UCare Connect and Connect + Medicare
Care Coordination Requirements Grid
Effective 1/1/2025

Contents

All related UCare forms can be found, HERE, all DHS forms can be found HERE, Care Coordination Manual can be found HERE

*All items marked with an asterisk have a definition included on the Definitions and Abbreviations page

UCare Connect and Connect + Medicare
Care Coordination Requirements Grid
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CONNECT AND CONNECT + MEDICARE REQUIREMENTS GRID	

Initial Assignment	Initial assignment* is the first day the care system or county receives the care coordination enrollment roster. ALL members enrolled in Connect and Connect + Medicare are required to be offered a Health Risk Assessment (HRA). **Upon receiving the monthly enrollment roster, the care coordinator (CC) is required to:**
	• Provide the member with the name and phone number of the CC within 10 business days of initial assignment*.
	  ○ This may be done by phone or letter and must be documented in the member's record. If contact is by letter, the CC must use UCare's approved Connect/Connect + Medicare Welcome Letter (for new members) or Change of Care Coordinator Letter (for transferred members) found on the UCare website.
	  ○ Document verification of eligibility and waiver status via MN-ITS*
	  ○ Add care coordinator location and staff assignment in MnCHOICES within 60 days of enrollment

Initial Contact	**The CC is required to:**
	• Contact the member to complete an HRA within 60 days of enrollment*
	  ○ Document a minimum of 4 actionable attempts* or fewer if member is reached
	  ▪ Contacts may be by phone, televideo, in-person, or secure email on different days, at different times, and by using the Unable to Reach Member Letter on the UCare website
	  NOTE: Sending the Welcome Letter is not considered an actionable attempt to contact the member
	  ○ Proceed with appropriate section below

ASSESSMENTS	

New Member/Initial Health Risk Assessment (HRA)	A member is considered NEW when newly enrolled into UCare Connect or Connect + Medicare and has not had a previous assessment entered in MMIS* within the last 365 days. ALL members enrolled in Connect and Connect + Medicare are required to be offered an assessment within 60 days of new enrollment. If a member declines an in-person assessment, a televideo assessment may be completed. If member declines a televideo, a telephonic HRA may be completed per member choice. Document the in-person and televideo HRA was offered and member preferences in the member's record. Members with previous coverage that experience a gap due to loss of MA eligibility (IE: exceeding 90-day grace period) reflected on the enrollment roster as a NEW member if re-enrolled. The assessment used for Connect and Connect + Medicare is Health Risk Assessment – MCO form located within MnCHOICES application. **NOTE:** See *Connect + Medicare Additional Encounter Requirements* and *Assessment Guide* for additional assessment requirements.

	CC is required to:
	• Contact the member per *Initial Assignment* and *Initial Contact* sections
	• Members on waiver: Document outreach to waiver case manager and include CC contact information. Document review of waiver Support Plan
	• Complete the MnCHOICES HRA-MCO assessment with the member within 60 calendar days of enrollment
	  ○ When completing the HRA-MCO form, all questions and sections must be completed or marked as "not applicable"
	  ○ Ensure assessment is in 'Completed' status
	• Have *Safe Disposal of Medication** conversation. Document discussion and that the form was provided on the MnCHOICES Signature Sheet under 'Materials shared: Other information'
	  ○ Not required for members living in a skilled nursing facility
	• Connect + Medicare only: Educate members on transitions of care and provide a Transition of Care Member Handout. Document discussion and that the handout was provided in case notes or MnCHOICES Signature Sheet under 'Materials shared: Other information'
	• Develop a person-centered Support Plan-HRA
	  ○ Ensure Support Plan is in 'Plan Approved' status
	  ○ See *Support Plan* and *Support Plan Signature* sections for additional details and timelines

	• MMIS entry NOT required • Add member to Monthly Activity Log and update Health Status code, based on assessment outcome ○ Return the Monthly Activity Log to UCare by the 15th day of the following month **NOTE:** If new member is Unable to Reach or Refusal refer to their respective sections
Transferred Member between UCare Delegates	**Transferred Member from a UCare Delegate:** Members who are transferred between UCare delegates and the member remains on the same product at transfer. The enrollment roster will indicate "care coordinator change" in the status column to notify of a UCare delegate change (e.g., MHR to UCare, Olmsted County to MHR, etc.).

	The previous (sending) CC is required to:
	• Thoroughly complete all areas of the DHS-6037 Transfer Form and send via secure email or fax to the new (receiving) CC when confirmed via enrollment roster.
	  ○ Care Coordination Contact List is located on the UCare website
	• The transfer must also include:
	  ○ The most recent HRA, Support Plan, Support Plan Signature Sheet with member signature, relevant case notes, and other applicable case documents if not found in MnCHOICES.
	  ○ This includes UTR/Refusal Support Plans as applicable
	  ○ **NOTE:** If a CC has completed an assessment and is notified of a member transfer, the CC must complete all assessment paperwork PRIOR to transfer, including the Support Plan.
	• Unassign location and staff in MnCHOICES
	• Ensure MnCHOICES forms are left in a completed status
	
	The new (receiving) CC is required to:
	• Provide the member with the name and phone number of the CC within 10 business days of transfer.
	  ○ This may be done by phone or letter and must be documented in the member's record. If contact is by letter, the CC must use UCare's approved Change of Care Coordinator Letter found on the UCare website.
	  ○ Document the review of transfer documents
	  ○ Fill in any missing information with member if necessary

	○ If Signature Sheet not received, CC ensures evidence in transfer documentation of at least 2 attempts to obtain member signature. If not present, CC completes any remaining attempts to obtain (up to 2 attempts). ○ **NOTE:** If the Member was previously a UTR or Refusal, treat as a New Member. Four outreach attempts are due. ○ Assign staff and location in MnCHOICES ○ No MMIS entry required ○ No Monthly Activity Log entry required
Transferred Member to/from a Different MCO	**Transferred Member from different SNBC Managed Care Organization (MCO) to UCare Connect/Connect + Medicare:** When a member enrolls in UCare Connect/Connect + Medicare and was previously with a different MCO. The enrollment roster does not indicate a change of MCO (e.g., UCare to Medica, Medica to UCare, etc.). Member will have a status of "New Member/Termed Member." Care coordinators (CC) may use Transfer Member Health Risk Assessment (THRA) when an HRA and Support Plan completed within the last 365 days are obtained, and the member is able to be reached within 60 calendar days of enrollment. By completing the THRA the CC is adopting this assessment and Support Plan as their own. If the member was a previous UTR/Refusal, the THRA process may not be used.
	The previous (sending) CC is required to: • Thoroughly complete all areas of the DHS-6037 Transfer Form and send via secure email or fax to the new (receiving) CC when confirmed via enrollment roster ○ Care Coordination Contact List is located on the UCare website • The transfer must also include: ○ The most recent HRA, Support Plan, Support Plan Signature Sheet with member signature, relevant case notes, and other applicable case documents. ▪ This includes UTR/Refusal Support Plans as applicable ▪ NOTE: If a CC has completed an assessment and is notified of a member transfer, the CC must complete all assessment paperwork PRIOR to transfer, including the Support Plan • Unassign location and staff in MnCHOICES • Ensure MnCHOICES forms are left in a completed status

The new (receiving) CC is required to:

- Provide the member with the name and phone number of the CC within 10 business days of transfer.
  - This may be done by phone or letter and must be documented in the member's record. If contact is by letter, the CC must use UCare's Welcome Letter found on the UCare website.
- Verify eligibility in MNITS and request transfer documents from previous MCO. Contact information for MCOs is located on the DHS 6037 document.
- If unable to obtain a copy of the most recent HRA from the previous CC or there has been a change in condition, treat as new member. Refer to *New Member/Initial Health Risk Assessment* section for requirements.
  - Contact ConnectIntake@ucare.org if transfer documents have not been received
  - CC may complete a Support Plan if one has not been received in the transfer or at CC's discretion due to significant updates
    - If creating a new Support Plan, CC must obtain a Signature. Share the new Support Plan with member and PCP within 30 days of THRA
- Review the DHS-6037, current HRA with supporting documents, and update the Support Plan received from the previous (sending) CC
  - Ensure a signature sheet is received or check with sending CC to get a copy. If unable to obtain, follow the *Support Plan Signature Sheet* section to obtain a new member signature.
- Identify when the next assessment is due
  - THRA will not reset assessment timeline. Reassessments are kept on the same schedule and due within 365 days of the last HRA.
- Make 4 actionable attempts* to reach the member. The contacts may be by phone, in-person, or secure email on different days, different times, and by using the *Unable to Reach Member Letter* on UCare website.
- Complete the THRA form from UCare's website and attach in MnCHOICES. This may be completed with the member by phone, televideo, or in-person within 60 days of enrollment.

	○ When completing the THRA, all questions and sections must be completed or marked as "not applicable" ○ Document review in member record ○ Update HRA/Support Plan as needed • Complete the THRA HRA type/date in MnCHOICES within 60 days of enrollment • Ensure the full HRA-MCO and Support Plan are reviewed and updated as needed ○ Document review in member record • If a member with a current HRA/Support plan is unable to be reached or declines the THRA, document the final outcome in member record. Do not revise the MnCHOICES Support Plan. Do not complete an Unable to Reach or Refusal Support Plan. MnCHOICES THRA type/date entry still required. • Connect + Medicare ONLY: If the member is unable to be reached, add member to Monthly Activity Log. Because the member has a current HRA/Support Plan, the HS code is HP. ○ Return Monthly Activity Log to UCare by the 15th day of the following month • MMIS Entry not required
Product Change	A Product Change is when a member moves from Connect to Connect + Medicare or vice versa. Members who have product changes are considered "new" members and must have an assessment completed within 60 days of the enrollment into the new product. Care coordinators may use a Transfer Member Health Risk Assessment (THRA) when an HRA and Support Plan completed within the last 365 days are obtained, and the member is able to be reached within 60 calendar days of enrollment. By completing the THRA the CC is adopting this assessment and Support Plan as their own. If there is not a previous HRA/Support Plan within the previous 365 days, a new assessment* is required within 60 days of enrollment. • If the member was a previous UTR/Refusal, the THRA process may not be used. Follow New Member process.
	The CC is required to: • Provide the member with the name and phone number of the CC within 10 business days of Product Change.

	○ This may be done by phone or letter and must be documented in the member's record. If contact is by letter, the CC must use UCare's approved *Welcome Letter* found on the UCare website. • Identify when the next assessment is due • THRA will not reset assessment timeline. Reassessments are kept on the same schedule and due within 365 days of the last HRA. • Make 4 actionable attempts* to reach the member within 60 calendar days following enrollment date The contacts may be by phone, in-person, or secure email on different days, different times, and by using the *Unable to Reach Member Letter* on UCare website • Complete the THRA form from UCare's website and attach in MnCHOICES. This may be completed with the member by phone, televideo, or in-person within 60 days of enrollment. When completing the THRA, all questions and sections must be completed or marked as "not applicable". ○ Review/update Support Plan as needed • Complete the THRA HRA type/date in MnCHOICES within 60 days of Product Change ○ Open a Health Risk Assessment-MCO form and use 'Transitional HRA' for the 'HRA Type'. Enter 'Product Change' for the 'Transitional HRA type' and 'Referral Date'. • Requirements are fulfilled after completing Assessment Information. Review all additional areas applicable. • If a member with a current HRA/Support plan is unable to be reached or declines the THRA, document the final outcome in member record ○ Do not revise the MnCHOICES Support Plan ○ Do not complete an Unable to Reach or Refusal Support Plan ○ Do not complete the THRA document ○ MnCHOICES THRA type/date entry still required • Connect + Medicare ONLY: if the member is unable to be reached, add member to Monthly Activity Log. Because the member has a current HRA/Support Plan, the HS code remains HP. ○ Return Monthly Activity Log to UCare by the 15th day of the following month • MMIS Entry not required

Institutionalized Members	Connect/Connect + Members living in Skilled Nursing Facilities/Institutionalized settings utilize the Health Risk Assessment – MCO form and Support Plan-HRA documents within the MnCHOICES application. This includes members identified as "institutional" on the enrollment roster living in ICF/Group Home/AFC. • For new admission to skilled nursing facility from community, reference *Admission to Nursing Facility* section.
	The CC is required to: **New Members:** Contact the member per the *Initial Assignment* and *Initial Contact with Members* sections above • NOTE: All institutional assessments are to be completed in-person effective 1/1/2024 • If the member is UTR/Refusal complete steps per *UTR/Refusal Support Plan* sections as applicable • See *New Member/Initial Health Risk Assessment (HRA)* • See *Support Plan* and *Support Plan Signature* sections o Reminder: A signature sheet is required for Institutional members o Documentation of the review of MDS and facility care plan is required for members living in SNF A copy of the MDS and facility care plan is NOT required to be retained in the member record o Determine if there are any additional needs or changes to the MDS or facility care plan and make suggestions to SNF staff **Product Change:** • Provide the member with the name and phone number of the CC within 10 business days of Product Change o This may be done by phone or letter and must be documented in member's record. If contact is by letter, the CC must use UCare's approved Connect/Connect + *Welcome* found on the UCare website. • Make 4 actionable attempts* to reach the member within 30 calendar days following enrollment date to review the current IHRA*/Support Plan *with* the member/representative*. This can be done via phone, televideo, or in-person. • Complete the THRA form from UCare's website and attach in member's record • Review the Support Plan and update/revise as necessary

	• If the member is unable to be reached for the THRA or refuses the THRA, document final outcome in member record. Do not revise the MnCHOICES Support Plan. Do not complete an Unable to Reach or Refusal Support Plan. MnCHOICES THRA type/date entry still required.
	• Connect + Medicare ONLY: if the member is unable to be reached, add member to Monthly Activity Log.
	
	Reassessment:
	• Contact the member to complete an assessment* WITHIN 365 days of previous HRA AND upon a change in condition*
	  ○ When a reassessment is following an initial UTR/Refusal the Reassessment Due Date* is based on member initial enrollment date in the current heath plan product. This is only applicable to the first reassessment following an initial UTR/Refusal.
	• Document a minimum of 4 actionable attempts,* or fewer if member reached
	  ○ If member is UTR/Refusal, proceed to *Unable to Reach* or *Refusal* sections
	  ○ Contacts may be by phone, televideo, in-person, or email on different days, at different times, and by using the "Unable to Reach Member Letter" on the UCare website
	• See *Annual Reassessment* section
	• See *Support Plan* and *Support Plan Signature Sheet* sections
	  ○ Reminder: A signature sheet is required for Institutional members
	  ○ Documentation of the review of MDS and facility care plan is required for members living in SNF A copy of the MDS and facility care plan is NOT required to be retained in the member record
	  ○ Determine if there are any additional needs or changes to the MDS or facility care plan and make suggestions to SNF staff

Annual Reassessment	**The CC is required to:**
	• Contact the member to complete an in-person assessment* WITHIN 365 days of previous HRA AND upon a change in condition*
	  ○ When a reassessment is following an initial UTR/Refusal the Reassessment Due Date* is based on member initial enrollment date. This is only applicable to the first reassessment following an initial UTR/Refusal.
	• If a member declines an in-person assessment, a televideo assessment may be completed. If member declines a televideo, a phone assessment may be completed per member choice. Document the member's informed choice of assessment methods and member preferences in the member's record.
	  ○ **NOTE**: *Additional Connect+ Medicare Encounter Requirements*
	• Document a minimum of 4 actionable attempts* or fewer if member reached
	  ○ If member is UTR/Refusal, proceed to *Unable to Reach* or *Refusal* sections
	  ○ Contacts may be by phone, in-person, or secure email on different days, at different times, and by using the "Unable to Reach Member Letter" on the UCare website
	• Members on waiver: Document outreach to waiver case manager and include CC contact information. Document review of waiver Support Plan
	• When completing the HRA-MCO form, all questions and sections must be completed or marked as "not applicable"
	  ○ Ensure assessment is in 'Completed' status
	• Have Safe Disposal of Medication* conversation. Document discussion and that the form was provided on the MnCHOICES Signature Sheet under 'Materials shared: Other information'.
	  ○ Not required for members living in skilled nursing facility
	• Connect + Medicare: Educate members on transitions of care and provide a Transition of Care Member Handout. Document discussion and that the handout was provided in case notes or MnCHOICES Signature Sheet under 'Materials shared: Other information'
	• Update and close the "Status of Goal/Status Date" field in the current Support Plan
	• Develop a new person-centered Support Plan-HRA with new and ongoing goals
	  ○ Ensure Support Plan is in 'Plan Approved' status
	  ○ See *Support Plan* and *Support Plan Signature* sections for additional details and timelines

	• MMIS entry NOT required • Add member to Monthly Activity Log and determine the Health Status code based on assessment outcome ○ Return the Monthly Activity Log to UCare by the 15th day of the following month

Unable to Reach (UTR)	**The CC is required to complete tasks for the following scenarios:**
	Initial Enrollment: Initial outreach to complete an HRA is due within 60 days of enrollment
	-OR-
	Annual Reassessment: If the member is due for their first annual reassessment, the required tasks listed below are to be completed within 365 days from the original enrollment date and within 365 days thereafter
	• Example: Member enrolls new to UCare 01/01/22 and is Unable to Reach after the 4th attempt on 01/27/22, member's annual assessment is due PRIOR to 12/31/22 (all 4 contact attempts must be completed by 12/31/22)
	  ○ See *Reassessment Due Date**
	
	Both Scenarios require these tasks:
	• Document a minimum of 4 actionable attempts* to reach the member to schedule an assessment*
	  ○ Contacts may be by phone, in-person, or secure email on different days, at different times, and by using the "Unable to Reach Member Letter" on the UCare website
	  ○ For members with no known working number, a good faith effort should be documented to locate member's contact information. Investigative research is not considered an actionable attempt. The UTR Support Plan provides outreach investigation options. Alternatives may be used to locate a member's contact information as able. Examples may include:
	  ▪ Contact waiver case manager (as applicable) to collaborate and obtain working number
	  ▪ Review historical information – check to see if previous number is now working
	  ▪ As available – utilize other electronic health records accessible to the County or Care System (MIIC, PROMPT, EPIC)
	  ▪ *Public records* search
	• Complete HRA-MCO form within MnCHOICES indicating assessment results as "person not located for health risk assessment" and save as completed
	• If the member is CAC/CADI/DD/BI, document outreach to waiver case manager and share CC's contact information. Document review of waiver Support Plan
	• **Connect + Medicare**: Complete the UCare Unable to Reach Support Plan with at least one high-priority goal within 30 calendar days of the activity date. Attach in MnCHOICES.

	○ It is not required to mail the UCare Unable to Reach Support Plan to the member ○ Reminder: at the time of annual reassessment, close previous UCare Support Plan goals ○ When completing the UCare UTR Support Plan, all questions and sections must be completed or marked as "not applicable" ○ Safe Disposal of Medications* is not required for UTR members • **Connect:** Document outreach attempts and outcomes in member record ○ Reminder at the time of annual reassessment, close any previous Support Plan goals • Send the Provider Engagement Letter to the PCP **IF** known within 30 calendar days of the 4th actionable attempt • MMIS entry NOT required • Add the member to the Monthly Activity Log as an Unable to Reach member ○ Update Monthly Activity Log with the Health Status Code of "NR" ○ Return the Monthly Activity Log to UCare by the 15th day of the following month **Product Changes** • For UTR members that experience a Product Change, refer to the *New Member* section **Mid-Year Review** • Complete ongoing contact mid-year at a minimum • **Connect + Medicare**: Update the UTR Support Plan with the outcome of contact, new goals/interventions as applicable • **Connect:** Document mid-year outreach attempts and outcome in member record • Complete transition of care outreach/tasks when known • Assist with member requests for transportation, services/supports as needed • For members that are actively reaching out with needs, care coordinator is encouraged to attempt an assessment • At any point if member is able to be assessed, refer to *Annual Assessment* section above

Refusal	**The CC is required to complete tasks for the following scenarios:**
	Initial Enrollment: Initial outreach to complete an HRA is due within 60 days of enrollment
	-OR-
	Annual Reassessment: If the member is due for their first annual reassessment and refuses, the required tasks listed below are to be completed within 365 days from the original enrollment date and within 365 days thereafter
	• Example: Member enrolls new to UCare 01/01/22 and Refuses HRA after on the 2nd attempt on 01/27/22, member's annual assessment is due PRIOR to 12/31/22 (all 4 contact attempts must be completed by 12/31/22)
	  ○ See *Reassessment Due Date**
	
	Both Scenarios require these tasks:
	• Document a minimum of 4 actionable attempts* to schedule an assessment* or fewer if member reached
	  ○ Contacts may be by phone, in-person, or secure email on different days, at different times, and by using the "Unable to Reach Member Letter" on the UCare website
	• Document the conversation with the member/representative* noting the member refusal
	• Complete HRA-MCO form within MnCHOICES indicating assessment results as "person declines health risk assessment" and save as completed
	• If the member is CAC/CADI/DD/BI, document outreach to waiver case manager and share CC's contact information. Document review of waiver Support Plan
	• **Connect + Medicare:** Complete the UCare Refusal Support Plan with at least one high-priority goal within 30 calendar days of the activity date (date member refused assessment). Attach in MnCHOICES.
	  ○ It is not required to mail the UCare Refusal Support Plan to the member
	  ○ Reminder: at the time of annual reassessment, close previous UCare Support Plan goals
	  ○ When completing the UCare Refusal Support Plan, all questions and sections must be completed or marked as "not applicable"
	  ○ Safe Disposal of Medications* is not required for refusal members
	• **Connect:** Document outreach attempts and outcomes in member record

	○ Reminder at the time of annual reassessment, close any previous Support Plan goals • Send the Provider Engagement Letter to the PCP **IF** known within 30 calendar days of member refusal • Send Member Refusal Letter to member within 30 calendar days of member refusal • MMIS entry NOT required • Add the member to the Monthly Activity Log as a Refusal member ○ Update Monthly Activity Log with the Health Status Code of "NI" ○ Return the Monthly Activity Log to UCare by the 15th day of the following month **Product Changes** • For Refusal members that experience a Product Change, refer to the *New Member* section **Mid-Year Review** • Complete ongoing contact mid-year at a minimum • **Connect + Medicare:** Update the Refusal Support Plan with the outcome of contact and new goals/interventions as applicable • **Connect:** Document mid-year review outreach attempts and outcome in member record • Complete transition of care outreach/tasks when known • Assist with member requests for transportation, services/supports as needed ○ For members that are actively reaching out with needs, care coordinator is encouraged to attempt an assessment • At any point if member is able to be assessed, refer to *Annual Assessment* section above
SUPPORT PLANS	

Support Plan	The Support Plan reflects a summary of the member's assessed strengths, supports, and identified risks and choices. The Support Plan is located within the MnCHOICES application and is titled Support Plan-HRA. It is a living document that should be updated routinely throughout the year. All members receive outreach at the mid-year at a minimum to monitor progress toward goal completion, to provide health education, support, and resources or to attempt to complete the HRA. Updates include additional follow up as stated on the Support Plan as well as transition of care updates.

	The CC is required to:
	
	• Develop a new person-centered Support Plan with the member at the time of the initial or annual reassessment using the Support Plan-HRA located in the MnCHOICES application.
	• Support Plan must include the names and disciplines of members' Interdisciplinary Care Team (ICT)* as applicable
	• **All elements are to be completed in its entirety. Any sections that do not apply should be marked "N/A"**
	• Ensure Support Plan is in 'Plan Approved' status
	• The Support Plan must include identification of any risks to health and safety and plans for mitigating these risks, including informed choices made by enrollees to manage their own risk
	• Information collected through the HRA with the member or representative*/legal guardian includes:
	  ○ Input from the member and/or family members, the member's authorized health care decision maker, Primary Care Physician (PCP), and other ICT* members
	• Develop person-centered goals for identified areas noted in the HRA-MCO form including any goals to be continued from previous Support Plan. It is not required to develop goals for problems that are not currently active - I.e., when a member's chronic condition is well-managed and/or stable.
	  ○ Goals should be written based on needs identified with the member during their assessment
	  ○ Goals should be written as SMART goals (Specific, Measurable, Attainable, Relevant, and Time-bound)
	  ○ Goals should be prioritized using high, medium, or low. At least one goal is ranked as high priority

	○ Interventions should include the necessary steps to achieve the goal, who will provide assistance and resources/referrals needed to meet the goal • Clearly document in the 'My Plan to Address Safety Needs' section any areas of identified risks that the member has declined goals for or prefers no intervention • <u>The Support Plan is shared within 30 calendar days of the assessment. Day 1 is the date of the assessment.</u> Document the date the Support Plan is shared with applicable ICT* members: ○ Member and/or representative*. Include UCare *Care Plan Letter*. ○ PCP* ○ Waiver Case Manager (if CAC/CADI/DD/BI) ▪ Share by phone, email, or by sending a notification in MnCHOICES message center • As applicable, address each previously established goal by updating the "Status Date" and "Status of Goal" by selecting one of the following: ○ Achieved (goal met; Goal may or may not continue onto new Support Plan) ○ In-Progress (goal is not met and goal continues over to new Support Plan) ○ Discontinued (goal no longer relevant; member no longer wants goal) • Add additional comments or updates under "Monitoring Progress" section with a date

Support Plan Signature Sheet	**The CC is required to:**
	• Obtain a Support Plan signature from the member or member's representative* using the e-signature within MnCHOICES. This signature demonstrates that the CC has discussed the Support Plan with the member.
	  ○ **NOTE:** Only use the MnCHOICES Support Plan Signature Sheet when unable to use the offline function of MnCHOICES
	  ○ The Support Plan is not valid unless signed by the member or representative*
	  ○ This includes members living in skilled nursing facility
	• Sign Support Plan Signature Sheet using the e-signature within MnCHOICES and include CC credentials
	• If the Support Plan is mailed to the member to obtain the signature, document the date of when the Signature Sheet and corresponding *Support Plan Signature Letter* found on UCare website was sent.
	  ○ Conduct at least one follow-up attempt by phone or mail within two weeks of the Signature Sheet being sent to the member if the Signature Sheet has not been returned to the CC
	  ▪ Document the date the follow-up attempt was made
	  ○ Attach Signature Sheet to MnCHOICES when obtained from member

Mid-Year Review and Ongoing Support Plan Updates	**CC is required to:**
	• Maintain ongoing contact with the member/representative* at mid-year at a minimum to update the Support Plan which includes:
	  ○ 4 actionable attempts* to complete mid-year review update
	  ▪ Document the "monitoring of progress" directly on the Support Plan within MnCHOICESNOTE: If member's active Support Plan is not in MnCHOICES, document the "monitoring of progress/goal revisions" and any sections titled "update" directly on the Support Plan. Include date of contact.
	  ▪ **NOTE:** This includes UTR and Refusal Support Plans
	  • If there is no UTR/Refusal Support Plan for a Connect member, CC should document outreach and outcome in member record
	• Contact may be completed by phone, televideo, or in-person and is allowed any time 5-7 months from the last assessment date
	  ○ If the member has a completed HRA-MCO form and Support Plan and is unable to be reached or refuses the mid-year review, the CC must revise the existing Support Plan in the Monitoring Progress section, and any other applicable areas. This scenario does not require an Unable to Reach Support Plan or Refusal Support Plan to be completed.
	• Connect + Medicare members: If the assessment was by phone, continue to offer an in-person or televideo visit for the mid-year review and ongoing contact
	• Send the updated Support Plan to the Interdisciplinary Care Team* with significant changes
	• Communicate with the Interdisciplinary Care Team* at least annually
	• **Monthly Activity Log:** Add mid-year review to the Monthly Activity Log
	  ○ Do not change HS code when reporting these updates
	• If member is unable to be reached or refuses the mid-year review, no log entry is needed
	  ○ Return the Monthly Activity Log to UCare by the 15th of the following month

OTHER REQUIRED ACTIVITIES	

Monthly Activity Log	**The CC is required to:** • Enter all assessments, unable to reach and refusals on the Monthly Activity Log • Enter mid-year reviews and transition of care Support Plan updates on the Monthly Activity Log. Do not change HS code when reporting mid-year reviews. ○ If member is unable to be reached or refuses the mid-year review, no log is needed • Enter all Connect + Medicare additional encounters completed • Connect + Medicare ONLY: enter transfers from another MCO/FFS if member is unable to be reached • Connect + Medicare ONLY: Enter Product Change THRAs if member is unable to be reached • Submit the Monthly Activity Log to connectintake@ucare.org by the 15th calendar day of the following month

Connect + Medicare Additional Encounter Requirements	Care coordinators are to ensure a completed in-person or televideo encounter is completed at least once in a 12-month period with a member of the ICT. If the member declines to meet in-person or via televideo for the assessment, care coordinators may opt to conduct an in-person or televideo encounter at the time of the mid-year review or provide another in-person encounter during the year. Alternatively, if the care coordinator can confirm the PCP or Waiver case manager has seen the member in-person or via televideo, the care coordinator may document this in the member record. If none of the above is successful, the care coordinator should support the member in setting up an in-person or televideo encounter with the PCP or other ICT Specialty Care Provider engaged in the member's treatment plan. Document the refusal to meet in-person or televideo with the care coordinator. Also document the time and date of the in-person or televideo encounter with the PCP or other ICT Specialty Care Provider to meet the CMS encounter requirement. • **Monthly Activity Log (MAL):** Add all care coordination additional encounters to MAL* under Support Plan update using the "Other" drop down. Do not change HS code when reporting mid-year reviews or other Support Plan updates. ○ Return the Monthly Activity Log to UCare by the 15th of the following month
Transition of Care (TOC)	Transition of care (TOC) assistance is provided when a member experiences a planned or unplanned movement from one care setting (e.g., member's home, hospital, and skilled nursing facility) to another care setting. Each movement from one setting to another is considered a separate transition. **Transition of care activities are completed within one business day of the notification.**
	The CC is required to: • Monitor EAS for admissions and discharges on business days • Monitor the Daily Authorizations Reports for out-of-state and out of network admissions and discharges • Assist with care transitions • Follow steps below

	CONNECT + MEDICARE MEMBERS:
	• Assist with the member's planned and unplanned transitions from one care setting to another care setting
	  ○ Complete the **TOC* Log**, found on the UCare website along with TOC Log instructions. When completing the TOC Log, all questions and sections must be completed or marked as "not applicable"
	  ○ Contact member/representative* to assist with transition
	  ▪ When reaching out to the member/representative* for TOC Log tasks, make and document at least 2 actionable attempts*
	  ○ Share CC contact information and Support Plan/services with receiving setting within one business day of notification of transition
	  ○ Notify PCP* of transition via fax/phone/EMR/secure email (if PCP was not admitting physician) within one business day of notification of each transition
	  ○ Document reason for admission and all other relevant information on TOC Log
	  ○ Continue to log subsequent transitions until member returns to usual setting
	• In addition, the below tasks should be completed when the member discharges TO their usual care setting. This includes situations where it may be a 'new' usual care setting for the member (i.e., a community member who decides upon permanent nursing home placement).
	  ○ Communicate with member/representative about care transition process, changes to the member's health status, and support plan updates within 1 business day of notification of transition
	  ○ Provide education about transitions and how to prevent unplanned transitions/readmissions
	  ○ Complete 4 Pillars for Optimal Transition
	  ▪ Indicate if the member has a follow-up appointment scheduled with primary care or specialist. If not, provide explanation in comments.

	• For mental health hospitalizations, indicate if the member has a follow-up appointment scheduled with a mental health practitioner within 7 days of discharge ▪ Indicate if the member can manage their medications or has a system in place to manage medications. If not, provide explanation in comments ▪ Indicate if member can verbalize warning signs and symptoms and how to respond. If not, provide explanation in comments ▪ Indicate if the member uses a Personal Health Care Record. If not, provide explanation in comments ○ Indicate whether the member's Support Plan has been updated following this transition. If not, provide explanation in comments. ▪ Indicate whether you have reviewed the discharge summary with the member. If not, provide explanation in comments. • Conduct an Early Reassessment in the event of a care transition when a member experiences significant health changes, repeated or multiple falls, recurring hospital admissions, or recurring emergency room visits • **NOTE:** Because members are categorically at-risk during times of transition of care, the care coordinator's judgment may dictate additional follow up based on the care coordinators knowledge of the members situation • If the TOC resulted in a change to member's services, goals, and/or needs, enter the Support Plan modifications on the *Monthly Activity Log* **NOTE:** If the CC is notified of the transition(s) 15 days or more after the member has returned to their usual care setting, the CC is not required to complete a TOC Log. However, the **CC is still required to:** • Follow-up with the member to discuss the care transition process, any changes to their health status, and their Support Plan. • Provide education about how to prevent a readmission and document this discussion in the member record.

	• When reaching out to the member/representative*, make and document at least 2 actionable attempts*.
	  ○ The 15-day exception only applies if the CC finds out about *all* the transitions after the member has returned to their usual care setting.
	
	CONNECT MEMBERS:
	• Upon return to usual setting, follow-up with the member to discuss the transition, any changes to their health status, and/or changes to their Support Plan. Use Transition of Care Talking Points on the UCare website.
	  ○ When reaching out to the member/representative*, make and document at least 2 actionable attempts*
	• Provide education about how to prevent a readmission and document this discussion in the case notes
	• If the TOC resulted in a change to member's services, goals, and/or needs, enter the Support Plan modifications on the *Monthly Activity Log*
	• Conduct an Early Reassessment* in the event of a care transition when a member experiences significant health changes, repeated or multiple falls, recurring hospital readmissions, or recurring emergency room visits
	• Use professional judgement to determine additional care coordination intervention
	
	NOTE (Connect/Connect+ Members): If member's reassessment is due and member is temporarily hospitalized or outside of their normal living setting, offer assessment options according to encounter requirements. Complete Unable to Reach or Refusal as applicable.

Admission to Nursing Facility	UCare completes **ALL Nursing Facility (NF)** OBRA/Pre-admission Screening and Resident Review (PASRR) activity internally. Those tasks include: • Completing and faxing the OBRA Level 1 to the NF. Make a referral for OBRA Level II if applicable • For non-waiver members and members on a DD waiver, complete telephone screening (DHS-3427T form) and entering it into MMIS* if applicable **CC Responsibilities:** • Monitor EAS and the Daily Authorization Report for admissions • Assist with care transitions • Connect + Medicare: complete a TOC log • Determine if an Early Reassessment is warranted ○ An HRA is not required solely based upon admission to Skilled Nursing Facility • If the member is due for an annual reassessment while receiving care in a SNF, complete based on existing reassessment timelines
Advance Directives	**The CC is required to:** • Document on an annual basis that advance directives were discussed with the member • If advance directives were not discussed, document the reason
Member Death	**The CC is required to:** • Submit a Member Death Notification form to UCare • Submit the DHS-5181 form to the county of financial responsibility (CFR) • Unassign location and staff in MnCHOICES
Denial/Termination/ Reduction (DTR)	Denial, Termination, Reduction-UCare or one of its utilization review (UR) teams must review all services that require a medical necessity review. UCare sends a denial, termination, or reduction (DTR) letter to the member any time services that require prior authorization and review of medical necessity according to UCare's prior authorization grid are denied, terminated, or reduced. A DTR of these services requires review and determination by a UCare Medical Director. • Connect and Connect + Medicare care coordinators do not complete DTRs. CC will support the member and UR teams as needed.

Safe Disposal of Medications	**If member is taking any medications, including controlled substances, the CC is required to complete the below tasks at time of member's Initial Assessment or Annual Reassessment (Not required for UTR/refusal members or Institutional members as the facility has primary responsibility for the disposal of unused medications):** • Complete the *Dispose of Medications Safely* form and provide to member. CC must manually add two community drop-off sites closest to the member's location. • Discuss the information from the *Dispose of Medications Safely* form with the member ○ Document discussion and that the form was provided on the MnCHOICES Signature Sheet under 'Materials shared: Other information'
Change in Care Coordinator Within the Same Entity	The new care coordinator (CC) must notify the member of the CC's name and phone number within 10 calendar days of change in assignment. This can be done by phone or letter. The contact must be documented. If by letter, the CC must use UCare's approved Change in Care Coordinator Letter found on the UCare website. • Transfer staff assignment to new CC in MnCHOICES • No MMIS entry needed • No Monthly Activity Log entry required

Care System or Primary Care Clinic Change
 	
(PCC Change)
	The CC completes the following:
	• Confirm member has an established PCC
	• Ensure PCC is reflected correctly on the care coordination enrollment roster
	  ○ If the care coordination enrollment roster does not reflect the correct PCC the CC must submit a Primary Care Clinic (PCC) Change Request form and submit it to UCare
	• Submit to UCare no later than the 24th day of the month to ensure the change will be made the following month
	  ○ If the member states they plan to establish care with a new PCC, the CC works with the member in scheduling the appointment to establish care
	  ○ Ensure the PCC is in UCare's provider network, if not, the current CC should work with the member to establish care with an in-network provider, prior to completing a PCC change form
	NOTE: The change of PCC does not affect care coordination assignment

Transferring Member to MSC+/MSHO	**The current (sending) CC is required to:**
	• Ensure member has a PCC and it is reflected correctly on the care coordination enrollment roster
	• Educate member on enrollment options with MSC+/MSHO
	• Thoroughly complete all areas of the DHS-6037 Transfer Form and send via secure email or fax to the new (receiving) CC entity
	  ○ Send to the new CC entity by the 15th of the month
	• The transfer must also include:
	  ○ The most recent HRA, Support Plan, Support Plan Signature Sheet with member signature (if not found in MnCHOICES), relevant case notes, and other applicable case documents

Medical Assistance Eligibility Renewals	**The CC is strongly encouraged to:** • Remind members when they are at risk of losing MA* eligibility due to incomplete or unprocessed paperwork • Assist members with the completion of renewal paperwork as appropriate **NOTE:** The UCare Keep Your Coverage Team reaches out to members to offer additional assistance with maintaining eligibility. The CC may collaborate with the Keep Your Coverage Team for support.

90-Day Monitoring After MA Becomes Inactive	**If a member's Medical Assistance (MA) becomes inactive, the CC is required to:**
	• Connect: Track the status of the member, support efforts to reinstate MA, and complete any assessments and supporting documents that are needed in the following 90 days
	  ○ **NOTE**: 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. Examples may include: member moved out of state, incarcerated, no longer financially eligible for MA per Financial Worker.
	  ○ If a mid-year review comes due during the 90-day inactivity period, complete the mid-year review once MA has been reinstated and document why it is late
	• Connect + Medicare: Members will remain on the enrollment roster during the initial 90-day grace period and all care coordination activity continues
	  ○ **NOTE:** If member's 90-day grace period ends early, the member will fall off roster and CC may discontinue Care Coordination
	  ○ MMIS entry NOT required
	  ○ Add the assessment date to the Monthly Activity Log
	  ○ Return the Monthly Activity Log to UCare by the 15th day of the following month
	• **NOTE:** If a member enrolls in a new health plan during their 90-day grace period, the grace period ends and new MCO takes over care coordination responsibilities. Document transfer in member record.

Member Change of Address	**The CC is required to:**
	• Educate member if the new residence will impact care coordination assignment and/or UCare eligibility.
	  ○ Review DHS-5218, Health Plan Choices by County.
	• Send the DHS-5181 form to the county of financial responsibility to inform them of the member's new address and date of move
	  ○ Save a copy of the DHS-5181 in the member record

Behavioral Health Home (BHH) Services	**The CC is required to:**
	• Contact BHH provider within 30 business days of notification that the member is receiving BHH. During this call, the CC will:
	  ○ Provide the BHH provider with the CC's contact information
	  ○ Share information related to the member's Support Plan
	  ○ Establish contact frequency between BHH provider and CC and preferred method of communication
	• Include BHH service on the member's Support Plan
	• Include BHH provider as ICT
	• Notify BHH staff of any known ER/hospitalization admission and/or discharge
	• Notify BHH staff of any transitions of care, post-discharge plans and follow-up plans
	• Document all contact with BHH provider in the member's record

Care Coordination with Local Agencies	**The CC is required to make referrals and/or coordinate care with local/county social services and other community resources when needed by member, including but not limited to:** • Housing stabilization services • Pre-petition screening • Preadmission screening for HCBS • County case management for HCBS • Court ordered treatment • Case management and service providers for people with developmental disabilities. • Relocation service coordination • Adult protection • Assessment of medical barriers to employment • State Medical Review Team or Social Security disability determination • Working with Local Agency social service staff or county attorney staff for enrollees who are victims or perpetrators in criminal cases • Any other community resources, as appropriate

Communication Form – DHS-5841	Coordinate services with local and tribal agencies on the authorization of medical assistance home care services using DHS-5841 *Managed Care Organization/Lead Agency Communication Form - Recommendation for Authorization of MA Home Care Services State Plan Home Care Services.* For members on CAC/CADI/DD/BI: County waiver case managers fax the DHS-5841 to CLS Intake. The waiver case manager may share the DHS-5841 with the CC for collaboration and communication purposes. The CC must share the DHS-5841 with the waiver case manager for collaboration and communication regarding home care services and to initiate request for MA homecare services. This form ensures members received a coordinated plan of care and appropriate services, county or Tribal Nation waiver allocations are not over-authorized, MCO authorizations for home care services are completed in a timely manner, home care providers are paid in a timely manner, and duplication of services does not occur.

Policies and Procedures	UCare and all care coordination delegates are required to have policies and/or procedures that support all the requirements stated above.
Model of Care Training	UCare requires that all CCs complete the Model of Care training within 90-days of hire and annually thereafter. CCs may access this training via WebEx located on the Care Coordination and Care Management page of the UCare website (titled MSHO, ISNP, Connect + Medicare Model Of Care Recorded Training). UCare will also provide Model of Care training to CCs on an annual basis via the Quarterly All Care Coordination Meeting. • Each CC will need to submit the electronic attestation form following the completion of training located on the Care Coordination and Care Management page if MOC is not attended via live Quarterly Meeting
Documentation and Notes	**The CC is required to document in the member record, all evidence of:** • Care coordination requirements are being met • Care coordination requirements that were attempted but not completed • Member documents including, but not limited to, HRA, Support Plans and TOCs in member record. • Communication with members, representatives, providers, and any other ICT members

Definitions/Acronyms	
Term/Acronym	**Definition**
Actionable Attempts	An attempt to reach the member where the member can actively respond. This includes a message left on a known working number, letter mailed to a known address at least two days apart or a secure email sent to a known email address. Phone and email attempts are made on different dates and varying times. Best practice is to use working phone numbers when available before using letters/secure email. Unable to Reach Member Letter should be one of your 4 attempts.
Assessment Guide	There are 3 methods for completing assessments/reassessments: in-person, televideo, and by phone. Televideo requires robust documentation that member has been given an informed choice of in-person first. Phone assessments must have robust documentation that member has been given an informed choice of in-person first, then televideo second, before completing a phone assessment. See job aid and

	decision tree on CC website for more guidance. Televideo must be a visual, real time, interactive, HIPAA-compliant telehealth encounter. **NOTE:** An in-person assessment is required: • For all institutional assessments (effective 1/1/2024) • Any time a member/representative* requests an in-person assessment • If during a televideo or phone assessment, the CC determines an in-person assessment is necessary to complete the assessment • **Connect + Medicare:** CC is required to continue attempts to meet with member in-person or tele video at least once within the assessment year. If the member completes a phone assessment, the care coordinator will work with the member to set up an in-person or televideo encounter with a member of the ICT. Reference *Connect + Medicare Additional Encounter Requirements*.
Assignment Date	Date the member is assigned to the delegate via the monthly enrollment roster.
CAC/CADI/DD/BI/EW	Home and Community-Based Waiver Types: Community Alternative Care (CAC)/Community Access for Disability Inclusion (CADI)/Developmental Disability (DD))/Brain Injury (BI)/Elderly Waiver (EW).
Caregiver Support	A caregiver is a non-paid person that, without their help, paid services would have to be put into place. If there already are services in place, a caregiver is someone who provides care beyond reimbursed hours/service. Caregiver questionnaire located on eDocs DHS-6914.
CSP/CSSP	Community Support Plan/Coordinated Services & Supports Plan. These forms are used following a MnCHOICES Assessment.
Early Reassessment due to Change in Need	All CCs are Qualified Professionals*, and UCare depends on the use of their clinical, professional judgment to determine whether a change in condition due to significant health changes, repeated or multiple falls, recurring hospital readmissions, or recurring emergency room visits or care transition warrants a reassessment. In addition, members or their representatives may request a comprehensive assessment, and UCare must provide this within 20 calendar days of the request.
EAS	Encounter Alert Services – allows providers throughout the state to receive member encounter alerts, for individuals who have been admitted to, discharged, or transferred from, an EAS participating hospital, emergency department, long-term care facility, or other provider organization in real-time.

EMR	Electronic Medical Record.
Enrollment Date	First day of the month the member is enrolled in the current health plan.
FFS	Fee for Service. A person that remains on traditional Medical Assistance without a Managed Care Organization.
HCBS	Home and Community-Based Services. Refers to support/programs/supplies and/equipment paid for by a waiver and not covered by Medical Assistance. The member must qualify for a waiver to be eligible for HCBS support.
HRA-MCO	Health Risk Assessment within MnCHOICES Application.
ICT	Interdisciplinary Care Team: • At a minimum includes the care coordinator, the member and/or representative*, PCP, and Waiver Case Manager (as applicable) • ICT members may also include any and all other health and service providers (including Managed Long Term Supports & Service providers/Home & Community Based Service providers) as needed, as long as they are involved in the member's care for current health conditions • These may include but are not limited to: family, caregiver, specialty care providers, social workers, mental health providers, nursing facility staff, and others performing a variety of specialized functions designed to meet the member's physical, emotional, and psychological needs
Institutionalized	A member permanently residing in a Skilled Nursing Facility. This may include ICF/DD, Group Homes, Adult Foster Care, and Board and Lodge facilities.
MA	Medical Assistance.
MAL	Monthly Activity Log
MCO	Managed Healthcare Organization. A health plan that manages Medical Assistance for eligible members. UCare is an MCO.
MMIS	Medicaid Management Information System-Minnesota's automated system for payment of medical claims and capitation payments for Minnesota Health Care Programs (MHCP).
MnCHOICES	A single, comprehensive, web-based application that integrates assessment and support planning for all people who seek access to Minnesota's long-term services and supports. Health Risk Assessment form (HRA-MCO) – replaces the DHS-3428H

	MnCHOICES Assessment form with "Staying Healthy" section – replaces the DHS-3428 for managed care certified assessors MnCHOICES Assessment form – replaces the DHS-3428 for county assessors (NOT used by MCO care coordinators) Support Plan-HRA-replaces My Connect/Connect+ Medicare Support Plan. Use Program Type 'Health Risk Assessment' Support Plan-MnCHOICES Assessment-replaces the CSSP for county assessors (NOT used by Connect/Connect+ care coordinators)
MN-ITS	DHS system care coordinators use to verify member MA status, Medicare, Waiver, MCO and Restricted Recipient eligibility. MN-ITS is also the DHS billing system for providers enrolled in Minnesota Health Care Programs (MHCP). UCare requires checking MN-ITS to verify member's eligibility status upon initial assignment.
PCC	Primary Care Clinic.
PCP	Primary Care Physician.
Qualified Professional	Care coordinators are required to be Qualified Professionals defined in Minnesota as a licensed social worker, mental health professional, registered nurse, physician assistant, nurse practitioner, public health nurse or physician with the exception of a county social worker who is employed by the county.
Reassessment Due Date	Reassessment timelines differ based on the outcome of the initial assessment: If the initial assessment results in a UTR/Refusal the reassessment due date is within 365 days of the original enrollment date* on the current health plan product. Subsequent reassessments need to be within 365 days of the last activity date. • UTR Activity Date = date of last actionable attempt to reach member for assessment • Refusal Activity Date = date member verbally refused/declined HRA If the initial assessment results in a completed assessment the reassessment is due within 365 days of the previous assessment activity date.

Representative	A members verified legal alternative decision maker. For example: court appointed guardian/conservator or health care agent. Obtain a copy of guardian/conservator or Health Care Directive documents to verify level of representation. **Some examples of alternative decision makers, but not limited to:** **Guardian** is "A person with the legal authority and duty to act on behalf of another person. The legal guardian can make decisions for the person about where to live, medical treatment, training, and education, etc. Decision-making is limited to the specific powers the court assigns to the legal guardian (dhs.state.mn.us)." **Health Care Agent** is the person listed on a Health Care Directive that can make health care decisions if the individual is unable to make those decisions (MDH, Health Care Directives – Minnesota Dept. of Health (state.mn.us)). A designated health care agent may sign ROI, only if the principal is unable to sign for themselves, unless explicitly directed in the Health Care Directive. **Power of Attorney (POA)** "is a written document often used when someone wants another adult to handle their financial or property matters (Minnesota Judicial Branch, Power of Attorney, Minnesota Judicial Branch – Power of Attorney (mncourts.gov))." POA will cease when a person becomes incapacitated. • **Durable Power of Attorney** hold the same privileges as POA but maintains their power through incapacities and terminates upon death of the member **Authorized Representative (A-Rep)** is "a person or organization authorized by an applicant or enrollee to apply for a MHCP and to perform the duties required to establish and maintain eligibility (DHS, Eligibility Policy Manual, 1.3.1.2 MHCP Authorized Representative (state.mn.us)." This type of representative is exclusive to financial eligibility such as Medical Assistance eligibility and MHCP Eligibility. **Responsible Party (RP)** is "A person who is at least 18 years old and capable of providing the support necessary to help the person receiving PCA services to live in the community when the person is assessed as unable to direct their own care (DHS, PCA Manual, PCA responsible party and participant's

	representative (CFSS) (state.mn.us))." This type of representative is exclusive to PCA. The designated RP is not permitted to act as the PCA.
ROI	Release of Information. • A signed ROI does not grant decision making powers
SMART Goals	Specific, Measurable, Attainable, Relevant, Time-bound.
THRA	Transfer Member Health Risk Assessment. CC may use Transfer Member Health Risk Assessment (THRA) when an HRA and Support Plan completed within the last 365 days are obtained, and the member is able to be reached within 60 calendar days of enrollment. By completing the THRA the CC is adopting this assessment and Support Plan as their own. THRAs may be used for Product Changes, Members Transferred Between Delegates, and Members Transferred from different SNBC Managed Care Organizations (MCO) to UCare Connect/Connect + Medicare.
UTR	Unable to Reach.

eDocs Form Names	
eDocs Number	**Title of Document**
DHS-5181	*Lead Agency Assessor/Case Manager/Worker LTC Communication Form:* • This form is to be used by lead agency case managers and workers to ensure that the process to determine if applicants or enrollees are eligible to receive MA payments for services received through the HCBS waiver program is initiated promptly. It is also used to communicate address changes, death notification, care coordinator changes and name changes to the county financial worker.
DHS-5841	*Managed Care Organization, County Agency and Tribal Nation Communication Form - Recommendation for State Plan Home Care Services:* • Health plans, counties and tribes use this form to make initial or modified requests for authorization of home care services or provide information about changes in services authorized by a health plan. This form is used for clients in MSHO, MSC-Plus, SNBC and MA-Families and Children.
DHS-6037	*HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form:*

	• This form assists health plan, county and tribal care coordinators and case managers to share information
DHS-6914	*Caregiver questionnaire for persons on a waiver or AC programs.* • May be used as an additional tool for HRA-MCO forms as applicable
DHS-3428M	*Mini-Cog© Instructions for Administration and Scoring* • Screening tool to detect possible presence of dementia
DHS-8354	*MCO Member Address Change Report Form.* • This form is for Care Coordinators to report member change of address. Online use only: DHS-8354-ENG (MCO Member Address Change Report Form) (mn.gov)