation services when contacting members who speak a different language or to schedule a telephone interpreter at a specific time. UCare partners with Certified Language Interpreters (CLI) to provide telephonic interpretation for members with limited English proficiency.

Telephone interpreter outbound call: See the CLI Interpreting Service Delegate Instructions.

Scheduled telephonic Interpreter Services: See CLI Pre-Scheduling Instructions. A customer code has been provided to each delegate agency. CLI recommends 1-2 weeks advance notice to schedule a telephone interpreter service.

In-Home Assessment/Other Visit Interpreter: To schedule an in-person interpreter for American Sign Language or members with limited English proficiency, care coordinators should contact a UCare contracted interpreter agency directly. Use the UCare Provider Manual to search (control F) "Contracted Interpreter Service" to locate the most recently updated contracted interpreter service agencies. When using contracted interpreters, care coordinators will need to review and sign interpreter work orders. Interpreter agencies have individual requirements related to advance notice. UCare encourages care coordinators to schedule at least two weeks in advance to ensure interpreter availability.

90-day Monitoring Period for CT/MSC+ Members and Using Interpreters

Interpreter agencies submit claims under the member's UCare ID (not the PMI). If an interpreter claim is submitted for an MSC+ member during their 90-day monitoring period due to inactive MA, the claim will be denied. Contact the Clinical Liaison Team at MSC_MSHOClinicalLiaison@ucare.org who will notify UCare's internal Configuration and Claims Operations team to create an exception. Once the exception is in place, the interpreter provider can resubmit the claim. If the agency fails to submit a timely claim (within 6 months of the date of service) to ensure a denial is in the system, UCare is not able to render payment.

Assessment and Support Planning Overview

DHS and CMS regulations help define the requirements for care coordination tasks. It's important to ensure timelines are adhered to for regulatory compliance.

Assessment

The care coordinator completes an annual assessment with members to understand what's important to and for the member and how the person is using health care.

Support Planning

With the member, the care coordinator helps develop goals, supports and interventions related to needs identified in the assessment that will help the member improve health outcomes.

Ongoing Caseload Management

Care coordinators maintain the relationship with members throughout the year. Follow-up is a minimum of bi-annually (mid-year review) to review goals as well as during hospitalizations (aka Transition of Care).

The Assessment

An MSC+/MSHO assessment is completed within 30 days of the member's enrollment date and thereafter reassessed within 365 days and before the capitation date (for EW). The capitation date will be explained in more detail in the Elderly Waiver section. If a member requests an assessment or if there is a significant change in the member's condition, a new assessment is to be completed within 20 business days of the request or change.

UTR/Refusal Reassessment Due Dates

Reassessment timelines differ for members who are Unable to Reach (UTR) or Refusals at the time of initial assessment. For UTR/Refusal members, the first reassessment is due within 365 days of the previous UTR/Refusal and before the member's original enrollment date. Subsequent reassessments are completed within 365 days of the previous year's activity date.

- UTR Activity Date: date of last actionable attempt to reach member for assessment
- Refusal Activity Date: date member verbally refused/declined HRA

Reference: Assessment Timelines Job Aid for examples of UTR/Refusal reassessment timelines.

Assessment Tools and Methods

The assessment tool care coordinators use depends upon the member's situation. Care coordinators are encouraged to utilize the MSC+/MSHO Assessment Checklist MnCHOICES as a guide to complete tasks.

Assessment Methods

DHS and CMS provide guidance on the method of assessment (e.g., in-person, phone, televideo). In preparation for the assessment, care coordinators must determine the appropriate method based on the member's situation. Initial EW assessments, CFSS assessments and all Institutional Member Health Risk Assessments are completed in person. EW reassessments completed via phone or televideo require an additional member encounter during the year.

Reference: MSC+ and MSHO In-Person Assessments Job Aid | In-Person Assessment Methods Decision Tree

Preparation for Assessment:

To prepare for the assessment, care coordinators review MnCHOICES for member information, add the appropriate role designation, choose the appropriate assessment type to be completed and update the member's MnCHOICES profile with known information. The MnCHOICES assessment is taken "offline" when completing the assessment. In addition, CCs review past support plan goals (as applicable) and gather additional member handouts/educational materials, ROI and Safe Disposal of Medication information (as applicable). It may also be helpful to print the MnCHOICES support plan signature sheet.

Reference: Member Handouts | How to Safely Dispose of Medication | TOC Member Handout

Gaps in Care Report / Quality Action List

Gaps in Care Reports, also known as Quality Action Lists, are provided monthly to all delegates via the SecFTP. A gap in care is a missing preventative care element that the member may benefit from completing. Examples include the annual wellness exam, colonoscopy, mammogram, dental exam, medication compliance, and diabetic lab work. Care coordinators review the UCare Gaps in Care Report for any identified information that may be used as talking points during the assessments and other member engagements. The care coordinator's role is to provide education, encouragement, resources, assistance with overcoming barriers to completion and assistance with coordinating care to close the gap. This report is one of several sent to CCs to aid in optimal coordination of care.

Reference: Reports

Completing the Assessment

Care coordinators use a conversational communication style and motivational interviewing skills to conduct assessments. The conversation is meant to encourage members to talk about needs and identify barriers and reasons for wanting to change. As part of the assessment, it's important care coordinators:

- Listen to and observe the member's situation to identify strengths, risks and potential supports
- Address preventative care needs (gaps in care)
- Provide information on the Safe Disposal of Medications
- Educate on UCare benefits that could support member goals
- Address the completion and updating of Health Care Directives

DHS permits UCare care coordinators who are also the disability waiver case manager to utilize the MnCHOICES Assessment tool to meet both UCare care coordination and disability waiver assessment requirements.

Reference: Additional & Supplemental Benefits | Member Handouts | Assessment Checklist MnCHOICES

Assessment Tools

MnCHOICES Assessment**	• Required for Elderly Waiver • Required for members accessing Personal Care Assistance • 4 actionable attempts to schedule assessment • See In-Person Assessment Job Aid for methods and additional encounter requirements
HRA-MCO	• Health Risk Assessment (HRA) for community non-EW members • Completed when member is on other waivers (CADI, DD,BI,CAC) • Completed for members that are Unable to Reach or Refusals • See In-Person Assessment Job Aid for assessment methods
TRANSFER MEMBER HRA (THRA)*	• Transitional tool for members with a product change or MCO transfer • Must review assessment/support plan completed w/in previous 365 days • Reassessment due 365 days from previous assessment • May be completed in-person or via phone
Institutional HRA (IHRA)*	• Stand-alone assessment for members living in skilled nursing facility • Designed to focus on unique needs of members living in nursing home • Institutional member assessments are completed in-person
Additional Assessment Tools	• OBRA 1 (not intended for IHRA) • DHS-6914 Caregiver Assessment (required when caregiver identified) • DHS-3428M Mini Cognitive Exam • PHQ9 Depression Screening (optional)

* Tools located on the Care Coordination and Care Management website.
** A Functional Needs Update is a remote MnCHOICES assessment that can be used to document a change to a person's assessed need(s) at any time during the service agreement year.

MMIS Entry

Medicaid Management Information System (MMIS). Care coordinators need access to the BlueZone application to enter MnCHOICES assessment activity into MMIS. Contact your agency's IT department for assistance with your agency's requirements for downloading BlueZone.

Timely MMIS Entry:

Care coordinators use the DHS-3427 LTC Screening Document as the guide for MMIS data entry requirements. UCare requires members open to EW to have reassessments completed within 365 days and entered into MMIS within 30 days of the assessment and before the DHS-specified capitation date. See capitation dates in the EW section.

MMIS Entry Required (Yes/No)		
MnCHOICES Assessment	YES	
HRA-MCO		NO
THRA Activity		NO
FNU Activity *(excluding PCA/CFSS only)*	YES	
Change in Care Coordinator *(EW Only)*	YES	
HRA-MCO Unable to Reach/Refusal		NO
Institutional Member HRA		NO
Temp EW Exit (on day 31) after SNF admit	YES	
Full EW Exit (on day 121) after SNF admit	YES	

Reference: DHS-4669 MMIS Instructions Manual

Transfer Member HRA

Transfer Member Health Risk Assessment (THRA) may be completed when an assessment has been completed within the last 365 days, is obtained, and the member is able to be reached within 30 calendar days of enrollment. By completing the THRA the CC is adopting the assessment as their own. An advantage of the THRA is the member's reassessment timeline remains on the same schedule. If a member's annual reassessment is due within two months of the transfer, the best practice is to complete a new assessment.

Examples of when to use a THRA include:

1. Product Changes: MSC+ to MSHO or vice versa
2. Other MCO to UCare transfer
3. Assessment completed in MnA 1.0 with completed CSP/CSSP

The previous (sending) case management/care coordination entity provides the new (receiving) CC with the most recent copy of the assessment (or it is viewed in MnCHOICES) and the most recent support plan with the signed signature sheet. If unable to obtain the completed support plan or signed Signature Page from the previous (sending), the receiving CC works with the member to review the needs and complete the support plan. The CC will also obtain the required signature sheet.

65th Birthday assessment and MA FFS to UCare

A transfer Functional Needs Update (FNU) is completed in lieu of a THRA for members who have had a 65th birthday disability waiver assessment completed using Revised MnCHOICES by the county case manager and are enrolling in EW or have transferred from MA fee-for-service to UCare and opening to EW within 60 days of the 65th Birthday Assessment. This does not count as a full assessment and applies to members on EW with a MnCHOICES assessment. Members' assessment timeline is based on the original assessment.

When completing the transfer member FNU, the CC completes the "staying healthy" section of the MnCHOICES and completes a new Support Plan – MCO MnCHOICES Assessment.

Reference: MnCHOICES Guidance | Requirements Grid MnCHOICES | Assessment Checklist MnCHOICES

Elderly Waiver Overview

The Elderly Waiver (EW) program funds home and community-based services (HCBS) for people aged 65 and older who are eligible for Medical Assistance (MA) and require the level of care provided in a nursing home but choose to live in the community. The additional services go beyond what is otherwise available through MA. The DHS Community-Based Services Manual is the primary resource related to EW rules.

Members may be eligible for the Elderly Waiver program when they meet the following criteria:

The Long-Term Care Consultation process involves a Certified Assessor completing the MnCHOICES assessment and using the assessment results to determine if the member meets the nursing facility level of care. The assessment will aid in determining the appropriate case mix (for cost-effectiveness and budget purposes) and identifying the member's preferred living arrangements. Members approved for EW subsequently have supports and services authorized by the care coordinator.

References: Long-Term Care Consultation Services | DHS EW Program Info Elderly waiver

Nursing Facility Level of Care Criteria

For nursing facility (NF) level of care, a person must meet **one of the following five categories** of need:

1. Does/would live alone or be homeless without current housing type **and** meets one of the following:
- Has had a fall resulting in a fracture within the last 12 months
- Has a sensory impairment that substantially impacts functional ability and maintenance of a community residence
- Is at risk of maltreatment or neglect by another person or is at risk of self-neglect

2. Has a dependency in four or more activities of daily living (ADLs).
- ADLs include dressing, grooming, bathing, eating, bed mobility/positioning, transferring, walking, toileting

3. Has significant difficulty with memory, using information, daily decision-making or behavioral needs that require intervention.

4. Needs the assistance of another person or constant supervision to complete toileting, transferring or positioning, and this assistance cannot be scheduled.

5. Needs formal clinical monitoring at least once a day.

Reference: DHS-7028 Nursing Facility LOC Criteria

Opening a Member to EW

When a CC determines a member is newly eligible for EW, the member must complete and sign the DHS-3543 Request for Payment of Long-Term Care Services. The CC sends the completed form along with a completed DHS 5181 LTC: Communication of Long-term Supports and Services eligibility form to the member's county of financial responsibility. These documents prompt the member's financial worker to complete the necessary steps in MN-ITS to officially "open" the member to EW.

Capitation Dates

Capitation dates are DHS-specified cutoff dates for Managed Care Organization payment of EW assessments completed. When an EW assessment is not completed and entered into MMIS prior to the capitation date, the MCO is not paid the enhanced EW rate that month. UCare's policy is to complete assessments for EW members within 365 days and enter into MMIS before the DHS-specified dates.

EXAMPLE: An initial MnCHOICES assessment was completed on 2/15/23, with an effective date of 2/15/23.

When an effective date is mid-month, the waiver span ends the previous month of the next year. In this example the waiver span is 2/15/23-1/31/24.

The reassessment would need to be completed and entered into MMIS on or before the capitation date of 1/24/24 effective 2/1/24.

Adjusting the Waiver Spans and Capitation Dates

MMIS entry and adjusting waiver spans affects MCO capitation payment. Waiver spans that are adjusted based on an 11-month reassessment schedule will preclude capitation payment for that month. To ensure MCO capitation payment, please use the examples below as a guide when adjusting EW spans.

SCENARIO**:** Current EW Span: 7/16/23 – 6/30/24
Initial Assessment: 7/16/23

CC considerations:

- Reassessment due within 365 days of previous assessment: 7/15/24
- Within 60 days prior to the waiver span beginning: 5/17/24
- June Capitation date: 6/24/24

Incorrect Example 1: Reassessment completed on 7/6/24 – after the June capitation date, prior to 365 days and within the 60-day window.

- Waiver span 7/6/24 – 6/30/25.
- Incorrect reason: Member would be without EW from 7/1-7/5 as WSAF is not able to be submitted prior to the assessment date.

Incorrect Example 2: Reassessment completed on 6/25/24 – after the June capitation date, prior to 365 days and within the 60-day window

- Waiver span 7/1/24- 6/30/25.
- Incorrect reason: UCare loses 1 month of EW capitation reimbursement due to the assessment being completed and entered into MMIS after the June capitation.

Correct Example 3: Reassessment completed on 6/15/24 – completed and entered before the June capitation date, prior to 365 days and within the 60-day window.

- Waiver span 7/1/24 – 6/30/25.

Correct, but less desired Example 4: Reassessment completed on 5/9/24 –before the June capitation date, prior to 365 days but outside the 60-day window

- Waiver Span 6/1/24-5/31/25
- Less desired reason: This example is not desired due to needing a change in the waiver span unless a member requires or requests an early reassessment.

Managing the EW Budget

When a member is determined eligible for EW using the MnCHOICES assessment, the assessment will generate a case mix classification that considers the member's number of activities of daily living needs along with other factors like the need for behavioral interventions and treatment and monitoring of medical health conditions. The case mix classification correlates to a maximum dollar amount available per month to use toward services and supports to meet the member's needs. Case Mix classification budgets are most often adjusted by DHS on an annual basis.

All HCBS services are budgeted using member's MnCHOICES Support Plan budget tool (see Support Plan section). Services and support costs must be able to be met under the case mix budget capitation.

Reference: DHS-3428B Case Mix Classification Worksheet | DHS-3945 LTSS Rate Limits

MA Services Included in EW Case Mix Cap

Elderly Waiver does not cover services available through another funding source (e.g., Medicare, MA state plan services, long-term care insurance, and UCare's supplemental benefits). Care coordinators ensure approved services and supports authorized under EW are not eligible for coverage by other payment sources. DHS outlines all EW-covered services in the CBSM. To determine if an item is eligible within the member's medical assistance benefit (thus not EW), CCs may review the MHCP manual and the DHS Medical Supply Coverage Guide.

UCare Care Coordination Fee: CCs include a $180/month care coordination fee within the member's case mix cap. The Support Plan—MCO MnCHOICES Assessment does not provide a drop-down option to enter the care coordination fee. CCs enter it under "People and Community Organizations that Support Me" and manually add the $180 to the budget.

Reference: Community-Based | MHCP Manual | DHS Medical Supply Coverage Guide

Request to Exceed Case Mix Cap

If a member has assessed needs requiring services above the budget cap, and attempts to resolve the budget discrepancy have been unsuccessful, CCs may submit a Request to Exceed Case Mix Cap. Resolutions to prevent the need to exceed the case mix cap include but are not limited to, adjusting services that do not affect health and safety or reviewing for duplication of services. UCare's Elderly Waiver Exception Case Review committee meets bi-weekly to review requests. The anticipated turnaround time is approximately 14 days from the date of request. A member of the EW review committee emails the requesting CC with approval/denial information. To avoid delay, care coordinators should ensure clear and thorough documentation is present in the request to justify the need for an increase in the case mix capitation.

Withdrawal of a request to exceed case mix cap: At the member's reassessment, the CC re-evaluates the need for services above the budget case mix cap. If needed, the CC submits a new Request to Exceed Case Mix Cap form for review and approval. A DTR is required to reduce/terminate services that are no longer being used in the previously exceeded case mix cap. A DTR is not needed to discontinue the initial request to exceed the case mix cap.

EW Diversion vs Conversion

EW diversion definition: a person who is not a resident of a skilled nursing facility (SNF) at the time of the initial referral for an assessment. A person will remain diversion until exited from EW.

EW conversion definition: a person who was a resident of a skilled nursing facility (SNF) at the time of the assessment. A person will remain conversion until exited from EW. If the person exits the program and later returns, it should be re-determined if they are now a diversion or a conversion.

Monthly Conversion Budget Limit

Monthly conversion budget limit is defined by DHS as an exception to the monthly case mix budget caps for a person on the Elderly Waiver (EW) who is leaving a nursing facility (NF). An EW conversion rate can be requested when the monthly EW case mix budget capitation amounts are insufficient to support the services a member needs to transition to community living from a skilled nursing facility (SNF). Members are eligible for the EW conversion rate when the member has lived in a certified SNF for 30 or more consecutive days at the time the person requested an eligibility determination for EW.

Requesting an EW Conversion Rate

The care coordinator may request approval from UCare for a monthly conversion budget rate by completing the DHS-3956 Elderly Waiver Conversion Rate Request. and securely emailing the completed form to MSC_MSHO_ClinicalLiaison@ucare.org. UCare's Oversight and Compliance team will review and approve as applicable. Once reviewed and approved, the CC will receive email communication within 5-7 business days. Members who have a monthly conversion budget limit must receive annual approval from UCare to continue the higher budget limit.

Withdrawing EW Conversion Rate:

If a member no longer needs a conversion budget when the person's needs can be met within the published monthly case mix budget caps. A DTR is needed when denying, reducing or terminating services as a result of a change to the member's service plan, not to discontinue the EW conversion rate.

Reference: DHS-3945 LTSS Rate Limits | EW Conversion Rates

Consumer Directed Community Support (CDCS)

CDCS is a service option that gives members open to EW flexibility and responsibility to direct their own services and supports. CDCS may include services, supports and items currently available through the Medical Assistance waivers, as well as additional services.

Care coordinators new to CDCS should view the DHS CDCS Online Learning Module which includes an overview of the CDCS program. UCare's CDCS Care Coordination Toolkit located on the Care Coordination and Care Management website includes care coordinator-specific CDCS instructions and requirements as well as member tools and resources to aid in CDCS compliance.

NOTE: All CDCS budgets require agency supervisor review and approval.

References: UCare Care Coordination CDCS Guidelines | DHS CDCS Policy Manual | DHS EW Program Info Elderly waiver

Residential Services: Customized Living (CL)

Customized Living and Foster Care Services can be funded under Elderly Waiver (EW) and typically are provided in an assisted living community or adult foster care settings. Care coordinators are responsible for managing the residential services plan & budget for MSC+ and MSHO members open to the Elderly Waiver using the MnCHOICES Support Plan Rate Tool. The total cost of services is added to the MnCHOICES services and supports on the support plan and included on the WSAF. See WSAF section for authorizing instructions.

Customized Living vs 24-Hours Customized Living Eligibility

Members residing in a Customized Living community are eligible for either regular Customized Living or 24-hour Customized Living support.

To be eligible for Customized Living, a person must:

- Be open to Elderly Waiver
- Have an assessed need for one of the regularly scheduled, health-related and supportive services
- Live in an eligible Customized Living setting

To be eligible for 24-Hour Customized Living, a member must:

In addition to the above requirements, a member is eligible to receive 24-hour CL if they have an assessed need for at least one of the following four requirements:

1. Cognitive or behavioral intervention
2. Clinical monitoring with special treatment
3. Dependency in at least one of the following activities of daily living (ADLs): toileting, positioning or transferring
4. All of the following assessed needs:
    - Dependency in at least three of the following ADLs: bathing, dressing, grooming, walking or eating (when eating is scored as "3" or greater)
    - Medication management
    - At least 50 hours of direct services per month. The care coordinator must approve these 50 hours of direct services in the individual, 24-hour CL service plan

Reference: CBSM Customized Living (including 24-hour customized living) | Customized Living and Foster Care Service

Elderly Waiver Service Providers

UCare does not contract for EW services. EW service providers must be registered with the Minnesota Department of Human Services to be eligible as a UCare EW participating provider. EW Providers can view information on UCare's website at Non Contracted Providers (ucare.org).

To locate an enrolled EW provider for services, care coordinators utilize MinnesotaHelp.info. The provider must have Elderly Waiver (EW) listed for payment accepted on MinnesotaHelp.info. All EW services require authorization from UCare, which generates a Service Authorization Letter (SAL) for the member and the EW provider. The care coordinator submits a Waiver Service Approval Form (WSAF) to UCare CLSIntake@ucare.org to be reviewed and an authorization is entered into the UCare system. See Waiver Service Authorizations section for additional details.

IMPORTANT: For newly participating EW providers who are not enrolled in UCare's claim payment system, the EW provider must complete and submit the UCare Facility Add Form for each location/service agency using the EW providers UMPI/NPI. EW providers will be notified by email when the process is complete. If EW providers have questions on how to enroll as a UCare EW participating provider, how to submit claims or other billing-related questions, the EW provider can be directed to contact UCare's Provider Assistance Center (PAC) at 612-676-3300 Monday-Friday, 8 am-5 pm.

Non-Waiver HCBS

Moving Home Minnesota (MHM)

MHM is a program designed to create opportunities for members to move from a skilled nursing facility/institution to a residence in the community.

Reference: Moving Home Minnesota Job Aid for additional criteria and instructions

Housing Stabilization Services (HSS)

HSS is an MA benefit to help people with disabilities, substance use disorders and seniors find and keep housing. HSS providers can be located on the MinnesotaHelp.info website. MSC+/MSHO care coordinators provide the Support Plan – MCO MnCHOICES Assessment to HSS service providers to include with eligibility documentation submitted to DHS for approval. Connect/Connect + Medicare care coordinators refer to the member's waiver case manager or county of residence for assessment and support planning for HSS services.

Reference: Housing Stabilization Services Job Aid for additional criteria, programs under HSS, and instructions.

In Lieu of Services

In lieu of services are interventions that prevent a member's emergency room visit, avoidable inpatient care, and more acute services or drugs used due to the member-facing barriers to safe, healthy, independent living and community integration that can be addressed with home and community-based services.

ILOS may be used as a bridge to temporarily support members' assessed needs while awaiting Elderly Waiver (EW) authorization or to meet acute needs. Members open to EW/CADI/BI/DD would not be eligible for ILOS as these programs provide services covered under ILOS. If a member chooses not to enroll in EW d/t waiver obligation, ILOS is not an option. Care coordinators (CC) should also consider whether the member is eligible for MSHO supplemental benefits before requesting ILOS.

Reference: In Lieu of Service Request Instructions | In Lieu of Service Request Form

Waiver Service Authorizations (WSAF)

Care coordinators must comply with all Elderly Waiver program rules according to the DHS Community-Based Services Manual and follow applicable DHS bulletins and directions.

- EW is always the payor of last resort
- Care coordinators must be fiscally responsible when utilizing EW
- Adhere to DHS Service Rate Limits
    - Care coordinators may approve rates up to, but not over the DHS Service Rate Limits without an approved exception
- Care coordinators aim for the most cost-effective way to meet needs - this does not always mean the least costly
- UCare utilizes the DHS MHCP Provider Manual as the primary resource for a list of EW Covered Services

- UCare does not contract directly with EW providers but rather utilizes enrolled Minnesota Health Care Programs (MHCP), the state's network of EW providers.

Reference: EW Budget Worksheet

Care coordinators are the primary authorizing entity for all EW services. Some common reasons a WSAF/T2029 WSAF may be sent back are:

- Not enough information or explanation of need
- Potential duplication of service
- Unclear if additional or supplemental benefits are exhausted
- HCPC code missing or incorrect
- Missing provider information (i.e.: email address or NPI)
- Member information missing or incorrect
- T2029 being used for an item covered by medical benefit

There are two forms care coordinators submit to UCare to approve HCBS.

1. Waiver Services Authorization Form
2. T2029 Specialized Equipment and Supplies WSAF

NOTE: These forms are not used for authorization of CFSS/Extended CFSS nor Extended Home Care Services.

T2029 Equipment and Supplies

A member is eligible to receive specialized equipment and supplies if the item allows the member to do one of the following:

- Communicate with others
- Perceive, control or interact with their environment
- Perform activities of daily living (ADLs)

UCare has developed additional guidance related to T2029 Equipment and Supplies. The Elderly Waiver T2029 Equipment and Supplies Waiver Service Job Aid outlines care coordination steps to ensure the T2029 is the appropriate and cost-effective avenue for meeting the member's needs. Additionally, UCare's Elderly Waiver T2029 Equipment and Supplies Guide provides detailed guidance on specific items for T2029 consideration. The CC should ensure guidelines are reviewed and followed to avoid delay in authorization.

NOTE: T2029 requests over $500 and other items require additional agency supervisor review prior to submitting the authorization. See the EW T2029 Equipment and Supplies Job Aid for details.

Reference: EW T2029 Equipment and Supplies Job Aid | EW T2029 Equipment and Supplies Guide

DHS Resources

CBSM Specialized Equipment and Supplies | Environmental Accessibility Adaptations
DME Coverage Guide | T2029 Specialized Equipment and Supplies

What to Expect After Submitting a WSAF and T2029

UCare's CLS Intake team enters the WSAF and T2029 information for claims payment purposes. The estimated turnaround time for processing is 14 calendar days. UCare provides the EW provider with a written service authorization letter (SAL) of all EW services via fax. Care coordinators receive notification of authorizations via Daily Authorization Report (DAR). See DAR section below.

EW Provider Signature

During the assessment, care coordinators review the member's choice of sending the full support plan, a summary of the support plan, or not sending the support plan to each of the indicated EW service providers.

When sending a full support plan, it is accompanied with the Elderly Waiver Provider Support Plan Cover Letter. When sending a Support Plan summary, it is accompanied with the Elderly Waiver Provider Support Plan Summary Letter.

- Document member choice(s) on the Support Plan Signature Sheet
- For EW service providers receiving a full support plan or summary, the CC is required to make at least two attempts to obtain signatures within 60 days

NOTE: If there are multiple providers, the member can choose a different option for each provider. A signed ICLS Planning form meets this requirement.

Community First Services and Support (CFSS)

Community First Services and Supports (CFSS) is a Minnesota health care program that offers flexible options to meet the unique needs of members. CFSS allows people greater independence in their homes and communities. CFSS will replace personal care assistance (PCA) and the Consumer Support Grant (CSG).

Members will transition from PCA to CFSS at reassessments occurring on or after 10/1/24 or new member assessments completed on or after 10/1/24. Eligibility for CFSS is the same as it is for PCA. People currently eligible for PCA, will remain eligible for CFSS unless there has been a change in condition. CFSS covers all the same services as PCA and offers more choices for who can serve as the CFSS worker such as a spouse or minor child. Members who use CFSS can also serve as the CFSS worker for others. Members have a worker training and development budget, the ability to purchase goods, services and PERS and the ability to choose between two service models: agency or budget.

Reference: Transition from PCA and Consumer Support Grant to CFSS | CFSS Eligibility Training

CFSS Covered Supports

Activities of daily living (ADLs): Activities a person needs to carry out daily to remain healthy and safe. Covered ADLs: dressing, grooming, bathing, eating, positioning, transfers, and mobility.

Instrumental activities of daily living (IADLs): Activities a person needs to carry out on a regular basis to remain independent. Examples include accompanying to medical appointments, shopping, paying bills and meal preparation.

Health-related procedures and tasks: Tasks such as supporting a person with self-administered medications, providing immediate attention to health and hygiene, or helping with range-of-motion exercises.

Observation and redirection of behaviors: Monitoring a person's behaviors and redirecting them to more positive behaviors when needed.

Goods and Services: increase independence, decrease or replace human assistance, cost differences, PERS (criteria)

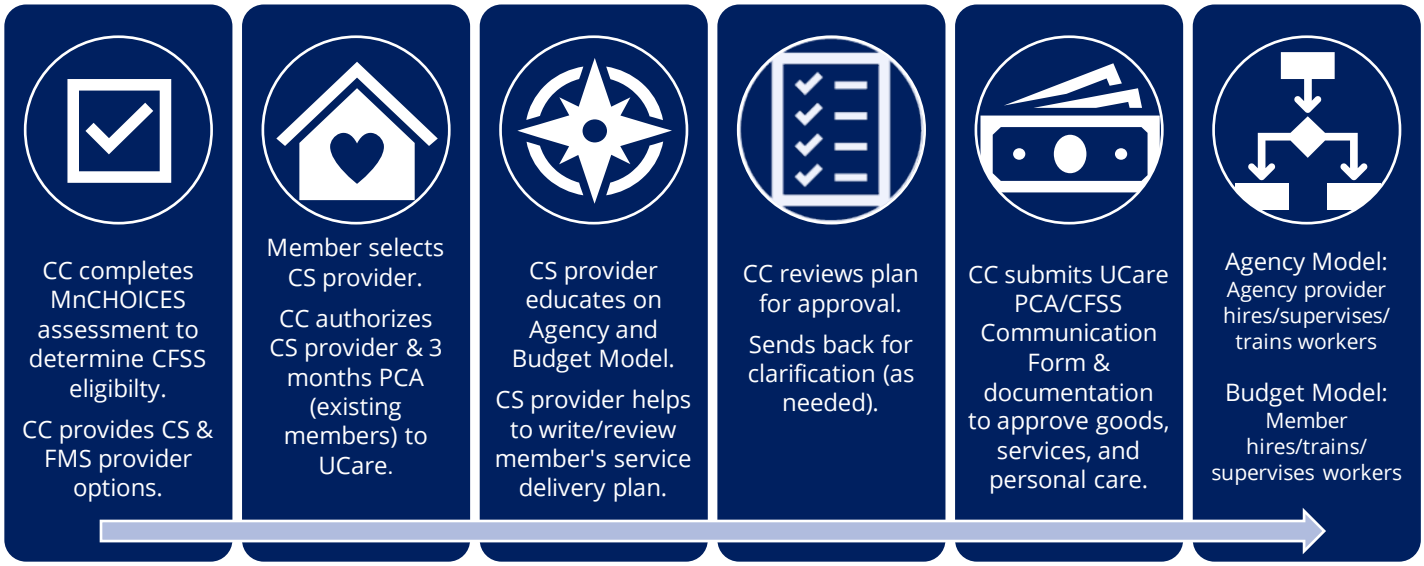
Reference: CFSS Policy Manual

CFSS Training

Care Coordinators are required to complete DHS training for CFSS. In addition, UCare has established updated CC guidelines to ensure a smooth transition to CFSS. The CC CFSS Guidelines provide detailed instructions on the assessment, support plan, authorization and ongoing monitoring of CFSS.

Reference: Course: CFSS_LA | CFSS Frequently Asked Questions

CFSS Process Flow



Reference: CFSS Care Coordination Guidance | PCA/CFSS Communication Form Instructions

Individual Community Living Supports (ICLS)

ICLS is a bundled service that includes six service components: adaptive support services, activities of daily living (ADL), active cognitive support, household management, health, safety, wellness and community engagement. A member may not receive ICLS if they are living in Adult Foster Care, Customized Living (including 24-hour customized living) nor if receiving support through Moving Home Minnesota. ICLS is not an appropriate service to meet a person's need for constant supervision or physical assistance with ADLs throughout the task, except for bathing. CFSS is the service designed to meet this level of need for ADL assistance.

Who Can Provide ICLS to a Member

An ICLS provider must be an enrolled DHS provider and meet DHS Licensure requirements as a basic support service provider, comprehensive home care license with HCBS designation or meet one of the three requirements for a non-agency provider. To provide ICLS, all providers must have a completed background study that allows for direct contact services. An ICLS provider may be a family member (not spouse) or non-professional legal/guardian/conservator to a member if the individual meets certain criteria. See: CBSM - Paying relatives and legally responsible individuals (state.mn.us)

ICLS Provider Limitations

An ICLS Provider:

- May not be a spouse of the member
- May not be a licensed assisted living provider where the member resides
- May not be a home care provider in an affordable housing setting where the member resides
- May not be a legal guardian or conservator to the member
- May not be a landlord to the member
- May not have a financial interest in the member's housing

Authorizing ICLS

Based on the member's assessed needs, a member:

- May receive up to 12 hours of ICLS services per day (i.e., 48 15-minute units per day) and,

- Must have face-to-face in-person support scheduled at least weekly and,
- Must receive a minimum of two ICLS service components

The care coordinator works with the member to complete DHS-3751 ICLS Planning Form to communicate to the ICLS provider the specific service components the person will receive. The ICLS services are included on the member's Support Plan-MCO MnCHOICES Assessment form. Care coordinators can locate DHS enrolled ICLS providers using MinnesotaHelp.info.

Reference: Elderly Waiver Service Providers

On the DHS-3751 ICLS Planning Form, the care coordinator must:

- Identify the person's individual goals the ICLS service is intended to support
- Describe and provide details about the type of support the person will receive within a minimum of two ICLS service components
- Calculate the total amount of units and cost of ICLS services the person will receive each week

The member, care coordinator and ICLS provider must sign the completed DHS-3751 ICLS Planning form. Then, the care coordinator must provide a copy to the person and the ICLS provider. Once signatures are received, the CC may submit the UCare WSAF to authorize ICLS. The care coordinator is responsible to review and update the DHS-3751 ICLS Planning Form at least annually.

ICLS vs CFSS

If a member meets the dependency for needing CFSS services with an identified activity of daily living (ADL), it is not appropriate for the ICLS provider to support that need as the member's needs are greater than what the ICLS provider is allowed to assist the member. Typically, a member would go from CFSS to ICLS only if the member's condition has improved and they have gained independence since the last assessment.

Care coordinators using multiple services should clearly document defined roles and responsibilities for service providers including what needs each service provider is meeting. CCs may not authorize duplication of state plan home care or other EW services the person already receives.

Member's with ICLS Annual Reassessment

If the member is currently receiving ICLS services, the care coordinator must review the need for ICLS services at the next scheduled assessment to ensure the person's need meets the requirement of at least two ICLS components. If the member does not meet the minimum requirement, the care coordinator cannot reauthorize ICLS. Instead, they must authorize the service that meets the person's identified need. A DTR is required if ICLS is being denied, reduced or terminated.

Both the care coordinator and ICLS provider must keep a copy of the completed and signed DHS-3751 ICLS Planning Form. The ICLS Planning Form can be used to meet the provider signature requirements for the support plan. CC would not have to send out the UCare Provider Signature request.

Reference: CBSM - Individual community living supports (ICLS) (state.mn.us)

State Plan Home Care Services Authorization

Skilled Nursing Visits and Home Health Aide

The actions by the CC when coordinating home care services will vary depending upon who the payor is for the services. Authorized home service providers will receive notification of authorized services via mailed letter. Care coordinators are notified via the Daily Authorizations Report of approved authorizations for service paid by UCare.

Who is the Payor?

UCare is the Home Care Services Payor

UCare MSC+/MSHO members do not require authorization for skilled nursing visits nor home health aide when using an in-network provider. The in-network home care agency submits the appropriate claim directly to UCare.

CADI, BI, DD, CAC Receiving MA Home Care Services Paid by UCare

When a member is open to a community disability waiver, the county waiver case manager faxes the DHS-5841 to 612-884-2499 to authorize state plan services. The waiver case manager may share the DHS-5841 with the care coordinator for collaboration and good communication purposes. Care coordinators initiating state plan services for members on disability waivers are required to send the DHS-5841 to the county waiver case manager to communicate that services will need to be approved and included in the member's waiver budget.

Medicare Eligible Home Care Services

MSC+ with non-integrated Medicare: because Medicare is the primary insurance payor, a Medicare enrolled home care agency submits the claim directly to the member's Medicare insurance plan. UCare is not an authorizing agent and will coordinate the payment of any related co-payments/deductibles for Medicare covered services.

Elderly Waiver Extended Home Care Services

Services that follow Medical Assistance (MA) state plan home care policies are allowed to exceed the limits on amount, duration and frequency. When MA allowable coverage for Home Care Services is exhausted, the care coordinator may use the Home Health Communication Form to authorize member eligible extended services. Extended services need to fit within the member's waiver budget limit.

Reference: CBSM - Extended home care services | UCare Authorization & Notification Requirements

Daily Authorizations Report (DAR)

UCare utilizes a Secure File Transfer Portal (Sec FTP) to share confidential member information with counties and care system partners. UCare Secure File Transfer Portal website is https://secftp.ucare.org. The DAR is one example of reports provided through the Sec FTP.

Three reports on the DAR:

- Admissions to hospitals and nursing homes
- Discharges from hospitals and nursing homes
- Approved Authorization of Services (EW, T2029, HHA, PCA/CFSS, ARMHS, etc.)

Action by care coordinators:

- Those with access to the SecFTP disseminate reports with appropriate parties
- Review DAR for submitted WSAF and other approved authorizations
- If the CC does not see the service authorization within 14 calendar days of submission to UCare, call the CLS Intake line at 612-676-6705 option 2 then option 5. A response will be provided within 2 business days.
- Review DAR for admission/discharges and Transition of Care assistance needs

Denial Termination or Reduction (DTR) of UCare Paid Services

Services being denied (based on lack of need), terminated (based on member's request or other reason) or reduced (based on member's request or other reason) require care coordinators to submit a DTR form to UCare within **one day** of determination. The DTR form submitted varies based on the service (see table below). The purpose of the DTR is to provide members with appeal rights in a timely manner. UCare care coordinators complete the EW DTR Notification Form in its entirety for any denial, termination, or reduction to Elderly Waiver services within one business day of the determination and at least 14 days prior to the ending of services. UCare provides additional guidance on DTRs' on the Care Coordination and Care Management Elderly Waiver resources titled DTR Instructions and the DTR Waiver Situations: Reason Codes Decision Tool.

EW DTR Form	PCA/CFSS Communication Form	Home Health Care Communication Form
•Used when denying, terminating or reducing an EW paid service. •Denial: a request for homemaking is denied •Termination: chore services ending per member request or terminating EW eligibility •Reduction: homemaking reduced from 5 hours to 2 hours weekly	•Used when denying, terminating or reducing requested by a member: •PCA/CFSS •Extended CFSS services •NOTE: Also used to authorize PCA and communicate CFSS changes	•Used when reducing or terminating: •Home Health Aide •Extended HHA •Skilled Nursing Visits •NOTE: Also used to authorize EW Extended HHA

NOTE: DTRs are required for EW services paid for by UCare. If the service is being paid by Medicare or another payor, UCare does not require DTRs.

EW DTR and Skilled Nursing Facility (SNF) Admissions

When an EW member is admitted to a SNF for 30 days, on day 31 the CC is required to complete a DTR for the member's SERVICES using code 1621. Enter MMIS 07/53 to temporarily close EW. If the member returns to the community, the CC enters MMIS 07/54 to restart EW with a partial eligibility waiver span. A new WSAF is needed if the member returns to the community for the remaining waiver span. If the member remains in the SNF for greater than 120 days, the CC completes the DTR for EW eligibility on day 121. Day one is the date of admission to the nursing facility. Reference Admissions to Nursing Facility for more information.

The Support Plan

A support plan is a person-centered written summary of the assessment that includes what's important to and for the member. Essential elements of the support plan include:

- Accounting for all the member's identified risks, preferences, supports, barriers
  - Identified risks and declined interventions are included on the support plan in "My Plan to Address Safety Needs"
- At least one high priority goal
- Identifying the members Interdisciplinary Care Team (ICT)
- Maintaining at least one active/open goal
- Monitoring for achievement at mid-year or more frequently based on the agreed upon follow up plan
- Adjusting target dates when target surpassed or exceeded
- Writing goals in the SMART (Specific, Measurable, Attainable, Realistic, and Time Bound) format
  - See SMART Goals Job Aid and SMART Carte
- Including interventions/"My Supports" the member chooses to help achieve the goal

Support Plan Tools

The support plan tool used varies based on the type of assessment being completed with the member. All support plans are completed and shared with the member/responsible party, the member's primary care provider, the community waiver case manager, and other members of the ICT per member's choice within 30 days of the assessment. The UCare Support Plan letter or Support Plan Signature Letter accompanies the mailed support plan.

Reference: MSC+ and MSHO Letters Guide.

Support Plan - MCO MnCHOICES Assessment	• Assessment information pulled from MnCHOICES Assessment or HRA-MCO • Support Plan completed and provided to member/responsible party, PCP and other member of the member's ICT w/in 30 days of assessment
Institutional Support Plan*	• Institutional Support Plan is a stand-alone document for members living in a skilled nursing facility • IHRA Support Plan completed and provided to member/responsible party, PCP and other members of the ICT w/in 30 days of assessment
Unable to Reach Support Plan*	• Four "actionable attempts" via phone, email, or letter are completed to reach the member to schedule an assessment • **MSHO:** completes the UTR Support Plan • **MSC+:** documents outreach attempts and outcome in member record
Refusal Support Plan*	• Up to four "actionable attempts" to reach the member to schedule an assessment • **MSHO:** If at any point the member is reached and verbally declines an in-person assessment, document and complete the Refusal Support Plan • **MSC+:** document outreach attempts and outcome in member record

* Tools located on the Care Coordination and Care Management website.

Signature Requirements

Members/legal representative must provide a signature indicating agreement with the support plan/Institutional support plan to complete the support plan. This may be done in person via electronic signature, or the MnCHOICES Signature Sheet may be mailed to obtain. The Institutional Support Plan includes a signature area. If mailed, the CC must document at least one additional follow-up attempt by phone or letter to obtain the Signature Sheet within two weeks of the mailing date if not obtained.

Ongoing Caseload Management

Support Plan Revisions

Care coordinators create a follow-up plan with the member based on the member's request, identified risks, needs and fragility to monitor goal progress. While UCare requires a minimum follow-up plan of bi-annually, also known as a mid-year review, follow-up plans should be adjusted based on the specific member's needs.

- UCare allows a 5-to-7-month window of time to complete the mid-year review
- Revisions to the support plan are completed within the MnCHOICES application in the monitoring progress section of the most recently revised support plan

UTR/Refusal Members and Support Plan Updates

All members, regardless of completed assessment type, require a mid-year review. At the mid-year review, the care coordinator completes the required four actionable attempts to reach the member. If the member is reached, the CC should continue to learn more about the member's situation, offer assistance where applicable, provide education on member benefits and offer an assessment. If the member accepts the invitation to complete an assessment, the UTR/Refusal Support Plan is closed and a new MnCHOICES Support Plan – MCO HRA is completed. If the member continues to be UTR/Refusal:

- MSHO: Document update on the UTR/Refusal Support Plan
- MSC+: Document update in the member's record

Care Coordinator's Support Members in the Following Areas:

- Managing all aspects of the member's Elderly Waiver assessment, authorization, support planning and ongoing case management
- Facilitating provider visits, closing gaps in preventative care and assistance in removing barriers members may be facing related to obtaining care
- Arranging and coordinating supports and services identified through the assessment and support planning process
  - Referral to providers
  - Obtaining equipment and supplies
  - Arranging medical transportation – See Transportation Job Aid
  - Approving and arranging EW transportation
- Facilitating informed decision making to encourage control over services and supports
- Health plan related issues
- Education around good health practices, including wellness and preventive care needs
- Assisting members with accessing formal and informal supports
- Coordinating services and supports provided by the Veteran's Administration (VA) for eligible members
- Assisting members through transitions of care

Collaboration with Other Case Managers

Care coordinators are required to collaborate with all member's ICT, including case managers for members with CADI/DD/BI/CAC waivers, Behavioral Health Home, Targeted Case Management, Hospice, Adult Rehabilitative Mental Health Support (ARMHS) or who are enrolled in the Restricted Recipient program.

Members on Other Waivers

When a member who is on a CADI, CAC or BI waiver turns 65 years old, the member may choose to remain on the current waiver. If they choose to move to EW, they may only return to CADI, CAC or BI if certain criteria are met. Members of any age may access the DD waiver if eligible.

Care coordinators review the waiver case manager's support plan to better understand the member's needs, supports and services and to avoid duplication. Care coordinators also share the CC support plan with the waiver case manager and communicate member updates throughout the year. When initiating State Plan Services, the CC uses the DHS-5841 to communicate with the waiver case manager and request/approve Home Care, Home Health Aide, Physical Therapy, Occupational Therapy, and Speech Therapy,

Locating County Case Manager: Care Coordinators may use the County and Tribal Nations Office contact information to locate a member's case manager or, alternatively, use MnCHOICES member search to identify the case manager information.

UCare Care Coordinator Responsibilities	CADI/DD/BI/CAC Case Manager Responsibilities
MnCHOICES Assigned Role: Care Coordinator **Assessment tool:** HRA-MCO	**MnCHOICES Assigned Role:** Certified Assessor **Assessment tool**: MnCHOICES Assessment *Waiver CM determines waiver and CFSS eligibility*
Care Coordinator: Completes Support Plan - HRA	**Case Manager (CM):** Completes MnCHOICES Support Plan
Areas of Focus	
Assist to access medical care, preventative health education and closing Gaps in Care	Authorize HCBS, CFSS, and home care services

Send 5841 to Waiver CM when initiating State Plan Services	Sends the DHS-5841 to UCare to authorize State Plan Services
Education on health plan benefits assist with access to supplemental benefits	Education on wavier covered HCBS
Community resource referrals *Both CC and Waiver CM provide support with community resources*	
Collaborate with ICT: CC shared support plan with PCP, waiver CM, BHH (as applicable) and other ICT members	Waiver case manager shares MnCHOICES Support Plan
Coordinate MA covered medical equipment and supply needs	Coordinate waiver covered housing, equipment and supply needs
Transportation to UCare covered medical appointments	Transportation to waiver covered supports
Transition of Care support* *communication/collaboration with PCP, BHH and waiver case manager (as applicable)	Collaborate with CC on waiver covered support needs
UCare completes PAS for care coordination non-waiver members	Waiver CM completes OBRA II as applicable for UCare members

Behavioral Health Home (BHH)

The term "behavioral health home" services refers to a model of care focused on integrating primary care, mental health services, and social services and supports for adults diagnosed with mental illness. The BHH services model utilizes a multidisciplinary team to deliver person-centered services designed to support a person in coordinating care and services while reaching his or her health and wellness goals.

Care coordinators are notified of members' Behavioral Health Home service providers via fax or email. Within 30 days of notification, the CC is to provide the BHH provider with the CC's contact information and support plan and establish an agreed-upon method/frequency of contact. Care coordinators should ensure the BHH is included as a member of the ICT and communicate changes with the BHH provider, including but not limited to emergency room use and Transitions of Care.

Reference: Behavioral Health Home Job Aid

Restricted Recipients

The Minnesota Restricted Recipient Program (MRRP) is a program for Minnesota Health Care Program recipients developed and operated under the direction of the DHS for recipients who have used services at a frequency or amount that is not medically necessary or in the best interest of their health.

MN-ITS will identify individuals who are enrolled in the MRRP. Members are enrolled for 36 months or longer if continued eligibility is met. UCare MRRP case managers are assigned to enrolled members. Upon eligibility, members must designate a Primary Care Provider (PCP), clinic, hospital (including emergency room) and a pharmacy location. If a member wishes to change designated providers, the member may contact UCare's Mental Health and Substance Use Disorder Services team at 612-676-3397.

For full details about the Restricted Recipient Program and referral forms, please reference the provider manual or the Authorizations page under Resources & Information, then Restricted Recipient Program.

Members on Hospice

For members who have elected hospice, care coordinators continue to be involved, complete all care coordination processes including annual reassessments and corresponding paperwork, and communicate and collaborate with the hospice care team and ICT. Care coordinators should consider asking to participate in Hospice case discussions. Elderly Waiver services continue while on Hospice. Support plans may be adjusted based on new or changes in service

providers/payors. For additional information refer to the Hospice Benefit in the UCare Provider Manual keyword HOSPICE.

Note: Hospice agencies, in addition to other UCare network providers, can be found using the UCare Provider Search tool.

Transition of Care

A member's movement from one care setting to another setting due to changes in the member's health status is called a Transition of Care (TOC).

Example: a member is admitted to a hospital from their home as the result of an exacerbation of a chronic condition; then, the member moves from the hospital to a skilled nursing facility for ongoing care. Each move is one TOC.

Care Coordinators (CCs) act as a consistent person to support the member throughout the transition, and to help prevent transitions:

- Educate to avoid unnecessary ER visits and hospitalizations
- Look for risks (falls, lack of preventive care, poor chronic care disease management) and take action
- Share with hospital discharge planners the support and services the member currently has, assisting with discharge planning
- Identify when a member may need assistance to manage their medications
    - Refer to Medication Therapy Management as applicable
- Set up crucial follow-up appointments with primary care or specialists upon hospital discharge
- Utilize UCare supplemental benefits to aid in the reduction of readmission

Notification of TOC

Care coordinators may be notified of admissions via:

- Review of MN Encounter Alert System (EAS)* on business days
- DAR
- Member/legal representative
- Other

*MN Encounter Alert System

In partnership with DHS, the Encounter Alert Service (EAS) allows providers (including care coordinators) serving Medical Assistance enrollees throughout the state to receive alerts, for individuals who have been admitted to, discharged, or transferred from, an EAS-participating hospital, emergency department, long-term care facility, or other provider organization in real-time. Care coordinators are expected to access EAS on business days to receive notifications of member transitions.

TOC Log

MSHO care coordinators use the TOC Log to ensure all required documentation elements have been addressed. Care coordinators should work to support and manage members during all transitions regardless of whether the log is required. If the TOC log is not used for MSC+ transitions, it is expected that the care coordinator will document transition management activities in the member record.

UCare provides training for care coordinators on Transitions of Care in addition to helpful tools and member handouts. See Transition of Care (TOC) Scenarios and the Transition of Care Member Handout.

TOC Requirements

Task	MSHO	MSC+
TOC Log (Activity initiated within **one business day** of notification) NOTE: if notification of transition is 15 days or more after discharge to home, TOC log not required. Document care coordination support in member notes.	X	
Follow up with member/responsible party with each transition (First attempt to reach member within **one business day** of notification)	X	
Follow up with the receiving care setting to share current support plan and important member information	X	
TOC notification to PCP via letter/fax/phone call (Within **one business day** of notification)	X	
Follow up with other members of ICT (CADI/BI/DD/CAC case manager and other ICT as appropriate)	X	
Follow up with member/responsible party upon return to usual setting (First attempt to reach member within **one business day** of notification)	X	X
Complete 4-pillars (Completed upon return to usual setting/home. First attempt to reach member within **one business day** of notification.)	X	
Document all follow-up efforts	X	X

Admission to a Nursing Facility

UCare internal staff complete ALL Nursing Facility (NF) OBRA/Pre-admission Screening and Resident Review (PASRR) activities. Internal UCare staff tasks include:

- Completing and faxing the OBRA Level 1 to the nursing facility
- Making referrals for OBRA Level II if applicable for non-waiver members and members on a DD waiver
- Completing telephone screening (DHS-3427T form) and entering it into MMIS* if applicable

CC Responsibilities:

- Monitor MN EAS and the Daily Authorization Report for admissions
- Complete transitions of care activities
- MSHO members complete a TOC log
- Determine if an early assessment due to a change in needs is warranted. An assessment is not required solely based upon admission to a nursing facility.
- If the member is due for an assessment while receiving care in a SNF, CC reviews the living status on the enrollment roster (Institutional vs Community) to determine assessment type and requirements.
    - Living Status: Institutional, complete IHRA and follow Institutional Requirements Grid
    - Living Status: Community, complete the MnCHOICES MCO Assessment/HRA-MCO and follow MnCHOICES Requirements Grid

NOTE: If the enrollment roster displays an incorrect Living Status, the CC should complete the correct assessment according to the actual living status and ensure the address is updated accordingly. To update the Enrollment Roster's Living Status from "community" to "institutional" the nursing facility submits the DHS-1503 to the member's

county of residence. To change from institutional to community, CC sends the DHS-5181 to notify the county of member address change.

Additional tasks are outlined on the MSC+ and MSHO Requirements grids related to admissions lasting over 30 days including but not limited to:

- Temporarily exiting EW in MMIS on day 31 of admission to a nursing facility
- Communication with the county of financial responsibility using the DHS-5181
- Reopening EW for members returning to the community between 30-120 days
- Reassessments to open EW for members returning to the community after 120 days

Reference: Nursing Facility Coverage Guide

Institutionalized Members

Care coordinators may manage members who are residing in a long-term care facility (e.g., a skilled nursing facility or Intermediate Care Facility (ICF). The CC's role is to review the member's overall care needs and assess the need to return to the community. CCs provide education on additional and supplemental benefits and assist with obtaining as needed. CCs ensure preventative care needs are being met and act as advocates for member wishes and potential vulnerable adult concerns.

Members will appear on the enrollment rosters as "Institutional." Initial outreach, assessment timelines, mid-year reviews and TOC requirements do not differ for institutional members. However, the assessment type and support plan used are unique to institutional members. Institutional Health Risk Assessments (IHRA) and Institutional Support Plans (ISP) are not completed within the MnCHOICES application and are maintained in the member record. See Assessment Tools and Support Plan Tools. Additionally, assessments are required to be conducted in person. A signature is required for the ISP.

Tip: It may be advantageous to present in person to introduce yourself as the member's CC to the facility staff and member to complete the assessment rather than attempting to call to schedule. Phone calls may produce poor results due to possible hearing deficits, misunderstanding the purpose for calling, time of day/sleep schedule or not being able to use the phone among other possible barriers.

In the rare instance that the member is unable to complete the IHRA due to being unable to communicate or declining participation, the care coordinator should gather as much information as possible through conversations with facility staff, chart review, and the member's caregivers/family, and member (if able or willing) to complete the IHRA and ISP.

Reference: Institutionalized Care Coordination Requirements Grid | MSC+/MSHO Assessment Checklist
Example Documents: IHRA | ISP

Medical Assistance Renewals

It is important to assist members in maintaining MA eligibility to ensure they have access to care. Care coordinators are encouraged to provide reminders to members when they are at risk of losing MA eligibility due to failure to complete and return paperwork. Care coordinators may also assist members with completing renewal paperwork as appropriate.

CCs may view member's renewal information using the Renewal Lookup. If a member's address has changed, the DHS-8354 MCO Member Address Change Report Form may be completed online to expedite updating member address information. A DHS-5181 to the member's county of financial responsibility is still needed.

NOTE: Refer to UCare's Keep Your Coverage Team for support at KeepYourCoverage@ucare.org or 612-676-3438.

Change in Care Coordinator

The information below references CC changes for members moving to a new CC. Refer to The Assessment section for additional tasks related to receiving transferred members. All changes in care coordinator assignment require updates to the MnCHOICES application including removing the CC location and assignment for exiting members and ensuring all documents are in the completed status. It's important to complete the removal of CC assignment and location in a timely manner to ensure continuity of care.

Transfer to a New MCO or Between UCare Care Coordination Delegates

The sending care coordinator completes and sends the DHS-6037 within 5 business days to the receiving entity to ensure continuity of care. When the sending CC's transfer documents are in MnCHOICES, the sending CC ensures assessments and support plans are in the "completed/plan approved" status. Legacy documents are included with the DHS-6037. If the receiving CC has not received the DHS-6037 and or is missing transfer documentation, the CC may contact the sending entity (if known) using the Care Coordination Contact List or emailing UCare UCare's CMIntake@ucare.org for additional assistance.

UCare EW member to Fee-for-Service Medical Assistance

Members who move from UCare MSC+/MSHO who are open to EW to fee-for-service MA require the DHS-6037 to be completed and sent to the member's county of residence within 60 days of terminating from UCare. The UCare Enrollment Roster will show the member as a "Termed Member." MN-ITS reconciliation will validate the member is active with MA. Contacts for counties is noted on the DHS-6037.

Reference: DHS-6037 Lead Agency Transfer and Communication Form | Care Coordination Contact List

Internal Change in Care Coordinator

Members must be notified of agency internal changes of care coordination assignment within 10 calendar days of the change. This can be done by phone or letter. If completed by phone it is documented in the member record. If contact is made by letter, the CC must use UCare's approved Change in Care Coordinator Letter.

The new CC documents a review of the current assessment/support plan, ensuring ongoing contacts and assessments are completed according to the member's current schedule.

Reference: Letters Guide

Temporary absence of CC

UCare advises to lessen the disruption to the member's case management and reduce the frequency of care coordinator changes, if a CC is temporarily out of office due to vacation, leave of absence or other temporary reason, the CC should use professional judgment to communicate with the members the upcoming absence. It would be advised to forward phone calls and emails to a CC that can assist members with immediate needs. The supporting CC may document the assistance to the assigned CC they are providing in the member record when completing required tasks and other communications. Do not send a CC change letter for temporary absences unless the change in CC is intended to be permanent.

Other Case Closure Responsibilities

Termination Event	Care Coordination Tasks	Additional EW Tasks	MnCHOICES Task
Member Death	• Document in member record • Submit UCare Death Notification form • Send DHS-5181 to County of Financial Responsibility (COFR) • Members will remain on the Enrollment Roster until DHS has removed their program and DOD • Notify providers to stop services	• Exit EW in MMIS effective the DOD	• Upon notification of UCare Enrollment roster, remove CC location and assignment

Member Moves Out of State/Country	• Document in member record • Send DHS-5181 to COFR • Continue care coordination while the member remains on UCare's Enrollment Roster • Follow 90-day grace period instructions • Notify providers to stop services	• Exit EW in MMIS upon MA termination notification	• Upon notification on the UCare Enrollment Roster, remove CC location and assignment
EW Member's MA is Inactive	• Enrollment Roster informs CC of change • Document in member record verified MA termed • Follow 90-day grace period instructions	• If not reinstated within 60 days, complete the DHS-6037 to transfer to the member's County of Residence • UCare continues EW services through the 90-day grace period • Exit EW in MMIS effective last date of eligibility when 90-day grace period is concluded	• Upon notification on the UCare Enrollment Roster, remove the CC location and assignment
Member moves to FFS MA	• Enrollment Roster informs CC of change • Verify in MN-ITS MA is active • Document in member record • Notify providers of change in payor	• Send DHS-6037 to COR • Do not exit the waiver	• Upon notification on the UCare Enrollment Roster, remove CC location and assignment
Non-EW Member with state plan home care services MA Inactive	• Enrollment Roster informs CC of change • Verify in MN-IT'S THE member is inactive • Document in member record • Notify state plan home care providers of change in payor • Follow 90-day grace period instructions	• If not reinstated within 60 days, complete the DHS-6037 to transfer to the member's County of Residence	• If not reinstated, remove CC location and assignment
Member Changes to Non-UCare Health Plan	• Enrollment Roster informs CC of change • Document in member record • Complete the DHS-6037 to transfer to the new MCO • Do not stop services	• Do not exit the waiver	• Upon notification on the UCare Enrollment Roster, remove the CC location and assignment

Documentation

Care coordinators and others working to support care coordination tasks document all activities related to member contacts, actions, and follow-up. Documentation provides evidence of compliance with required tasks and validates care coordination engagement. Certain requirements are best documented in member case notes, while others are documented within the assessment and support plan. Examples of the recommended case note documentation include: Enrollment and Assignment dates, evidence of follow-through on member requests/needs, summary notes related to communication with support providers, review of delegate-to-delegate transfer documents, transportation and interpreter coordination, as well as communications with all members of the ICT.

Monthly Activity Log

The MSC+ and MSHO Monthly Activity Log (MAL) is designed as a tool for delegates to report to UCare the assessment outcome of each member assigned and the mid-year/TOC support plan updates that occur throughout the year. The required reporting applies to all assigned members in both MSC+ and MSHO health plans. The MAL is completed and emailed to UCare at assessmentreporting@ucare.org by the 10th day of the month.

Reference: MSC+ / MSHO Monthly Activity Log Job Aid

Additional Resources:

- UCare Network Provider Search
- UCare Health Ride Transportation
- Disease Management Programs
- Pharmacy and Formulary
- Fraud Waste and Abuse