



MSC + and MSHO 101

Laying the Foundation for Effective Care Coordination



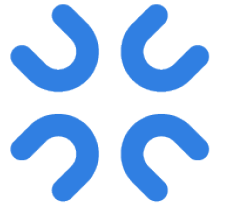


Part Three: Assessments, Support Plans & Ongoing Case Management

Care Coordination Tools and Resources



Care Coordination Makes Difference!



Assessment

The Care Coordinator completes an annual assessment with members to understand the persons needs and how the person is utilizing their health care.



Support Planning

With the member, the CC's help develop goals, supports and interventions related to needs identified in the assessment that will help the member improve health outcomes.



Ongoing Case Management

Care Coordinator maintains the relationship with member throughout the year. Follow up is a minimum of every 6 months (Mid-Year Review) to review goals as well as during hospitalizations (AKA Transition of Care/TOC).



MSC+ and MSHO Clinical Liaisons

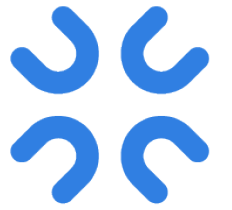
MSC_MSHO_ClinicalLiaison@UCare.org

Available to provide care coordinators support, information, education and regulatory guidance.





Assessments & Support Planning



An assessment is completed **within 30 days** of the members enrollment and thereafter reassessed **within 365 days*** and **before capitation date**.

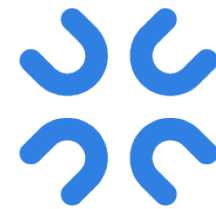
If a member requests an assessment or if there is a significant change in the member's condition, a new assessment is to be completed **within 20 days** of the request or change.

*Reassessment timelines differ for members who are Unable to Reach or Refusals at the initial assessment.

The Support Plan is created based on the members identified needs and agreed upon goals and is provided to the member and other members of the Interdisciplinary Care Team (ICT) based on member's preferences **within 30 days** of the assessment.

To Learn More:
[Assessment Timeline Job Aid](#)

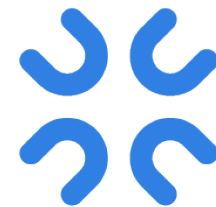




Health Risk Assessment Tools

MnCHOICES Assessment	<ul style="list-style-type: none">• Required for EW• Required for members accessing PCA• 4 actionable attempts to schedule assessment• See in-person guide for assessment method
HRA-MCO	<ul style="list-style-type: none">• HRA for non-EW members• See in-person guide for assessment method
TRANSFER MEMBER HRA (THRA)	<ul style="list-style-type: none">• Transitional tool for members with a product change, transferred from a different agency or other Managed Care Organization• 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	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• OBRA 1 (not intended for IHRA)• DHS-6914 Caregiver Assessment• DHS-3428M Mini Cognitive Exam• PHQ9 Depression Screening (optional)





“Actionable Attempts”

Outreach to members requires communication methods that members can act upon. For example, a voicemail left at a known working number, mailing a letter to a known address, or sending a secure email to a verified email address.



When mailing Unable to Reach letters, allow at least 2 days in between mailings to allow time for member to respond.



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

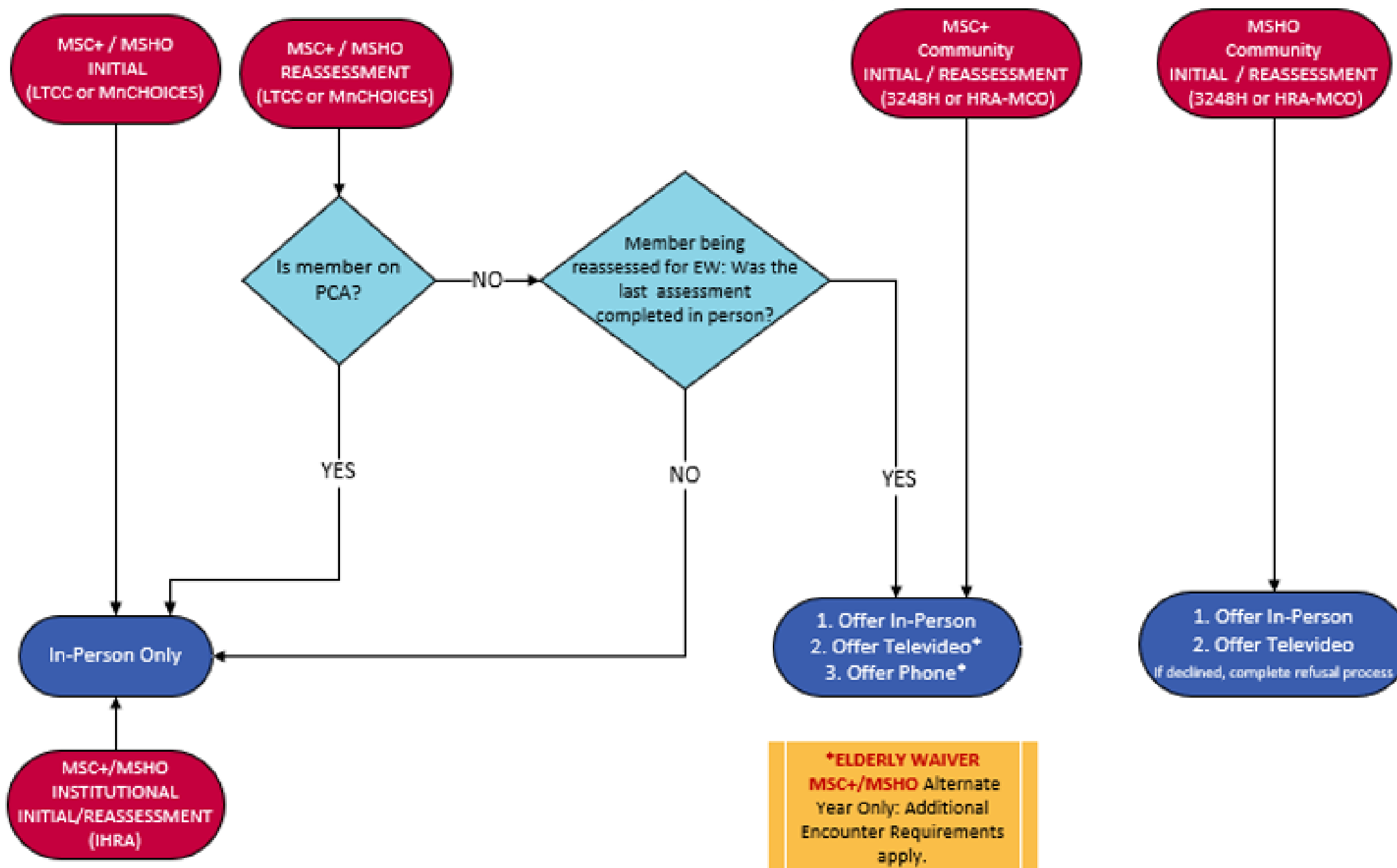
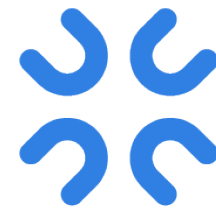
Initial contact includes either sending a “Welcome Letter” or phone call to members to provide the name/contact of the assigned care coordinator within 10 days of enrollment notification.

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

To Learn More:
[Letters Guide](#)



MSC+ AND MSHO ASSESSMENT METHODS



***ELDERLY WAIVER**
 MSC+/MSHO Alternate Year Only: Additional Encounter Requirements apply.

To Learn More:
[In Person Assessments Job Aid](#)

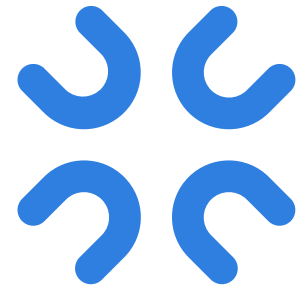




Elderly Waiver

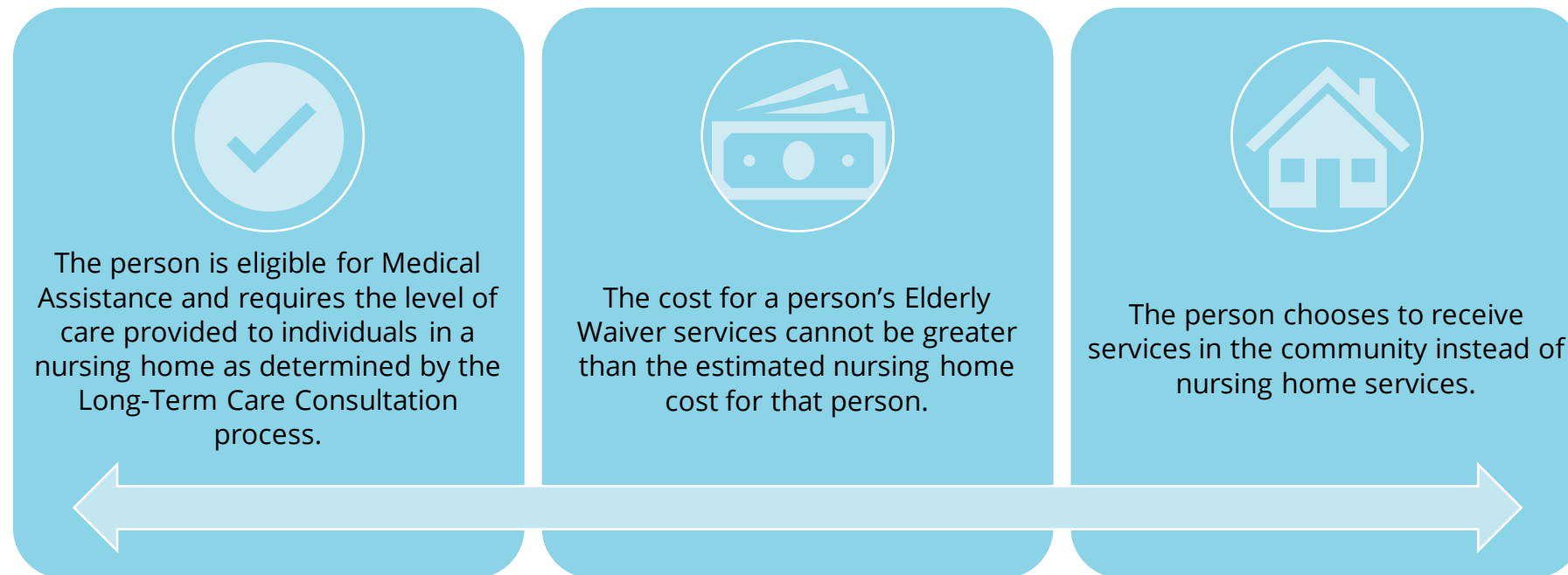
EW Basics





Who is Eligible for an Elderly Waiver

A person aged 65 or older who receives an assessment through the Long-Term Care Consultation* process is eligible for the Elderly Waiver program when they meet the following criteria:



To Learn More:

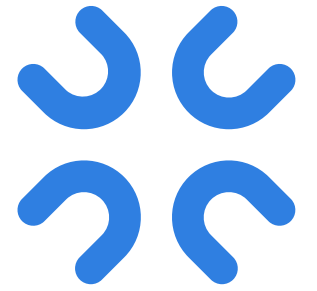
[Long-Term Care Consultation Services](#)

DHS EW Program Info: [Elderly waiver](#)

DHS 7028: [Nursing Home LOC Criteria](#)



Elderly Waiver Benefits Overview



The Elderly Waiver program funds home and community-based services for people age 65 and older who are eligible for Medical Assistance and require the level of care provided in a nursing home but choose to live in the community. These services are not covered by Medical Assistance. They are approved through an assessment to determine eligibility and authorized by the care coordinator. Some examples include:

Home Delivered Meals

Adult Day Care Services

Non-Medical Transportation

Homemaking Services and Extended Home Health Services

Chore Services
(lawn mowing, snow shoveling???)

Companion Services

Customized Living Services
(payment to assisted living homes for care/services provided)

Home Modifications

Adult Foster Care

Personal Emergency Response System

Special Equipment and Supplies (not covered by MA)

Consumer-Directed Community Supports

And more.

To Learn More:
[DHS-5357: Elderly Waiver Program](#)



Waiver Services: Managing the Budget



Case Mix Classification Summary

A - Low ADL

B - Low ADL Behavior

C - Low ADL Special Nursing

D - Medium ADL

E - Medium ADL Behavior

F - Medium ADL Special Nursing

G - High ADL

H - High ADL Behavior

I - Very High ADL (Eating 3-4)

J - High ADL, Severe Neurological Impairment/3+ Behavior

K - High ADL Special Nursing

L - Very Low ADL/Age 65+

V - Ventilator Dependent - EW



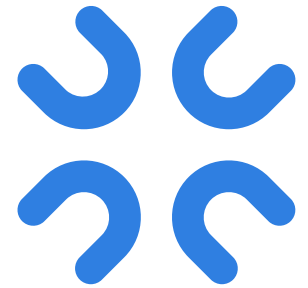
To Learn More:

DHS 3945 - [LTSS Rate Limits](#)

DHS 3428B - [Case Mix Classification Worksheet](#)



Elderly Waiver Eligibility Capitation




Care coordinators must comply with all Elderly Waiver program rules and follow applicable DHS bulletins and directions.

- EW is always the payor of last resort.
- Care coordinators must be fiscally responsible when utilizing EW in addition to staying under the budget cap.
- If a member has assessed needs requiring services above their budget cap, CC's may submit a "[Request to Exceed Case Mix Cap](#)"

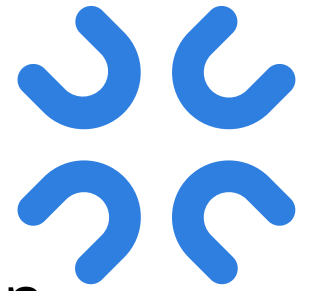
To Learn More:

DHS EW Program Info: [Elderly waiver](#)
[MN Health Care Programs \(MHCP\) Provider Manual](#)
[DHS Community-Based Services Manual \(CBSM\)](#)

 ucare people powered health plans		REQUEST TO EXCEED CASE MIX CAP MSHO and MSC+ Form must be completed by UCare Care Coordinator	
<i>Incomplete, illegible or inaccurate forms will be returned to sender.</i> All information is required in order for UCare to process the request. Please allow up to 14 calendar days for processing of this request.			
			Date of Request: <input type="text"/>
CARE COORDINATOR INFORMATION			
Care Coordinator:	<input type="text"/>		
Email Address:	<input type="text"/>	Care System:	<input type="text"/>
Telephone Number:	<input type="text"/>	Fax Number:	<input type="text"/>
MEMBER INFORMATION			
Member Name:	<input type="text"/>		
Date of Birth:	<input type="text"/>	UCare ID:	<input type="text"/>



Elderly Waiver Eligibility Capitation Dates



Member's open to EW must have their reassessments completed within 365 days and entered into MMIS before the DHS specified cap dates.



1 st Capitation Date
12/21/23
01/24/24
02/22/24
03/22/24

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 1/24/24 effective 2/1/24.

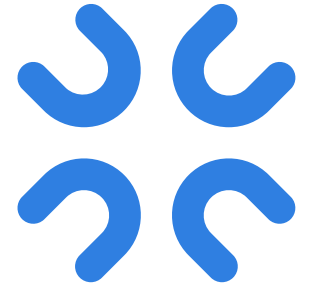
To Learn More:

[DHS Cap Dates](#)

DHS 4669 [MMIS Instructions Manual](#)




Consumer-Directed Community Supports (CDCS)




CDCS is a unique service option that gives members open 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.

To be eligible for CDCS, members must be able to direct their own care.

CDCS Toolkit

[Care Coordinator CDCS Guidelines](#)  (NEW)


[CC CDCS Plan Approval Checklist](#)  (NEW)

[CDCS DHS 6532 CSP Change Form](#)  (NEW)

[CDCS Member Agreement and Checklist](#)  (NEW)

[Consumer Directed Community Supports \(CDCS\) Policy Manual](#) 

[Member Guide to CDCS Allowed Expenditures](#)  (NEW)

[Notice of Technical Assistance](#)  (NEW)

To Learn More:

[CDCS Toolkit](#)

[CDCS Policy Manual](#)

[DHS CDCS Online Learning Module](#)

[DHS EW Program Info: Elderly waiver](#)



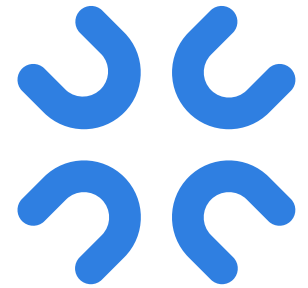


Community First Services and Supports (CFSS)

CFSS Basics



CFSS Benefits Overview



Activities of daily living (ADLs): Activities a person needs to carry out on a daily basis to remain healthy and safe. Covered ADL's: 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 accompany to medical appointments, shopping, paying bills and meal preparation.

Health-related procedures and tasks: Tasks such as supporting a person with self-administered medications, immediate attention for health and hygiene, or help 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, Services and PERS: Support related to an assessed need, for the direct benefit of the member, increases independence or decreases the need for assistance from others, and is included in the service delivery plan.

Worker training and development: Separate budget available to employers of CFSS workers to pay for training, observation, monitoring and coaching of CFSS workers. These activities help CFSS workers expand their skills to support the person's specific needs.

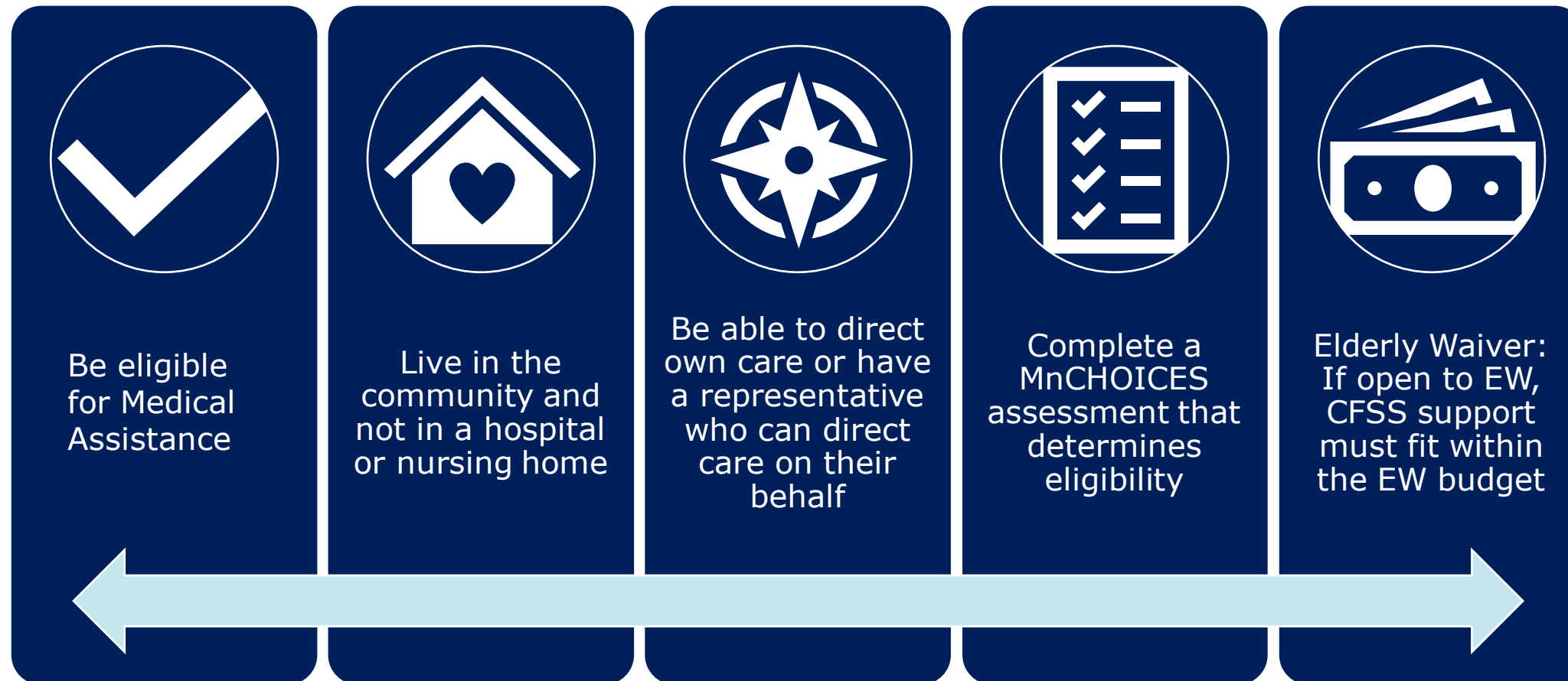
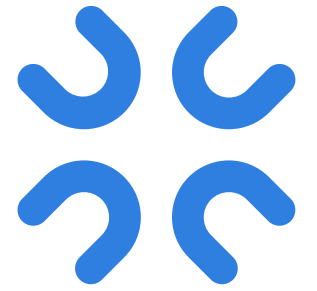
To Learn More:

DHS CFSS Care Coordination Training: [CFSS LA via TrainLink](#)

[DHS CFSS Policy Manual](#)



CFSS Eligibility



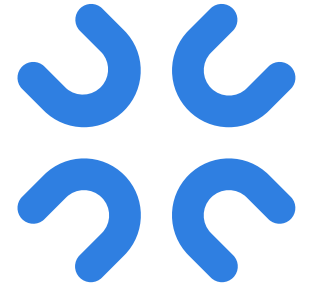
To Learn More:

[CFSS Policy Manual: Eligibility](#)

[UCare CFSS Care Coordination Guidance](#)



Service Delivery Models

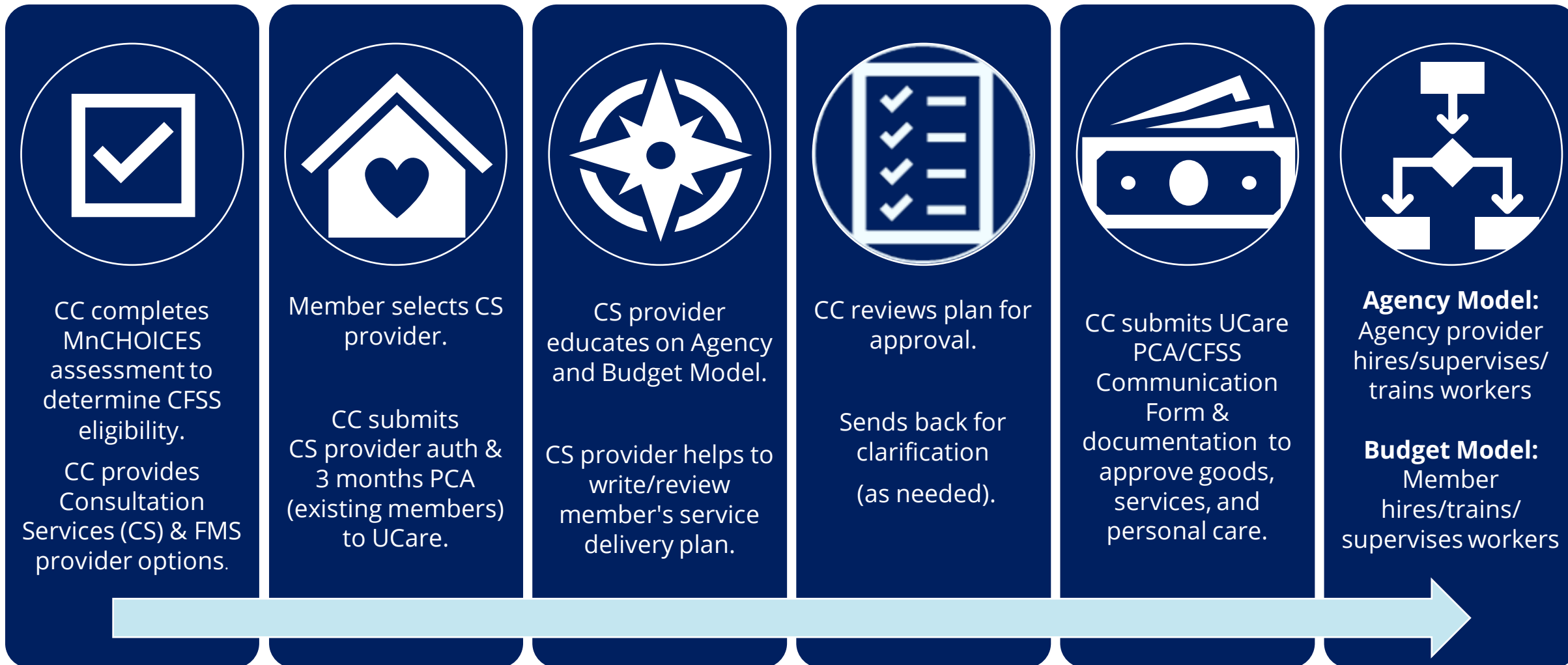
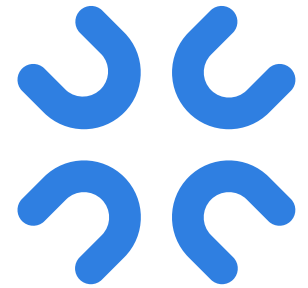


Agency Model	Budget Model
Member has service units designated for care and goods/services/PERS	Member has budget with allocated dollars for care and goods/services/PERS
Member uses designated CFSS agency to hire, train, and supervise workers	Member hires, trains, and supervises workers
CFSS agency pays workers	FMS provider pays workers
FMS assists with paying for goods and services	FMS assists with paying for goods and services
PERS: paid via CC authorization using in-network providers	PERS: paid via CC authorization using in-network providers

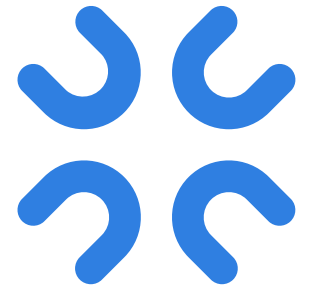
To Learn More:
[DHS CFSS Service Models](#)



CFSS Process Flow



Who Can Be a Member's CFSS Worker?



CFSS Service Workers:

Must be at least 16 yr. (16-17 yr. old must meet additional requirements)

Must complete and pass training

May be Legal Guardian or spouse of a member

May be an individual receiving CFSS

Must be employed by CFSS agency (Agency Model) or Member using an FMS (Budget Model)

Must be able to communicate effectively

Must be able to provide services according to the plan of care

Must be able to respond appropriately to needs

Must be able to report changes in the person's condition

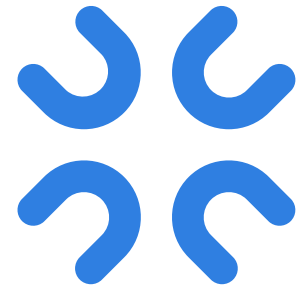
Must be able to maintain records

To Learn More:

[DHS CFSS Worker Criteria, Requirements and Responsibilities](#)



Member Transfers with CFSS



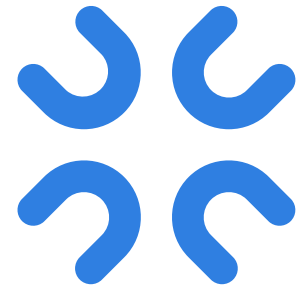
Members new to UCare from another MCO or from Fee For Service with existing CFSS authorization:



Care Coordinators offer MnCHOICES assessment within the required timelines. **Agency Model:** Ensure CFSS provider is in-network and (if needed) provide the CFSS transfer form to the existing CFSS agency.

- **Assessment declined:** UCare will honor the existing authorization through its current end date. Complete reassessment prior to CFSS authorization end date.
- **Assessment completed:** Submit CFSS information to UCare and UCare will extend the authorization through the new assessment span. Complete reassessment w/in 365 days of the assessment completed with the member.

Provider Search



People Places Pharmacies Drug List

Can we help you find a clinic, hospital, or other care location?

Pick your plan: 2024 Minnesota Senior Care Health Options (MSHO) ▼

Search by name(Optional): Search by name or specialties

Choose a location: St | St Paul MN, USA ← | St. Louis Park MN, USA

Search

Filter The Results By:

[Clear Filters](#) [Filter](#)

Specialty

Person

Personal Care ←
Attendant Services

Click to select Language

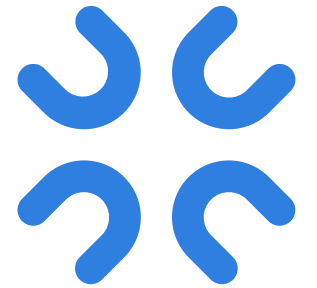
Distance(Optional)

within 60 miles ▼

- **Provider Search:** Allows you to select specific people, places, pharmacy locations or see drug lists for a specific health plan
- **Pick your Plan:** Select MSC+ or MSHO with the corresponding year.
- **Choose a location:** Start typing the city, then select from the options that populated on the screen to ensure the city title/state and USA present.
- **Specialty:** Select the alpha ordered specialty type, for example home care, CFSS or other providers. Specialty providers must be within 60 miles of the members residence.
- **Exceptions:**
 - Dental: Provider search populates dental providers for UCare health plans (IFP, Medicare etc.). For MSC+/MSHO dental providers contact the [UCare Dental](#) carrier to inquire about dental provider options.
 - Mental Health Providers: Contact [UCare's Mental Health Access and Triage line](#).



CFSS Reminders



- All CFSS assessments are completed in person.
- Authorization for Consultation Services is required prior to authorizing the CFSS Service Delivery Plan.
- CFSS reassessments can be done up to 60 days before the end of the authorization period.
- CCs authorize temporary PCA services for 3 months for existing PCA members at the time of reassessment to prevent gaps in coverage.
- CFSS assessments are completed at least annually and with change of condition/supports.
- CFSS reassessments may not be completed early due to member using up units before the end of the authorization period.
- CFSS cannot be denied via the PCA/CFSS Communication Form without a completed MnCHOICES assessment and corresponding paperwork attached.
- For members on disability waivers managed by the county, UCare accepts the MnCHOICES Assessment completed by the county waiver case manager.

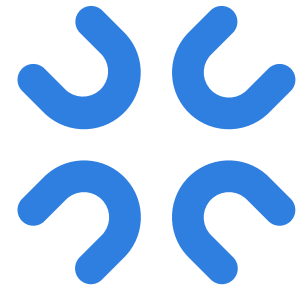




Support Planning



Support Planning



A Support Plan is a person-centered written summary of the assessment that includes what's important to and for the member.

Priority	Goal	Interventions	Target Date
<input type="checkbox"/> Low <input type="checkbox"/> Medium <input checked="" type="checkbox"/> High	Fred (S) would like to decrease his foot pain from 8 to 4 (M,A,R) in the next year (T).	Care Coordinator to assist with locating in network endocrinology providers. Fred or his wife, Wilma, will schedule visit within the next 6 mo. Fred is encouraged to use pain log to track his daily pain levels. Care Coordinator to assist with diabetic footwear if needed and other medical equipment as needed.	12.31.2022

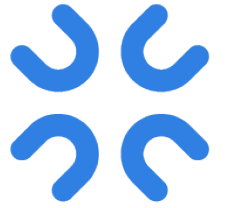
The Support Plan:

- Accounts for all the member's identified risks, preferences, supports, barriers, and includes at least one high priority goal.
- Always maintains at least one active/open goal.
- Goals are monitored for achievement at Mid-Year or more based on the agreed upon follow up plan.
- Target dates are adjusted when target surpassed or exceeded.
- Goals are written in the SMART (Specific, Measurable, Attainable, Realistic, and Time Bound) format.
- Interventions/supports include help/support the member wants to achieve the goal.

To Learn More:
[Smart Goals Job Aid](#)
[Smart Carte](#)



Support Planning Tools



Support Plan – MnCHOICES Assessment

- Completed and provided to member and ICT within 30 days of assessment.
- Assessment information pulled from MnCHOICES Assessment or HRA-MCO.
- Copy of the MnCHOICES Support Plan provided to member and PCP.

Institutional Member Support Plan

- Institutional Member Support Plan is a stand-alone document located on the UCare website.
- Completed within 30 days of the IHRA.
- Copy of the IHRA Support Plan provided to member and PCP.

Unable to Reach Support Plan*

- UTR Support Plan is a stand-alone document located on UCare website.
- Four “actionable attempts” via phone, email, or letter are completed to reach the member to schedule an assessment.
- If UTR, document and complete UTR Support Plan.

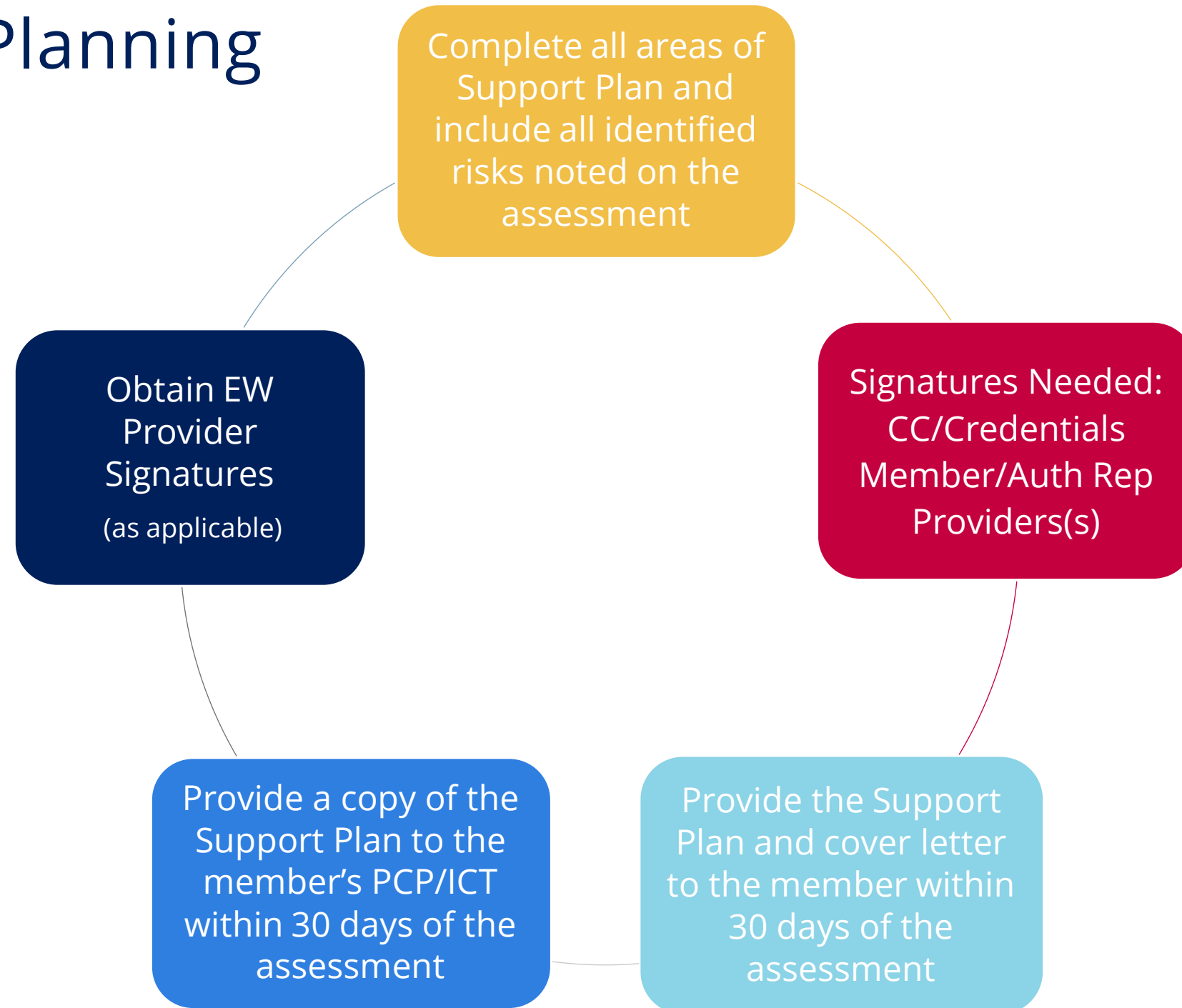
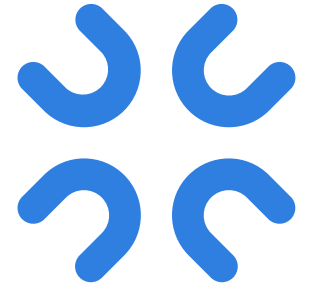
Refusal Support Plan*

- Refusal Support Plan is a stand-alone document located on the UCare website.
- Up to four “actionable attempts” to reach the member to schedule an assessment.
- If at any point the member is reached and verbally declines meeting, document and complete the Refusal Support Plan.

*Required for MSHO, optional for MSC+



MnCHOICES Support Planning





Authorizing Services



Authorization of Elderly Waiver Services



- Care Coordinators authorize all EW services.
 - Tools:
 - EW services require WSAF submission to UCare.
 - T2029 Specialized Equipment and Supplies WSAF.
- UCare enters the information for claims payment purposes.
- Estimated turnaround time for processing is 14 calendar days.
- UCare provides EW service provider with written notification of all EW services.
- Care Coordinator receives notification via Daily Authorization Report (DAR).

ucare Waiver Service Approval Form
Care Coordinator Use Only

FYI Incomplete, illegible or inaccurate forms will be returned to sender. Please complete the entire form. Allow 14 calendar days for processing of this request.

Fax form and any relevant documentation to: 612-884-2185 or 1-866-402-5018 For questions, call: 612-676-6705 Email: CLSIntake@ucare.org

MEMBER INFORMATION
Member Name _____ Member ID _____
Address _____ PMI _____
City, State, Zip _____ Date of Birth _____
Phone _____ Gender: Female Male

CC INFO
Care Coordinator Name _____ Phone _____
Care Coordinator Email _____ Fax _____

SERVICE AGREEMENT
Service Description Select a service _____
Start Date _____ Frequency _____
End Date _____ Total Units _____
Rate Per Unit – if negotiated _____
Total (\$) Amount Per Date Span – CDCS Only _____
Provider Name _____ NPI _____
Provider Phone _____ Fax _____
Please provide an explanation of your request. (If adjusting authorization due to case mix change, DTR is required. For all other changes to existing authorizations, specific details required.)

Waiver Service Approval Form
Care Coordinator Use Only

U7546
Page 1 of 2

WSAF Questions
Clinical Services Intake
Phone: 612-676-6705
CLSIntake@ucare.org

Provider Billing Questions
Provider Assistance Center
612-676-3300

Care Coordination Process Questions
MSC+ and MSHO Clinical Liaisons
MSC_MSHO_Clinicalliaison@ucare.org



Waiver Services: T2029



ucare **T2029 Equipment and Supplies Waiver Service Approval Form** **Care Coordinator Use Only** Reset Form

FYI Incomplete, illegible or inaccurate forms will be returned to sender. Please complete the entire form. Allow 14 calendar days for processing of this request.

Fax form and any relevant documentation to: **612-884-2185 or 1-866-402-5018** OR For questions, call: **612-676-6705**
Email: CSintake@ucare.org

MEMBER INFORMATION
Member Name _____ Member ID _____
Address _____ PMI _____
City, State, Zip _____ Date of Birth _____
Phone _____ Gender: Female Male

CC INFO
Care Coordinator Name _____ Phone _____
Care Coordinator Email _____ Fax _____

Waiver Span Start Date _____ Waiver Span End Date _____
Please note: services should not be authorized past the end of the waiver span. If a new assessment is performed, all previously authorized services must also be renewed.

LIFT CHAIR REQUEST (see page 2 for additional T2029 options)

Service Description, Select a Service _____
Start Date _____ Frequency _____
End Date _____ Total Units _____
Rate per unit _____

MHCP Criteria for Lift Chairs: Seat lift mechanisms are **covered** for members who meet all of the following:
1. The member has arthritis of the hip or knee, neuromuscular disease or another medical condition that affects his or her strength or mobility
2. The member is unable to stand up from a regular armchair at home
3. Once standing, the member has the ability to ambulate independently or with a properly fitted walker or cane. *Does this member meet criteria 3? Y N
***For a member to be eligible for a lift chair under the medical benefit or Elderly Waiver, criteria 3 must be met.**

Provider Name _____ Phone _____
EW UMPI/NPI*** _____ Fax _____
***To ensure accurate claims payment, please verify with the provider the billing UMPI/NPI for EW services.
Agency Email Address _____
Please provide an explanation and documentation to support request and manufacturer list price of mechanism vs. furniture.

Waiver Service Approval Form U7546
Care Coordinator Use Only Page 1 of 3

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

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

Tips:

- Ensure the items are not already covered by MA or other 3rd party payor
- Ensure the requested item is identified on the “covered services” in the CBSM
- Ensure the DME items is not more appropriate for Environmental Accessibility Adaptations (e.g., grab bars, portable ramp, adaptive utensils)

To Learn More:

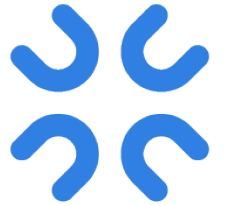
[CBSM Specialized Equipment and Supplies](#)
[Environmental Accessibility Adaptations](#)
[DME Coverage Guide](#)
[T2029 Specialized Equipment and Supplies](#)

Contact:

Clinical Liaisons
612-676-5045
msho_clinicaliaison@ucare.org



Home Health Care Services



DHS-5841-ENG 9-19

Managed Care Organization (MCO), County Agency and Tribal Nation Communication Form
Recommendation for State Plan Home Care Services

MEMBER NAME		DATE OF BIRTH	PMI
DIAGNOSIS	GUARDIAN NAME		PHONE NUMBER
MCO STAFF OR DELEGATE NAME	MANAGED CARE ORGANIZATION	STAFF PHONE NUMBER	FAX NUMBER
WAIVER CASE MANAGER NAME	AGENCY, COUNTY OR TRIBAL NATION	STAFF PHONE NUMBER	FAX NUMBER
REASON FOR COMMUNICATION <input type="radio"/> Providing information <input type="radio"/> Action or response required <input type="radio"/> Requesting information (see comments)		RECOMMENDED SERVICES <input type="radio"/> Initial <input type="radio"/> Increase in services <input type="radio"/> Decrease in services	
SPECIAL MEMBER CONCERNS OR OTHER COMMENTS			
SERVICING PROVIDER NAME		SERVICING PROVIDER NPI NUMBER	
SERVICING PROVIDER TAX IDENTIFICATION NUMBER (TIN)		PHONE NUMBER	FAX NUMBER

Recommended home health care services

Skilled nursing visits CODE: _____

START DATE	END DATE	FREQUENCY	UNITS OF SERVICE	COST PER UNIT
HOME CARE PROVIDER		PHONE NUMBER	FOR PLAN USE ONLY <input type="radio"/> Medicare <input type="radio"/> Medical Assistance	

Home health aide visits

START DATE	END DATE	FREQUENCY	UNITS OF SERVICE	COST PER UNIT
HOME CARE PROVIDER		PHONE NUMBER	FOR PLAN USE ONLY <input type="radio"/> Medicare <input type="radio"/> Medical Assistance	

Physical therapy

SERVICE AND HCPC CODE	START DATE	END DATE	FREQUENCY	UNITS OF SERVICE
COST PER UNIT	HOME CARE PROVIDER		PHONE NUMBER	FOR PLAN USE ONLY <input type="radio"/> Medicare <input type="radio"/> Medical Assistance

Members on **MSC+/MSHO** do not require authorization for SNV or HHA when using an in-network provider.

NOTE: Members on disability waivers (CADI, BI, DD) receiving medical assistance services paid for by UCare:

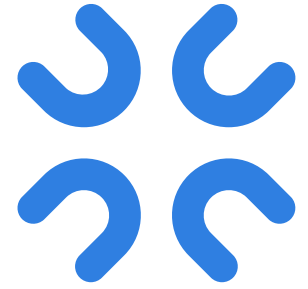
- County **waiver case managers** fax the DHS-5841 to CLS Intake at 612-884-2499. The waiver case manager may share the DHS-5841 with the care coordinator for collaboration and good communication purposes.
- Authorized Home Services will appear on the DAR.

To Learn More:
[Provider Authorizations Page](#)

Questions:
 Provider Assistance Center
 612-676-3300



Daily Authorizations Report (DAR)



UCare Secure File Transfer Portal (SecFTP) Website: <https://secftp.ucare.org>

Three reports on the DAR:

- Out of state admissions/discharges
- Nursing home admissions/discharges
- Approved Authorization of Services (EW, T2029, HHA, PCA/CFSS, ARMHS, etc.)



Approved WSAF and Prior Authorizations are entered into the UCare system within 14 calendar days.

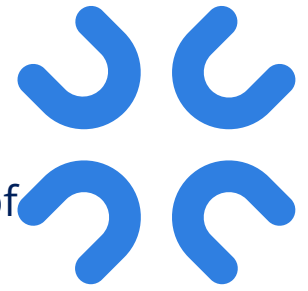
- UCare sends a notification letter with the authorization of the services to the provider and member.

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](tel:612-676-6705). A response will be provided within 2 business days.



Denial, Termination or Reduction (DTR)



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) must have a DTR form submitted to UCare within **one day** of determination. The purpose of the DTR is to provide member with their appeal rights in a timely manner.

NOTE: DTR's are needed for services paid for by UCare. If the service is being paid by Medicare or other payor, UCare does not consider determinations.

EW DTR Form

- **Denial:** a request for homemaking is denied.
- **Termination:** Chore services ending per member request.
- **Reduction:** Homemaking reduced from 5 hours to 2 hours weekly.

PCA/CFSS Communication Form

- Used when CFSS or extended **CFSS services are denied, terminated or reduced.**
- Also used for other communications.

Home Health Care Communication Form

- Used when **reducing or terminating the below:**
 - Home Health Aid
 - Extended HHA
 - Skilled Nursing Visits and Extended SNV

To Learn More:

[DTR Instructions](#)

[DTR Waiver Situations: Reason Codes Decision Tool](#)





Ongoing Caseload Management

Coordinating care throughout the year



Support Plan Updates

All members (EW, Non-EW, Institutional, unable to reach and refusers) receive ongoing contact a minimum of every 6 months (aka Mid-Year Review) unless otherwise noted on the Support Plan. Support Plans are also updated for Transition of Care and with significant changes.

Mid-Year Review allows a flexible window of 5-7 months to complete the review.

Tracking

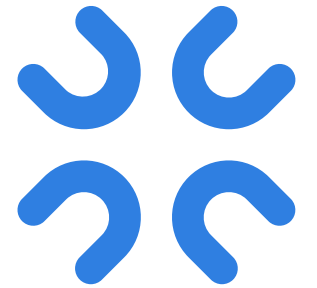
Care Coordinators must maintain a system for tracking ongoing follow-up needs to members assigned to their caseload.

Mid-Year Review & Other Updates

- 4 actionable attempts are required at Mid-Year Review.
- If a member had an assessment and was unable to reach or declined a routine support plan update, document the facts but do not complete a new UTR/Refusal support plan.
- Previously UTR/Refusal members should be offered an assessment at ongoing follow-up outreach attempts.



Referrals and Orders



UCare Supplemental Benefits:

* The Care Coordination and Care Management website provides the location for member benefits related referral forms.

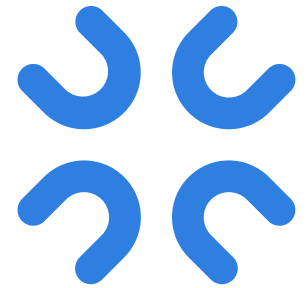


Medical Equipment & Supplies:

- * Check DME Coverage Guide or MHCP manual for coverage details and criteria.
- * Obtain a physician order – order may have prerequisites (like PT eval) & include member name, dx, quantities or other information to obtain.
- * Use in-network DME provider. TIP: Review order needs with selected DME provider to ensure complete.



Community Well Non-Waiver Care Coordination

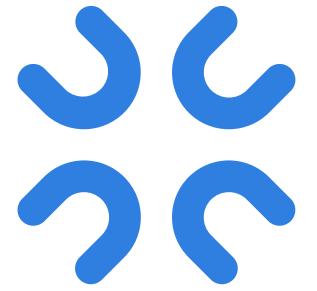


CC's act as a communication bridge between members, providers and Case Managers. This ensures member needs are met, avoiding duplication of interventions.

Care Coordinator	CAC/CADI/BI/DD Waiver Case Manager
Health Risk Assessment (HRA-MCO) & Support Plan	County Certified Assessor: MnCHOICES Assessment
Assist to access Primary Care and close gaps in preventative care	County Certified Assessor: Determine CAC/CADI/BI/DD waiver eligibility and PCA eligibility
Health education and community resource referrals	Case Manager: MnCHOICES Support Plan and authorize eligible waiver Home Community Based Services (HCBS)
Collaborate with ICT	Collaborate with ICT
Coordinate MA covered medical equipment/supply needs	Coordinate waiver covered housing/equipment/supply needs
Transportation to medical appointments	Transportation to waiver covered supports
Support during transitions of care* *communication/collaboration with BHH and waiver CM (as applicable)	
Educate/coordinate health plan benefits	



Conclusion



Care Coordinators foster ongoing primary and preventative care, create a person-centered support plan and assist with communication between all members of the interdisciplinary care team.

Care Coordinators work alongside our members to coordinate care, educate, motivate, and encourage to improve health outcomes.



Empathy



Communication Skills



Resilience



Time Management



Problem Solving





Continue to Supplemental Trainings TOC & Gaps in Care

Care Coordination 101 Training





Questions?

Clinical Liaisons

- MSC_MSHO_Clinicalliaison@ucare.org
- 612-294-5045

