Care Coordination Manual: Connect and Connect + Medicare

Contents

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.

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 – Health Risk Assessment and previously known as the Care 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.

Waiver: The Home and Community Based Services waiver programs authorized by a federal waiver under §1915(c) of the SSA, 42 USC §1396, and Minnesota Statues §256S. These include Elderly Waiver (EW), Community Access for Disability Inclusion (CADI), Brain Injury (BI), Developmental Disability (DD), and Community Alternative Care (CAC).

Introduction to UCare and Care Coordination

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

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

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

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

Key Contacts

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

UCare Care Coordination Products

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

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

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

*Reference: MSC+ and MSHO Additional and Supplemental Benefits

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

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

UCare Connect + Medicare (CT+MED) Overview: UCare Connect + Medicare is an SNBC health plan that combines benefits for people with a certified disability who qualify for MA and Medicare A and B

with extra UCare benefits*. UCare manages the covered benefits for Medicare A, B & D and MA. Members must actively choose to enroll in UCare Connect + Medicare or will be auto-enrolled in the Connect plan.

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

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

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

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

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

Care Coordinator Role and Purpose

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

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

Care Coordinator License and Training Requirements

Care Coordinator Qualifications

All care coordinators (CCs) need to meet UCare's requirements for professional care coordinators or have passed the Minnesota Merit System exam to qualify as a County Social Worker*. Counties may be excused of Merit System qualifications by the Commissioner of Human Services because the county personnel system follows federal

standards and has completed all necessary steps in accordance with the Commissioner of Human Services guidance. Counties that are excused maintain a record of the Commissioner of Human Services confirmation letter.

UCare's professional care coordinators include:

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

*MN licensure is not required

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

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

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

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

MnCHOICES Access and Handling Minnesota Information Securely

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

Handling MN Information Securely

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

Care Coordinator NPI/UMPI

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

Model of Care (SNP-MOC) Annual Training

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

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

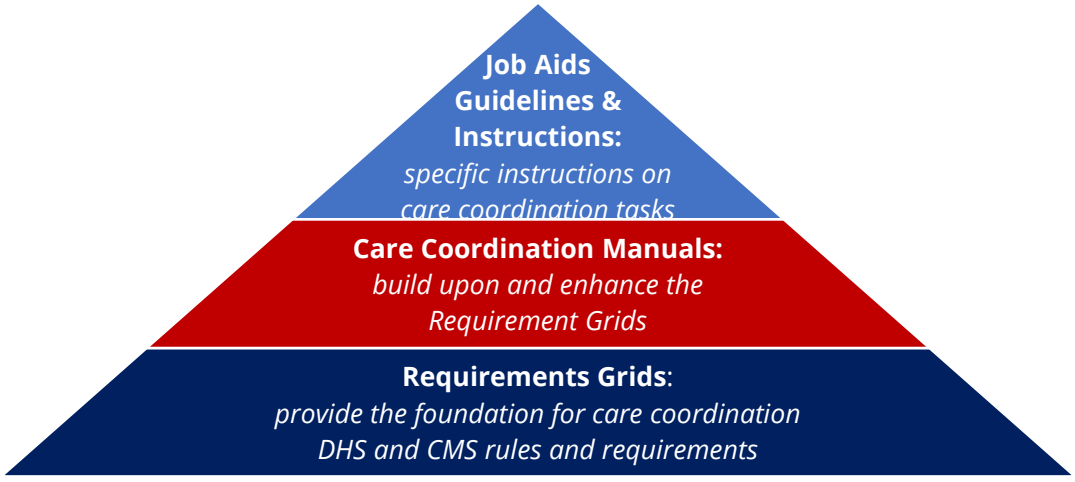
New Hire Onboarding

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

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

Care Coordination Rules and Requirements

The Federal Government (CMS) and State Government (DHS) provide the regulatory guidance for all MSC+, MSHO, Connect and Connect + Medicare health plans. UCare care coordination requirements are located on the Care Coordination and Care Management website. The Requirements Grids are the foundation for UCare's official policies and procedures for care coordination responsibilities. The Requirements Grids are typically updated twice yearly (January/July) or if significant DHS/CMS regulatory changes occur. In the event that a significant change occurs prior to a Requirement Grid update, delegates will receive an ALERT announcing the change.



Care Coordination Requirements Grids

- Connect/Connect + Medicare Care Coordination Requirements Grid

The Care Coordination and Care Management website houses many job aids and instructions that provide guidance on specific care coordination tasks. These resources are developed based on feedback from care coordinators and are designed to elaborate on specific care coordination requirements.

Caseload Size and Caseload Management

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

Recommendation for Caseload per Care Coordinator

When determining caseload ratios, delegates should consider:

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

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

Caseload Management

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

Delegated Activities

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

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

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

Recreating documents

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

Alternative Decision Makers

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

To speak with a UCare representative (e.g., UCare Customer Service) as an alternative decision maker, supporting legal documentation must be sent to UCare by:

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

Types of Alternative Decision Makers

Guardian: A person(s) appointed by the court to make the **personal decisions** for the person subject to guardianship. The guardian has the authority to make decisions on behalf of the person subject to guardianship about where to live, medical decisions, training and education, etc. A person may be subject to full guardianship or partial guardianship.

To verify if a person has a legal guardian, the care coordinator may check the Minnesota Judicial Branch: Search for Guardian or Conservator registry. If a member has a verified legal guardian, they must be contacted and invited to attend the assessment. It should be documented if the guardian refuses to participate in the assessment or defers to others to collaborate in the assessment (e.g., public guardian defers to the member's group home staff for health risk assessment information). Depending upon the powers granted in the legal documents, the private and public guardians may sign care coordination-related documents.

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

perform other financial functions for the person subject to conservatorship. For the purpose of care coordination activities, Conservators do not sign on behalf of members.

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

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

Health Care Agent: A designated person who may or may not make **health care decisions** on behalf of a person when the person has the capacity to speak on their own behalf, as noted in a person's Health Care Directive (HCD). For the purpose of care coordination activities, a health care agent may sign on behalf of members who are either unable to sign for themselves due to incapacity or if the Health Care Directive permits the designee to make decisions even if the person is capable.

Representative Payee: A representative payee is a person or entity appointed by Social Security to **manage Social Security benefit payments** for someone unable to do so on their own — for example, a minor child, a severely disabled person or a retiree suffering from advanced dementia. For the purposes of care coordination activities, Representative Payees do not sign on behalf of members.

Authorized Rep (A-Rep): A person or organization authorized by an applicant or enrollee to apply for an MHCP and to perform the duties required to establish and maintain eligibility. This type of representative may act on behalf of the member in all other matters with the county, tribal or state servicing agency, including matters related to MHCP eligibility and care coordination activities. Verified A-Reps may sign care coordination-related documents.

Participant Representative (PR): A person who is at least 18 years old and capable of providing the support necessary to help the person receiving PCA/CFSS services to live in the community when the person is assessed as unable to direct their own care. This type of representative is **exclusive to PCA/CFSS**. For the purposes of care coordination activities, the PR may sign on behalf of members. Per DHS, the PR must:

- Actively participate in planning and directing the person's PCA/CFSS services
- Help the person make choices about PCA/CFSS services
- Request changes to the person's service delivery plan, as needed
- Sign required forms, including all worker time and activity sheets
- Sign the Representative Agreement

Release of Information

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

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

Capable members are permitted to verbally authorize a one-time consent for another person to sign the Support Plan on their behalf. Care coordinators should clearly document this consent.

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

*UCare's standard ROI is available in various languages. For more information, see the UCare Member Plan Documents.

Fraud, Waste and Abuse

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

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

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

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

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

To report FWA, care coordinators may contact UCare via:


1-877-826-6847


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


compliance@ucare.org

Reference: UCare Fraud, Waste and Abuse

Vulnerable Adult Reporting

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

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

Reference: DHS Vulnerable Adult Mandated Training | Making Mandated Reports

Audits

Self-Audits

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

Annual Compliance Audit

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

Corrective Action Plans Apply: Yes

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

Quality Review

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

Corrective Action Plans Apply: No

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

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

Contact QualityReviewTeam@UCare.org to learn more.

TOC Audit

Frequency: Annual

Corrective Action Plans Apply: No. Supportive training and additional oversight may apply.

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

HEDIS

Frequency: Annual

Corrective Action Plans Apply: No

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

MDH Audit

Frequency: Every three years for MSHO and MSC+

Corrective Action Plans Apply: Yes

Summary: The Minnesota Department of Health (MDH) licenses all managed care organizations (MCOs) in the state. As part of that licensing review, MDH may audit plans once every three years. Regulation ensures that health plans follow applicable laws, standards and rules governing financial solvency, quality of care,

access to services, complaints, appeals and other consumer rights in compliance. MDH reviews managed care contracts to ensure MCOs are in compliance with the contract with DHS, as well as to ensure they meet federal standards.

CMS Audit

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

Part C Validation Audit

Frequency: Annual for MSHO and Connect + Medicare
Corrective Action Plans Apply: No
Summary: The Centers for Medicare & Medicaid Services (CMS) requires that sponsoring organizations (SOs) contracted to offer Medicare Part C and/or Part D benefits be subject to an independent yearly audit to validate certain data reported to CMS to determine its reliability, validity, completeness, and comparability in accordance with specifications developed by CMS. Audited areas include grievances, reconsiderations, and the care management documentation for Special Needs Plans.

Secure Communications

Secure File Transfer Protocol (Sec FTP) Portal

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

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

Provider Portal

The Provider Portal allows UCare contracted providers access to:

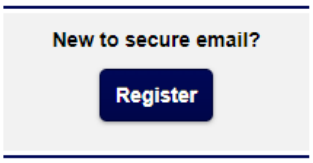
- Explanation of payments (monthly remit statements that show payment for care coordination per member per month fees)
- View claim status
- Complete the online Provider Claim Reconsideration Form
- Look up member eligibility
- Check authorization on medical service status
- Send a secure message to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

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

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

UCare Secure Email Message Center

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



Reports

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

Quality Measures

- Gaps in Care Reports
- QIMP (specific care systems only)

Supplemental Benefit Eligibility

- Grocery Ride and Utility Allowance Eligibility
- GrandPad Eligibility (MSHO)

MA Eligibility

- Future Termination/MA Eligibility
- Members Turning 65 (CT/CT+ MED)
- New to MSC+/MSHO with waiver CM
- New to CT/CT + MED
- Spenddown Report (MSHO)

Compliance and Administrative

- SNBC NU Codes and Late HRA (CT/CT+ MED)
- EW/NF Discrepancy Report (MSC+/MSHO)
- Date of Death (EW)
- Repeated Hospitalization and ER Admissions (CT + MED and MSHO)
- Clinic Closure Report

HCBS Initiatives

- Non-EW CFSS Reassessment
- EW Capitation Reassessment
- HCBS Utilization

MnCHOICES

- Lapsed Assessor
- Incomplete / Pending Status

Member Complaints and Grievances and Appeals

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

Complaints and Grievances

A complaint or grievance can be a written or spoken statement saying the member has a problem or concern about covered services or care. This includes any concerns about the quality of service, quality of care, UCare network

providers, or UCare network pharmacies. The formal name for "making a complaint" is "filing a grievance". Care coordinators may assist members in submitting complaints; however, they may not submit complaints on behalf of members. If a complaint is made about a specific care coordinator or delegate, UCare will contact the CC/delegate to inquire and gather more information. UCare encourages delegates to honor member requests to change care coordinators.

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

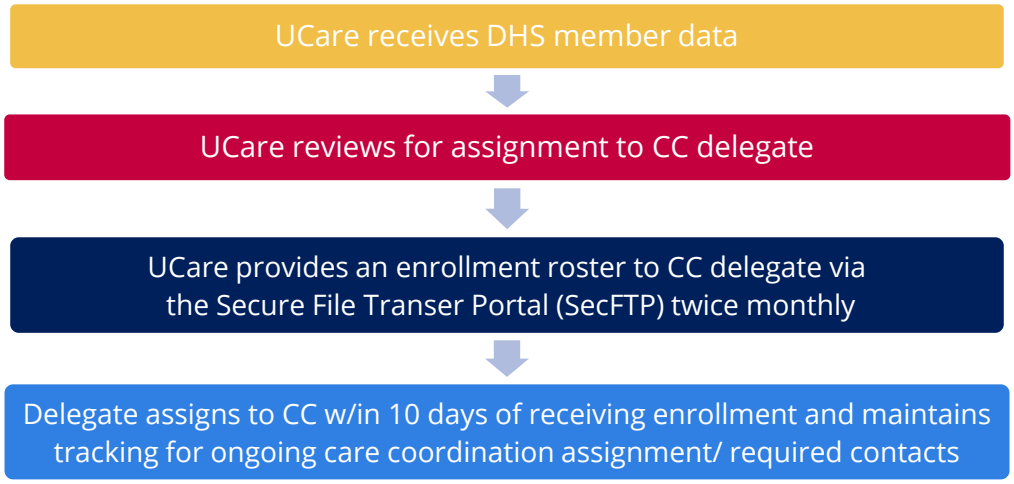
Phone: 612-676-3310 or 1-855-260-9707, TTY 612-676-6810 or 1-800-688-2534,
Email: cag@ucare.org or
Mail: UCare PO Box 52 Minneapolis, MN 55440-0052

Appeals

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

Connect and Connect + Medicare Care Coordination Enrollment Overview

The 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. Connect (CT) and Connect + Medicare (CT+MED) members are assigned to delegates based on the member's county of residence and contracted agreements with counties and care system partners. Some exceptions may apply based on specific contracted agreements.



Enrollment Rosters

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

- New Member: Member is new to UCare, or a member was reinstated to UCare after a gap in eligibility. Noted as NU in the Health Status code.
- Product Change: Change in UCare product from the prior month (i.e., CT to CT + MED Or vice versa)
- Termed Member: Member disenrolled from UCare
- Care Coordinator Change: Change in care coordination entity from the prior month
- Clinic Change: Primary care clinic change
- Health Status (HS) Code Change: Indicates a change in an assessment completed (HP), Not Reached (NR), or Not Interested/Refused (NI).
- 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 ConnectIntake@ucare.org to research, resolve, 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

Primary care clinic status must be confirmed with the member. Reviewing electronic health records is not sufficient to request a PCC change. 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.

- Updated PCC and care coordination assignment will be reflected on 2nd roster posting as appropriate.
- 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 on the first roster of the next month.

90-Day Grace/Monitoring Period for Medical Assistance

Care coordinators are required to monitor members whose medical assistance (MA) 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.

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

- Claims are not paid while CT/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.
- When MA is reinstated and backdated the CC ensures any missed contacts are completed (i.e. Quarterly contact or mid-year review)
- Medical providers can submit claims retroactively
- If not reinstated, ensure the assessment and support plan are in completed status and remove the location and CC assignment

CT 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.

CONNECT+ MEDICARE: Members remain on the enrollment roster because UCare covers all claims covered under the CT+ MED benefit during the 90-day grace period. During this period, members will 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 for 90 days following the date MA becomes inactive
- 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.
- Upon notification of disenrollment from UCare via the Enrollment Roster, ensure MnCHOICES documents are in completed status and remove the CC location and assignment

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

Medical Spenddowns and UCare Enrollment

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. 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.

CT/CT+ MED: Members who are enrolled in UCare Connect/Connect + Medicare 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. Members who have questions about spenddowns should be directed to speak to their county of financial responsibility eligibility worker. CCs do not have access to spenddown information.

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. 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, PCA/CFSS, or home care nursing.

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 a 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.

Reference: DHS MHCP Health Care Programs and Services | DHS-3017 What is a Spenddown | 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 60 days of the member's enrollment to UCare to complete an HRA

Member Contacts

Initial Contact

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

Outreach Attempts

The minimum required frequency and method of outreach attempts vary by the members' health plan type. When scheduling an assessment for a new, transfer or product change member and support plan reviews, the care coordinator completes:

CT: Three (3) attempts via phone, secure email, or Unable to Reach Letter. If three attempts are completed, one of the attempts must be a UTR letter.

CT + MED: Four actionable attempts* (three (3) phone calls and one (1) Unable to Reach Letter. If phone calls are to non-working or unconfirmed numbers, then additional letters are acceptable.

TIPS: When mailing Unable to Reach Letters, allow at least two days between mailings to allow time for the member to respond. When calling, the attempts must be made on different dates and at varying times.

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

*Actionable Attempt: CT+MED requires actionable attempts, which refer to contact methods that a member or their responsible party can act upon. These include leaving a voice message at a working number and mailing letters to known addresses. It is best practice to use actionable attempts for Connect members.

Using Interpreters

UCare provides interpreter services for American Sign Language and spoken language/limited English proficiency for members of UCare Connect and UCare Connect + Medicare 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 telephone interpreter services: See CLI Telephonic Pre-Scheduling Instructions.

Each delegate agency has been provided with a customer code. 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 Connect Members and Using Interpreters

Interpreter agencies submit claims under the member's UCare ID (not the PMI). If an interpreter claim is submitted for a Connect member during their 90-day monitoring period due to inactive MA, the claim will be denied. Contact the Clinical Liaison Team at SNBCClinicalLiaison@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 person-centered 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 every 6 months (mid-year review) to review goals as well as during Transitions of Care (aka hospital admit/discharge).

The Assessment

A CT/CT+ MED assessment is completed within 60 days of the member's enrollment date and thereafter reassessed within 365 days. If a member requests an assessment or if there is a significant change in the member's condition, it is best practice to complete it 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 outreach 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 CT/CT+ MED Assessment Checklist 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. Frequency and method of contact vary based on the member's health plan. See the table below. Robust documentation of the assessment options offered according to the grid below is key to maintaining compliance with DHS and CMS regulations.

	CT + MED 4 actionable attempts: 3 phone calls & 1 UTR letter	**CONNECT** 3 attempts: Phone, email, or UTR Letter. If three attempts are completed, one of the attempts must be a UTR letter.
Initial Assessment	**Offer HRA:** • 1st In Person • 2nd Televideo • 3rd Telephone* **Institutional:** In-person required *Additional encounter requirements	**Offer HRA:** • May be conducted via phone, televideo or in person ○ In-person must be offered Conversation example: "We can complete our visit on the phone or in person to review your needs." **Institutional:** In-person required
THRA	**Method:** May be conducted via phone, televideo or in person	**Method:** May be conducted via phone, televideo or in person

Annual Assessment	**Offer HRA:**
	• 1st In Person
	• 2nd Televideo
	• 3rd Telephone*
	
	Institutional: In-person required
	*Additional encounter requirements
		Offer HRA
		• May be conducted via phone, televideo or in person
		  ○ CT non-waiver: In-person must be offered
		  ○ CT waiver: Offering in-person is not required
		
		Institutional: In-person required

Mid-Year Review	**Method:** *Additional encounter requirements **Institutional:** Any method	**Method:** Any method **Institutional:** Any method

*CT+MED Additional Encounter Requirements

If a Connect + Medicare member assessment is completed via telephone, a separate in-person or televideo encounter during that same 12-month period is required. Ideally, this is completed by the Care Coordinator. Alternatively, the Care Coordinator can confirm the PCP, Waiver Case Manager, or other ICT Specialty Care Provider has seen the member in person or televideo.

Reference: CT/CT+ MED In-Person Assessment Requirements Job Aid

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

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 encounters. 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

Assessment Tools

MnCHOICES Assessment**	•An option for UCare care coordinators who have a dual role of being the member's county case manager for members on waivers (CADI, DD, BI, CAC) to complete in lieu of completing the HRA-MCO •See In-Person Assessment Job Aid for methods and additional encounter requirements
HRA-MCO	•Health Risk Assessment (HRA) for community and nursing home members •Completed when member is on other waivers (CADI, DD,BI,CAC) and county is not providing waiver case management •See In-Person Assessment Job Aid for assessment methods and additional encourter requirements
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
Additional Assessment Tools	•DHS-6914 Caregiver Assessment (optional when caregiver identified) •DHS-3428M Mini Cognitive Exam (optional) •PHQ9 Depression Screening (optional)

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

**DHS permits UCare care coordinators who are also the disability waiver case managers to utilize the MnCHOICES Assessment tool to meet both UCare care coordination and disability waiver assessment requirements. When electing to use this option, the CC/CM selects "I am the care coordinator and need the Staying Healthy Section, Notice of Action and Signatures" within the MNCHOICES application.

Dual-role CC/CMs are expected to meet all UCare care coordination requirements including but not limited to assessment timelines, in-person assessment requirements, support plan requirements, and submitting the Monthly Activity Log.

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

Reference: Additional & Supplemental Benefits | Member Handouts | CT/CT+ MED Assessment Checklist

Member No Show or Canceled Assessment

Scheduling assessments at least two weeks before the due date is best practice. This allows ample time to reschedule due to illness, poor weather or if a member misses a scheduled appointment. To prevent a missed assessment, it may be helpful to provide a reminder call to the member the day before the visit.

In the event that a member "no shows" or cancels an assessment, complete and document any of the remaining outreach attempts to reach the member. If documented, the conversation(s) scheduling the assessment and the unsuccessful assessment attempt to reach the member on the day of the assessment count toward the required outreach attempts.

- After completing outreach attempts, if the member is not reached, proceed with UTR process
- If a member is reached and declines assessment, proceed with the Refusal process
- If a member is reached and still interested in an assessment, reschedule the assessment and complete it at a scheduled time

NOTE: If the member is reached within the required timeframe but is unable to schedule the assessment within the required time frame, complete the Refusal process.

MMIS Entry

Medicaid Management Information System (MMIS). MMIS entry is not required for HRA-MCO assessments, nor completion of a THRA. Care coordinators who are also county case managers completing the MnCHOICES Assessment need access to the BlueZone application to enter activity into MMIS. Contact your agency's IT department for assistance with your agency's requirements for downloading BlueZone.

Transfer Member Health Risk Assessment

Transfer Member Health Risk Assessment (THRA) may be completed when an HRA-MCO 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: CT/CT+ MED or vice versa
2. Other MCO to UCare transfer

The previous (sending) case management/care coordination entity provides the new (receiving) CC with the most recent copy of the HRA-MCO (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.

The THRA may not be used for members transferring from a dual-role county CC/CM. See Change in Care Coordinator.

Reference: MnCHOICES Guidance | Connect Requirements Grid | Assessment Checklist

Waiver Case Management Referrals

When a CC identifies a member who may benefit from Home and Community-Based Services (HCBS), the CC completes a referral to the member's county of residence Intake Team for a Long-Term Care Consultation (LTCC). The LTCC process involves a Certified Assessor completing the MnCHOICES assessment and using the assessment results to determine if the member meets the designated level of care for the specific waiver. The assessment will aid in determining the appropriate waiver type. Members approved for a waiver subsequently have supports and services authorized by the County Case Manager. The most common waiver CCs encounter is the CADI waiver.

References: Long-Term Care Consultation Services | DHS CADI Waiver

Nursing Facility Level of Care Criteria (CADI example)

Before making a referral for a MnCHOICES assessment at the member's county of residence, the CC should have a basic understanding of how a member might qualify for a CADI waiver. Certified Assessors determine if members meet the nursing facility (NF) level of care based on **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: CBSM Nursing Facility LOC Criteria Guide

Consumer Directed Community Support (CDCS)

CDCS is a service option that gives members open to a disability waiver 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 learn more about CDCS, CCs may view the DHS CDCS Online Learning Module which includes an overview of the CDCS program.

References: DHS CDCS Policy Manual

Non-Waiver HCBS

Moving Home Minnesota (MHM)

MHM is a program designed to provide members with opportunities to move from a skilled nursing facility or institution to a residence in the community. For members enrolled in CT/CT+ MED, refer to the member's county of residence who may be interested in MHM.

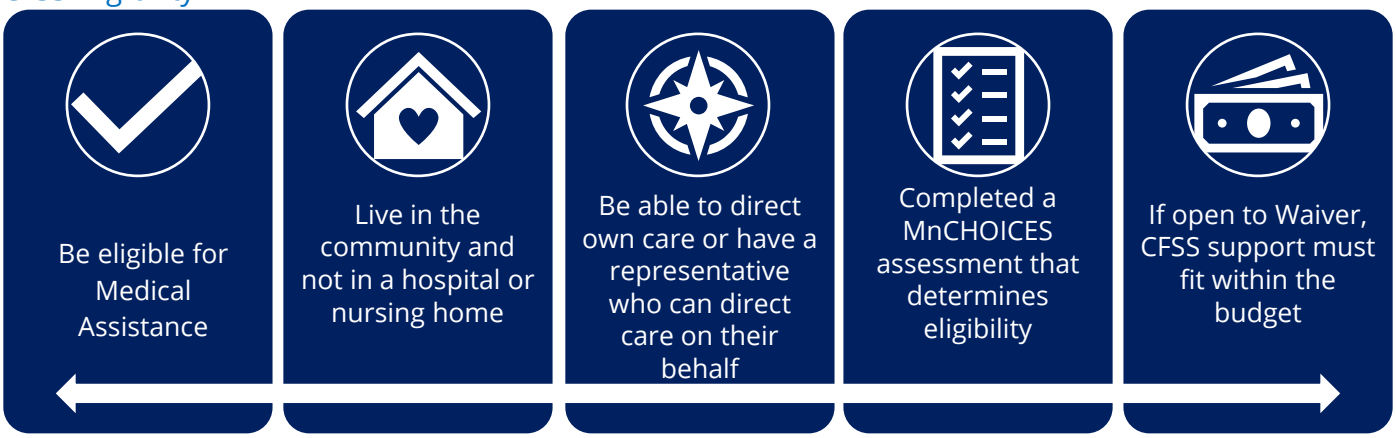
Reference: DHS Moving Home Minnesota | Moving Home Minnesota Job Aid

Community First Services and Support

On Oct. 1, 2024, DHS transitioned from personal care assistance (PCA) and the Consumer Support Grant (CSG) to a new combined program called Community First Services and Supports (CFSS). CFSS is a Minnesota health care program that provides services to seniors and people with disabilities to help them remain independent in the community. CFSS remains "carved out" of the SNBC plan and is not paid for by UCare. A Certified Assessor completes an in-person MnCHOICES assessment and uses the assessment results to determine eligibility for CFSS. The county case manager is responsible for authorizing CFSS.

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

CFSS Eligibility



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 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.

CFSS Referrals

When a CT/CT+ MED member needs CFSS, the CC should complete a referral to the member's county of residence human services agency. County case managers are responsible for completing the MnCHOICES assessment and authorizing CFSS through MMIS for members on community waivers (CADI, BI, DD, CAC) or who need CFSS only. Care coordinators collaborate with the community waiver case manager to ensure there is no gap in services.

Reference: DHS CFSS Program Info: CFSS Policy Manual

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 (non-waiver member)

UCare CT/CT+ MED members require prior authorization for skilled nursing visits and home health aide using an in-network home care provider. The in-network home care agency submits the UCare Universal Home Health Agency form directly to UCare to obtain authorization.

Disability Waiver (non-EW) Receiving MA Home Care Services Paid by UCare

When a member is open to a community disability waiver, the county disability waiver case manager faxes the DHS-5841 to 612-884-2499 to authorize state plan services. The disability 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

CT 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.

Reference: UCare Authorization & Notification Requirements

Daily Authorizations Report (DAR)

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

Information on the DAR:

- Admissions and discharges to/from hospitals, mental health/SUD residential care and nursing homes not available via MN EAS/PointClickCare
- Approved Authorization of Services (EW, T2029, HHA, PCA/CFSS, ARMHS, etc.)

Action by care coordinators:

- Those with access to the SecFTP disseminate reports to the appropriate parties
- Review DAR for approved authorizations (ARMHS, SNV etc.)
- Review DAR for admission/discharges and to initiate Transition of Care needs

Denial, Termination, or Reduction (DTR) of UCare Paid Services

The purpose of the DTR process is to provide members with information about how to appeal a denial, termination or reduction decision for service paid for by UCare. Denied, terminated, or reduced services require a care coordinator to submit a DTR form based on the type of service (see table below) to UCare within **one business day** of determination. Care coordinators submit DTR's for ILOS, and supplemental benefits paid for by UCare. If the service is being paid by another payor, UCare does not require DTRs.

Denial: Denying a requested service not currently authorized or an increase request to an existing service
Termination: Ending/stopping an existing service
Reduction: Decreasing an existing service

UCare recognizes the difference between providing a member with education about what services they may or may not be eligible for and whether a formal denial of the request is necessary. The discussion between a CC and a member about why a service may not be appropriate and redirecting to alternate services is not a formal denial; this is collaborative service planning. When the CC provides member education about benefit eligibility and the member agrees with the outcome, the CC documents the conversation, and a denial is not needed. If a member continues to request a service after the CC has provided education about why the service is not appropriate/the member is not eligible, then a formal denial is required. Lastly, when a member is on a UCare product that does not offer the supplemental benefit, the member is requesting, the member may file a grievance by contacting UCare customer service.

Reference: ILOS Discharge DTR Form | Supplemental Benefits Denial Termination Reduction Form

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 members' identified risks, preferences, supports, barriers
  - Identified risks and declined goals are included in "My Plan to Address Safety Needs"
- Writing goals in the SMART (Specific, Measurable, Attainable, Relevant, and Time-Bound) format
  - See SMART Goals Job Aid and SMART Carte
- Including interventions/"My Supports" the member chooses to help achieve the goal
- Identifying and maintaining at least one high-priority, in-progress goal
- Identifying the members Interdisciplinary Care Team (ICT)
- Ensure a person-centered emergency backup plan is established in "My Backup Plans" or "My Plan to Address Safety Needs"
- Monitoring for achievement at mid-year or more frequently based on the agreed-upon follow-up plan
- Adjusting target dates when target is surpassed or exceeded

Support Plan Tools

Support Plan - MCO MnCHOICES Assessment	• An option for UCare care coordinators who are also the member's county case manager for members on waivers (CADI, DD, BI, CAC) to use when having completed the MnCHOICES Assessment • Assessment information pulled from MnCHOICES Assessment • Support Plan completed and provided to member/responsible party, PCP and other members of the ICT w/in 30 days of assessment
Support Plan - Health Risk Assessment	• Completed by UCare care coordinators • Assessment information pulled from MnCHOICES 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
Unable to Reach Support Plan*	**CT+ MED:** completes the UTR Support Plan • **CT:** documents outreach attempts and outcome in member record
Refusal Support Plan*	• **CT+ MED:** If at any point the member is reached and verbally declines an in-person assessment, document and complete the Refusal Support Plan • **CT:** document outreach attempts and outcome in member record

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 the 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: CT/CT+ MED Letters Guide

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

Signature Requirements

Members/legal representatives must provide a signature indicating agreement with the support plan to complete the support plan. This may be done in person via electronic signature, or the MnCHOICES Signature Sheet may be mailed/surely emailed to obtain. If mailed, the CC must document at least one additional follow-up attempt by phone, secure email, 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 biannually, 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
- CT+Med: document three (3) actionable attempts and one (1) Unable to Reach Letter for the mid-year review
- CT: document two (2) attempts via phone or email and one (1) Unable to Reach Letter for 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
- Goals are updated as Achieved, In Progress, or Discontinued
    - There must always be at least one in-progress and high-priority goal on the member support plan
    - If all goals are achieved or discontinued (aka closed), a new high-priority goal must be created

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 outreach 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:

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

Care Coordinator's Support Members in the Following Areas

- Managing all aspects of the member's 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
  - Collaborating with the member's waiver CM to arrange non-medical transportation (as applicable)
- Facilitating informed decision making to encourage control over services and supports
- Assisting in resolving 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 Veterans Administration (VA) for eligible members
- Assisting members through transitions of care

Collaboration with Other Case Managers

Care coordinators are required to collaborate with all members' 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

Care coordinators review the waiver case manager's support plan to better understand the member's needs, supports and services and 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 (non-dual role) 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*
Care Coordinator: Completes Support Plan - HRA	**Case Manager (CM):** Completes MnCHOICES Support Plan
Areas of Focus	
Assist in accessing medical care, preventative health education, and closing Gaps in Care	Authorize HCBS, PCA/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 & assists 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	Waiver CM completes OBRA II as applicable for UCare members

Behavioral Health Home (BHH)

The term "behavioral health home" services refer 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 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 locate the 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. 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 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 home due to an exacerbation of a chronic condition; then, the member is discharged 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 additional transitions:

- Educate to avoid unnecessary ER visits and hospitalizations
- Look for risks (falls, lack of preventive care, poor chronic care disease management, social determinants of health and vulnerable adult concerns) 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 PointClickCare on business days
- DAR
- Member/legal representative
- Other

Mn Encounter Alert System powered by PointClickCare

In partnership with DHS, PointClickCare (PCC) 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 a PCC-participating hospital, emergency department, long-term care facility, or other provider organization in real-time. Care coordinators are expected to access PCC on business days to receive notifications of member transitions.

TOC Log

CT+ MED 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 CT 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 Required Tasks	CT+ MED	CT
TOC Log (Activity initiated within **one business day** of each notification) NOTE: if notification of transition is 15 calendar 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 each notification)	X	

Follow up with the receiving care setting* to share the relevant support plan and member information	X	
TOC notification to PCP via letter/fax/phone call (Within **one business day** of each notification)	X	
Follow up with other members of ICT (BHH and CADI/BI/DD/CAC case manager and other ICT as appropriate)	X	X
Follow up with member/responsible party upon return to the usual setting (First attempt to reach member within **one business day** of each notification)	X	X
4-pillars and Additional Discussion (Completed upon return to usual setting/home. First attempt to reach member within **one business day** of each notification.)	X	
Document all follow-up efforts	X	X

*The receiving setting includes home when home care services are in place, assisted living, hospital, SNF, TCU/rehabilitation facility, mental health or substance use disorder residential treatment. If the transition is a return to the usual care setting with no services, document N/A in this date field with a brief explanation in the comments section.

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 PointClickCare and the Daily Authorization Report for admissions
- Complete transitions of care activities
- CT+ MED 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.
- Complete the member's reassessment based on the member's assessment timeline requirements
- Update the member's support plan as applicable

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 the community, CC sends the DHS-5181 to notify the county of a member address change.

Institutionalized Members

Care coordinators may manage members who are residing in a long-term care facility (e.g., a skilled nursing facility or an Intermediate Care Facility (ICF). The CCs role is to review the member's overall care needs and assist members who wish to return to the community. CCs provide education on additional and supplemental benefits and assist with obtaining as needed. CCs ensure that preventative care needs are being met and act as advocates for members' 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. The HRA and support plan used are the same for community members and are completed within the MnCHOICES application. See Assessment Tools and Support

Plan Tools. Additionally, assessments are required to be conducted in person. A signature is required for the Support Plan.

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.

If a member does not have a guardian and is unable to participate in the assessment due to being unable to communicate, the CC can document the reason the member was unable to participate and document physical observations of the member. Continue to review collateral information to complete the assessment and support plan. It's important to note that the in-person observation of the member is essential to the institutional member assessment process. In the rare instance that the member is unable to reach (e.g., hospitalized or unable to locate) or declines all participation, consult with a supervisor or the clinical liaisons.

Reference: Care Coordination Requirements Grid | CT/CT+ MED Assessment Checklist

Medical Assistance (MA) Renewals

It is important to assist members in maintaining MA eligibility before their renewal date to ensure they maintain 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 members' 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.

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 CCs 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's ConnectIntake@ucare.org for additional assistance.

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 to care coordination assignments within 10 business 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.

Transfer from Dual Role County CC/CM to UCare Delegate non-dual Role Care Coordinator

Members transferred from a county case manager, who is also the UCare care coordinator, who completed a MnCHOICES Assessment and Support Plan-MnCHOICES, to a receiving CC who is not a dual-role case manager must treat the member as NEW, completing a new HRA-MCO and Support Plan-HRA.

Reference: Letters Guide

Temporary absence of CC

UCare advises lessening the disruption to the member's case management and reducing 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 about 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.

Members Turning age 65

Members who turn 65 are no longer eligible for CT/CT+ Med. UCare provides members in advance of their birth month with options on which they may act. Taking no action will result in members defaulting to an MSC+ health plan. CCs play a vital role in assisting members with a seamless transition as members age into UCare MSC+ or MSHO. As the care coordinator, it's important to assist members by:

- Providing education on changes in benefits/insurance to ensure a smooth transition
- Refer to UCare Sales team who can review medications, providers and more to ensure the member has the information needed to make an informed decision
- Discussing the potential of the member receiving a change of care coordinator
    - Provide a warm handoff to the receiving CC when able
- Confirming the member has identified their Primary Care Clinic (PCC)
    - MSC+ and MSHO members are assigned based on the member's PCC
    - Complete the PCC Change form as applicable to ensure accurate new assignment
- Educating the member on the differences between MSC+ and MSHO
    - Eligible members must actively choose MSHO, or they will automatically default to MSC+
    - To be eligible for MSHO, the member must also be eligible for Medicare
    - Utilize UCare Comparison: MSHO and MSC+ Member Handout
- Reminding the member they will get a new ID card(s) and to share with medical providers and pharmacy
- If UCare is not offered in the member's county for MSC+/MSHO, assist in finding other options
    - See the DHS DHS-4840-ENG (state.mn.us) for MCO choices by county
- Collaborating with the Community Disability Waiver case manager
    - Some members may benefit from remaining on their current waiver. The Waiver CM can assist the member with understanding the benefits and differences when transitioning to an Elderly Waiver.
- Addressing the transition of PCA/CFSS from county assessment to care coordinator authorization
    - CT/CT+ Med does not cover PCA/CFSS. MSC+/MSHO does.
    - Members will need to utilize an in-network provider for services as they move to MSC+/MSHO.
    - Verify current providers are in the UCare network as applicable
- Sending DHS-6037 if a member is transferring to a new care coordinator

Other Case Closure Responsibilities

Termination Event	Care Coordination 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	• 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/monitoring period • Notify providers to stop services	• Upon notification on the UCare Enrollment Roster, remove CC location and assignment and discontinue care coordination
Member Confirmed to be Incarcerated	• Complete outreach attempts to permanent residence, if known, for the member to act upon if released • Document confirmation in the member record • Follow the process for UTR or refusal (if reached and declined) • Send 5181 to COR	• Upon notification on the UCare Enrollment Roster, remove CC location and assignment and discontinue care coordination
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	• Upon notification on the UCare Enrollment Roster, remove CC location and assignment • Ensure documents are in completed status
Member Changes to Non-UCare Health Plan	• Enrollment Roster informs CC of change • Verify in Mn-ITS MA is active and ID new MCO • Document in member record • Complete the DHS-6037 to transfer to the new MCO	• Upon notification on the UCare Enrollment Roster, Remove the CC location and assignment • Ensure documents are in completed status

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, transition of care activities, 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 Connect and Connect + Medicare 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 that can not be obtained using MnCHOICES reports. The MAL is also used to record the applicable health status code used for CT/CT+ MED care coordination payment purposes. The required reporting applies to all

assigned members in both CT/CT+ MED health plans. The MAL is completed and emailed to UCare at assessmentreporting@ucare.org by the 10th day of the month.

Reference: CT/CT+ MED 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