**UCare Connect**
**Care Coordination Requirements Grid**
**Effective 1/1/2026**

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**Contents**

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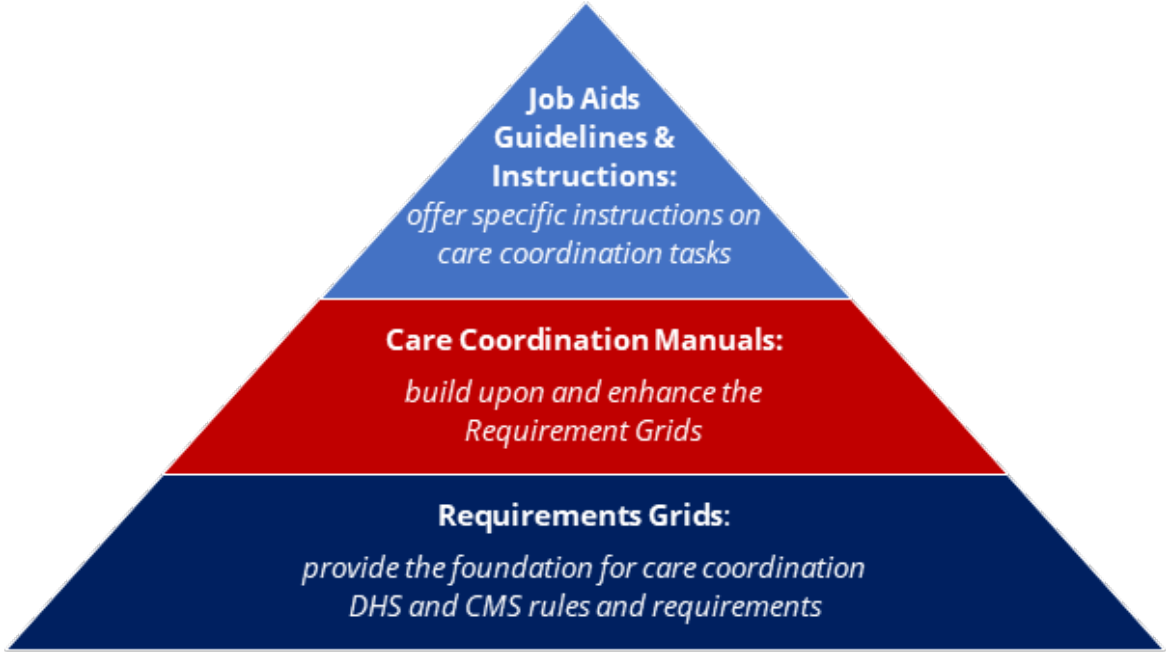
The Requirements Grids are the foundation for UCare's official policies and procedures for care coordination responsibilities. The UCare Care Coordination Manual builds upon and enhances the Requirements Grids. The care coordination website houses Job Aids, guidelines, and instructions that provide guidance on care coordination tasks and are designed to elaborate on specific care coordination requirements.




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

| CONNECT AND CONNECT + MEDICARE REQUIREMENTS GRID | |
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| **Initial Assignment** | Initial assignment* is the first day the care system or county receives the care coordination enrollment roster. ALL members enrolled in Connect are required to be offered a Health Risk Assessment (HRA). **Upon receiving the monthly enrollment roster, the care coordinator (CC) is required to:**<br>• Provide the member with the name and phone number of the CC within 10 business days of initial assignment*.<br>  ○ 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 (for new members) or Change of Care Coordinator Letter (for transferred members) found on the UCare website.<br>  ○ Verify eligibility and waiver status via MN-ITS*<br>  ○ Add care coordinator location and staff assignment in MnCHOICES within 60 days of enrollment |
| **Initial Contact** | **The CC is required to:**<br>• Contact the member to complete an HRA within 60 days of enrollment*<br>  ○ Document a minimum of 3 Connect outreach attempts*, or fewer if member is reached. If 3 outreach attempts are needed, first attempt must be a phone call and one attempt must be a UTR letter.<br>**NOTE:** Sending the Welcome Letter is not considered an actionable attempt to contact the member<br>Proceed with the appropriate section below |

| ASSESSMENTS | |
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| | A member is considered NEW when they are newly enrolled in UCare Connect and have not had a previous assessment entered in MnCHOICES * within the last 365 days. ALL members enrolled in Connect must be offered an assessment within 60 days of enrollment. Members with previous coverage who experience a gap |

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| **New Member/Initial Health Risk Assessment (HRA)** | due to loss of MA eligibility (IE: MA is not reinstated retroactively) are reflected on the enrollment roster as a NEW member if re-enrolled. The assessment used for Connect is the Health Risk Assessment – MCO form located within the MnCHOICES application.<br>An assessment must be offered to the member. Assessment may be conducted via in-person, televideo, or phone. |
| | **CC is required to:**<br>• Contact the member per Initial Assignment and Initial Contact sections<br>• Members on waiver: Document outreach to waiver case manager and include CC contact information.<br>• Complete the MnCHOICES HRA-MCO assessment with the member within 60 calendar days of enrollment<br>  ○ When completing the HRA-MCO form, all questions and sections must be completed or marked as "not applicable"<br>  ○ Ensure assessment is in 'Completed' status<br>  ○ Not required for members who don't take medications, or living in a skilled nursing facility<br>• Develop a person-centered Support Plan-HRA<br>  ○ Ensure Support Plan is in 'Plan Approved' status<br>  ○ See *Support Plan* and *Support Plan Signature* sections for additional details and timelines<br>• MMIS entry NOT required<br>• Add member to Monthly Activity Log and update Health Status code, based on assessment outcome<br>  ○ Return the Monthly Activity Log to UCare by the 15th day of the following month<br>**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. This includes members who were previously UTR/Refusal. 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:**<br>• Thoroughly complete all areas of the DHS-6037 Transfer Form and send via secure email, MnCHOICES upload, or fax to the new (receiving) CC when confirmed via enrollment roster. |

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| | ○ If the DHS-6037 is uploaded to MnCHOICES, the CC must notify the new (receiving) CC or entity of the upload<br>○ Care Coordination Contact List is located on the UCare website<br>• The transfer must also include:<br>○ The most recent HRA, Support Plan, Support Plan Signature Sheet with member signature (if not accessible in MnCHOICES), relevant case notes, and other applicable case documents. All documents in MnCHOICES must be referenced on the DHS-6037.<br>○ This includes UTR/Refusal Support Plans as applicable<br>○ **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.<br>• Unassign location and staff in MnCHOICES<br>• Ensure MnCHOICES forms are left in a completed status<br>**The new (receiving) CC is required to:**<br>• Provide the member with the name and phone number of the CC within 10 business days of transfer<br>○ 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.<br>○ Document the review of transfer documents<br>○ Fill in any missing information with member if necessary<br>○ 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).<br>○ Assign staff and location in MnCHOICES<br>○ No MMIS entry required<br>○ No Monthly Activity Log entry required<br>○ **NOTE:** The annual reassessment is due 365 days from the date of the last full assessment. For UTR/Refusal members, refer to the UTR/Refusal sections regarding assessment timelines. |
| | **Transferred Member from different SNBC Managed Care Organization (MCO) to UCare Connect:** When a member enrolls in UCare Connect and was previously with a different MCO. The enrollment roster does not |

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| **Transferred Member to/from a Different MCO** | indicate a change of MCO (e.g., UCare to Medica, Medica to UCare, etc.). Member will have a status of "New Member/Termed Member."<br><br>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:**<br>• Thoroughly complete all areas of the DHS-6037 Transfer Form and send via secure email, MnCHOICES upload, or fax to the new (receiving) CC when confirmed via enrollment roster<br>  ○ If the DHS-6037 is uploaded to MnCHOICES, the CC must notify the new (receiving) CC or entity of the upload<br>  ○ Care Coordination Contact List is located on the UCare website<br>• The transfer must also include:<br>  ○ The most recent HRA, Support Plan, Support Plan Signature Sheet with member signature (if not accessible in MnCHOICES), relevant case notes, and other applicable case documents. All documents in MnCHOICES must be referenced on the DHS-6037.<br>  ○ This includes UTR/Refusal Support Plans as applicable<br>  ○ 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<br>• Unassign location and staff in MnCHOICES<br>• Ensure MnCHOICES forms are left in a completed status<br><br>**The new (receiving) CC is required to:**<br>• Provide the member with the name and phone number of the CC within 10 business days of transfer<br>  ○ 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.<br>• Verify eligibility in MNITS and request transfer documents from previous MCO. Contact information for MCOs is located on the DHS 6037 document. |

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| | • 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.<br>  ○ Contact ConnectIntake@ucare.org if transfer documents have not been received<br>  ○ CC may complete a Support Plan if one has not been received in the transfer or at CC's discretion due to significant updates<br>  ○ 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<br><br>• Review the DHS-6037, current HRA with supporting documents, and update the Support Plan received from the previous (sending) CC<br>  ○ 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.<br>• Identify when the next assessment is due<br>  ○ THRA will not reset assessment timeline. Reassessments are kept on the same schedule and due within 365 days of the last HRA.<br>• Document a minimum of 3 Connect outreach attempts*, or fewer if member is reached. If 3 outreach attempts are needed, first attempt must be a phone call and one attempt must be a UTR letter.<br>• Complete the THRA form from UCare's website and attach in MnCHOICES. A new THRA form is required for each transfer/product change.<br>• THRA may be completed with the member by phone, televideo, or in-person within 60 days of enrollment.<br>  ○ When completing the THRA, all questions and sections must be completed or marked as "not applicable"<br>  ○ Document review in member record<br>  ○ Update HRA/Support Plan as needed<br><br>• Complete the THRA HRA type/date in MnCHOICES within 60 days of enrollment<br>• Ensure the full HRA-MCO and Support Plan are reviewed and updated as needed<br>• Document review in member record |

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| | NOTE: 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.<br>• Add THRA activity to the Monthly Activity Log and update HS code to HP<br>• NOTE: If the member is unable to be reached or refused the THRA, add member to Monthly Activity Log. Because the member has a current HRA/Support Plan, the HS code is HP.<br>• Return Monthly Activity Log to UCare by the 15th day of the following month<br>• 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 enrollment into the new product.<br><br>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.<br>• If the member was a previous UTR/Refusal, the THRA process may not be used. Follow New Member process. |
| | **The CC is required to:**<br>• Provide the member with the name and phone number of the CC within 10 business days of Product Change.<br>  ○ 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.<br>• Identify when the next assessment is due.<br>• THRA will not reset assessment timeline. Reassessments are kept on the same schedule and due within 365 days of the last HRA.<br>• Document a minimum of 3 Connect outreach attempts*, or fewer if member is reached. If 3 outreach attempts are needed, first attempt must be a phone call and one attempt must be a UTR letter. |

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| | • Complete the THRA form from UCare's website and attach in MnCHOICES within 60 days of enrollment. A new THRA form is required for each transfer/product change. When completing the THRA, all questions and sections must be completed or marked as "not applicable".<br>  ○ Review/update Support Plan as needed<br>• Complete the THRA HRA type/date in MnCHOICES within 60 days of Product Change<br>  ○ 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'.<br>  • Requirements are fulfilled after completing Assessment Information. Review all additional areas applicable.<br>• 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<br>  ○ Do not revise the MnCHOICES Support Plan<br>  ○ Do not complete an Unable to Reach or Refusal Support Plan<br>  ○ Do not complete the THRA document<br>  ○ MnCHOICES THRA type/date entry still required<br>• Add THRA activity to the Monthly Activity Log and update HS code<br>Note: If the member is unable to be reached or refuses THRA, the HS code remains HP because they have a current HRA/support plan.<br>  ○ Return Monthly Activity Log to UCare by the 15th day of the following month<br>• MMIS Entry not required |
| **Institutionalized Members** | Connect 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.<br>• For new admission to skilled nursing facility from community, reference *Admission to Nursing Facility* section. |
| | **The CC is required to:**<br>**New Members:** Contact the member per the *Initial Assignment* and *Initial Contact with Members* sections above |

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| | • NOTE: All institutional assessments are to be completed in-person<br>• If the member is UTR/Refusal complete steps per UTR/Refusal Support Plan sections as applicable<br>• See New Member/Initial Health Risk Assessment (HRA)<br>• See *Support Plan* and *Support Plan Signature* sections<br>  ○ Reminder: A signature sheet is required for Institutional members<br>  ○ 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<br>  ○ Determine if there are any additional needs or changes to the MDS or facility care plan and make suggestions to SNF staff<br><br>**Product Change:**<br>• Provide the member with the name and phone number of the CC within 10 business days of Product Change<br>  ○ 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 Welcome Letter found on the UCare website.<br>• Document a minimum of 3 Connect outreach attempts*, or fewer if member is reached. If 3 outreach attempts are needed, first attempt must be a phone call and one attempt must be a UTR letter<br>• Complete the THRA form from UCare's website and attach in member's record<br>• Review the Assessment/Support Plan with member/representative and update/revise as necessary<br>• 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.<br><br>**Reassessment:**<br>• Contact the member to complete an assessment* WITHIN 365 days of previous HRA AND upon a change in condition*<br>  ○ When a reassessment is following an initial UTR/Refusal the Reassessment Due Date* is based on member initial enrollment date in the current health plan product. This is only applicable to the first reassessment following an initial UTR/Refusal. |

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| | ○ Document a minimum of 3 Connect outreach attempts*, or fewer if member is reached. If 3 outreach attempts are needed, first attempt must be a phone call and one attempt must be a UTR letter<br>○ If member is UTR/Refusal, proceed to *Unable to Reach* or *Refusal* sections<br>• See *Annual Reassessment* section<br>• See *Support Plan* and *Support Plan Signature Sheet* sections<br>○ Reminder: A signature sheet is required for Institutional members<br>○ 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<br>▪ 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 assessment used for Connect is the Health Risk Assessment – MCO form located within MnCHOICES application.<br>An assessment must be offered to the member. Assessment may be conducted via phone, televideo, or in-person. |
| | **The CC is required to:**<br>• Contact the member to complete an assessment* WITHIN 365 days of previous HRA<br>○ 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.<br>○ Document a minimum of 3 Connect outreach attempts*, or fewer if member is reached. If 3 outreach attempts are needed, first attempt must be a phone call and one attempt must be a UTR letter.<br>○ If member is UTR/Refusal, proceed to *Unable to Reach* or *Refusal* sections<br>• Members on waiver: Document outreach to waiver case manager and include CC contact information.<br>• When completing the HRA-MCO form in MnCHOICES, all questions and sections must be completed or marked as “not applicable”<br>○ Ensure assessment is in ‘Completed’ status<br>• Update and close the “Status of Goal/Status Date” field in the current Support Plan<br>• Develop a new person-centered Support Plan-HRA with new and ongoing goals |

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| | ○ Ensure Support Plan is in 'Plan Approved' status<br>○ See *Support Plan* and *Support Plan Signature* sections for additional details and timelines<br>• MMIS entry NOT required<br>• Add member to Monthly Activity Log and determine the Health Status code based on assessment outcome<br>○ 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:**<br>Initial Enrollment: Initial outreach to complete an HRA is due within 60 days of enrollment<br>**-OR-**<br>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<br>• 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 outreach attempts must be completed by 12/31/22)<br>○ See *Reassessment Due Date**<br><br>**Both Scenarios require these tasks:**<br>• Contact member as follows:<br>• Document a minimum of 3 Connect outreach attempts*, or fewer if member is reached. If 3 outreach attempts are needed, first attempt must be a phone call and one attempt must be a UTR letter.<br>• Investigative research to locate a member's phone number 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:<br>▪ Contact waiver case manager (as applicable) to collaborate and obtain working number<br>▪ Review historical information – check to see if previous number is now working<br>▪ As available – utilize other electronic health records accessible to the County or Care System (MIIC, PROMPT, EPIC)<br>▪ *Public records* search<br>• Complete HRA-MCO form within MnCHOICES indicating assessment results as "person not located for health risk assessment" and save as completed |

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| | • If the member is CAC/CADI/DD/BI, document outreach to waiver case manager and share CC's contact information.<br>• **Connect:** Document outreach attempts and outcomes in member record<br>  ○ Reminder at the time of annual reassessment, close any previous Support Plan goals<br>• Send the Provider Engagement Letter to the PCP **IF** known within 30 calendar days of the last outreach attempt<br>• MMIS entry NOT required<br>• Add the member to the Monthly Activity Log as an Unable to Reach member<br>  ○ Update Monthly Activity Log with the Health Status Code of "NR"<br>  ○ Return the Monthly Activity Log to UCare by the 15th day of the following month<br><br>**Product Changes**<br>• For UTR members that experience a Product Change, refer to the *New Member* section<br><br>**Mid-Year Review**<br>• Complete ongoing contact mid-year at a minimum<br>• **Connect:** Document mid-year outreach attempts and outcome in member record<br>• Complete transition of care outreach/tasks when known<br>• Assist with member requests for transportation, services/supports as needed<br>• For members that are actively reaching out with needs, care coordinator is encouraged to attempt an assessment<br>• 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:**<br>Initial Enrollment: Initial outreach to complete an HRA is due within 60 days of enrollment<br>**-OR-**<br>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 product-specific outreach attempts must be completed by 12/31/22)
    - See *Reassessment Due Date**

**Both Scenarios require these tasks:**

- Document a minimum of 3 Connect outreach attempts*, or fewer if member is reached. If 3 outreach attempts are needed, first attempt must be a phone call and one attempt must be a UTR letter.
- 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 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
- Document mid-year review outreach attempts and outcome in member record
- Complete transition of care outreach/tasks when known

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| | • Assist with member requests for transportation, services/supports as needed<br>  ○ For members that are actively reaching out with needs, care coordinator is encouraged to attempt an assessment<br>• At any point if member is able to be assessed, refer to *Annual Assessment* section above |

| SUPPORT PLANS | |
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| **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.<br><br>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:**<br>• 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.<br>• Support Plan must include the names and disciplines of members' Interdisciplinary Care Team (ICT)* as applicable<br>• **All elements are to be completed in its entirety. Any sections that do not apply should be marked "N/A"**<br>• Ensure Support Plan is in 'Plan Approved' status<br>• 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<br>• Information collected through the HRA with the member or representative*/legal guardian includes:<br>  ○ Input from the member and/or family members, the member's authorized health care decision maker, Primary Care Physician (PCP), and other ICT* members<br>• 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. |

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| | ○ Goals should be written based on needs identified with the member during their assessment<br>○ Goals should be written as SMART goals (Specific, Measurable, Attainable, Relevant, and Time-bound)<br>○ Goals should be prioritized using high, medium, or low. At least one In Progress goal must be ranked as high priority<br>○ Interventions should include the necessary steps to achieve the goal, who will provide assistance and resources/referrals needed to meet the goal<br>• Ensure a person-centered emergency backup plan is established in “My Backup Plans”.<br>• 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<br>• <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:<br>○ Member and/or representative*. Include UCare *Care Plan Letter*.<br>○ PCP*<br>○ Waiver Case Manager (if CAC/CADI/DD/BI)<br>▪ Share by phone, email, or by sending a notification in MnCHOICES message center<br>• As applicable, address each previously established goal by updating the “Status Date” and “Status of Goal” by selecting one of the following:<br>○ Achieved (goal met; Goal may or may not continue onto new Support Plan)<br>○ In-Progress (goal is not met and goal continues over to new Support Plan)<br>○ Discontinued (goal no longer relevant; member no longer wants goal)<br>• Add comments under "Monitoring Progress" section to define goal outcome/progress |

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| **Support Plan Signature Sheet** | **The CC is required to:**<br>• 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.<br>  ○ **NOTE:** Print signature sheet from MnCHOICES Support Plan to obtain handwritten signature when unable to use the offline function of MnCHOICES<br>  ○ The Support Plan is not valid unless signed by the member or representative*<br>  ○ This includes members living in skilled nursing facility<br>• Sign Support Plan Signature Sheet using the e-signature within MnCHOICES and include CC credentials<br>• If the member was unable to sign electronically, a minimum of 2 attempts are required to obtain signatures. Document the date of when the Signature Sheet and corresponding *Support Plan Signature Letter* found on UCare website was sent.<br>  ○ If mailed, the CC must document at least one additional follow-up attempt by phone, letter, or secure email to obtain the Signature Sheet within two weeks of the mailing date if not obtained.<br>  ▪ Document the date the follow-up attempt was made<br>  ○ Revise Support Plan to attach Signature Sheet when obtained from member |
| **Mid-Year Review and Ongoing Support Plan Updates** | **CC is required to:**<br>• Maintain ongoing contact with the member/representative* at mid-year at a minimum to update the Support Plan which includes:<br>  ○ Document a minimum of 3 Connect outreach attempts*, or fewer if member is reached. If 3 outreach attempts are needed, first attempt must be a phone call and one attempt must be a UTR letter.<br>• Document the "monitoring of progress" directly on the Support Plan within MnCHOICES<br>  ○ The member support plan must always include one high-priority, in-progress goal. If all goals are achieved or discontinued, a new high-priority goal must be added.<br>  ○ **NOTE:** This includes UTR and Refusal Support Plans<br>  ▪ If there is no UTR/Refusal Support Plan for a Connect member, CC should document outreach and outcome in member record |

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| | • Contact is allowed any time 5-7 months from the last assessment date<br>  ○ 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.<br>• Send the updated Support Plan to the Interdisciplinary Care Team* with significant changes<br>• Communicate with the Interdisciplinary Care Team* at least annually<br>  ○ This includes sharing the Support Plan with the ICT<br>• **Monthly Activity Log:** Add mid-year review to the Monthly Activity Log<br>  ○ Do not change HS code when reporting mid-year support plan updates<br>• If member is unable to be reached or refuses the mid-year review, no log entry is needed<br>  ○ Return the Monthly Activity Log to UCare by the 15th of the following month |

| OTHER REQUIRED ACTIVITIES | |
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| **Monthly Activity Log** | **The CC is required to:**<br>• Enter all assessments, unable to reach and refusals on the Monthly Activity Log<br>• 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.<br>  ○ If member is unable to be reached or refuses the mid-year review, no log is needed<br>• Submit the Monthly Activity Log to connectintake@ucare.org by the 15th calendar day 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:**<br>• Monitor EAS for admissions and discharges on business days<br>• Monitor the Daily Authorizations Reports for admissions and discharges not included in EAS |

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| | • 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.<br>  ○ When reaching out to the member/representative*, make and document at least 2 Connect outreach attempts*<br>• Provide education about how to prevent a readmission and document this discussion in the case notes<br>• 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*<br>• 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<br>• Use professional judgement to determine additional care coordination intervention<br><br>**NOTE:** 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.<br><br>**NOTE Connect Members receiving Behavioral Health Home (BHH) Services:** CC must notify BHH staff of any transitions of care, post-discharge plans, and follow up plans. |

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| **Admission to Nursing Facility** | UCare completes **ALL Nursing Facility (NF)** OBRA/Pre-admission Screening and Resident Review (PASRR) activity internally. Those tasks include:<br>• Completing and faxing the OBRA Level 1 to the NF. Make a referral for OBRA Level II if applicable<br>• For non-waiver members and members on a DD waiver, complete telephone screening (DHS-3427T form) and entering it into MMIS* if applicable<br>**CC Responsibilities:**<br>• Monitor EAS and the Daily Authorization Report for admissions<br>• Assist with care transitions<br>• Determine if an Early Reassessment is warranted<br>  ○ An HRA is not required solely based upon admission to Skilled Nursing Facility<br>• 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:**<br>• Document on an annual basis that advance directives were discussed with the member<br>• If advance directives were not discussed, document the reason |
| **Members on CAC/CADI/DD/BI Waiver** | **For all members on CAC/CADI/DD/BI Waiver, the CC is annually required to:**<br>• Document outreach to Waiver Case Manager and share CC's contact information<br>• Share the Support Plan with Waiver Case Manager within 30 calendar days of the assessment<br>  ○ Share by phone, email, or by sending a notification in MnCHOICES message center<br>**NOTE:** CCs who are also the CAC/CADI/DD/BI waiver case manager may choose to utilize the MnCHOICES Assessment 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. Dual role CC/CMs should document their dual role and sharing the Support Plan with Waiver Case Manager as N/A. |

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| **Member Death** | **The CC is required to:**<br>• Submit a Member Death Notification form to UCare<br>• Submit the DHS-5181 form to the county of financial responsibility (CFR)<br>• Unassign location and staff in MnCHOICES |
| **Denial/Termination/ Reduction (DTR)** | The Utilization Review (UR) team must review all services that require a medical necessity evaluation. A Denial, Termination, or Reduction (DTR) letter is sent to the member whenever services requiring prior authorization—according to the Prior Authorization Grid—are denied, terminated, or reduced based on medical necessity. All DTR determinations must be reviewed and approved by a Medical Director.<br>**NOTE:** Connect care coordinators submit a DTR only for ILOS and supplemental benefits that are being denied, terminated, or reduced.<br>• The *Supplemental DTR form* is used for denying, terminating, or reducing supplemental benefits and is submitted to UCare within one business day of the determination<br>• The *ILOS Discharge DTR form* is used for denying, terminating, or reducing approved ILOS supports and is submitted to UCare within one business day of the determination.<br>**NOTE:** See the UCare website for additional resources on DTR determination and process. |
| **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 business 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.<br>• Transfer staff assignment to new CC in MnCHOICES<br>• No MMIS entry needed<br>• No Monthly Activity Log entry required |

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| **Care System or Primary Care Clinic Change (PCC Change)** | **The CC completes the following:**<br>• Confirm member has an established PCC<br>• Ensure PCC is reflected correctly on the care coordination enrollment roster<br>  ○ 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<br>• Submit to UCare no later than the 24th day of the month to ensure the change will be made the following month<br>  ○ 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<br>  ○ 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<br>**NOTE:** The change of PCC does not affect care coordination assignment |
| **Transferring Member to MSC+/MSHO** | **The current (sending) CC is required to:**<br>• Ensure member has a PCC and it is reflected correctly on the care coordination enrollment roster<br>  ○ Complete PCC change process to update member's PCP<br>• Educate member on enrollment options with MSC+/MSHO<br>• Thoroughly complete all areas of the DHS-6037 Transfer Form and send via secure email or fax to the new (receiving) CC entity<br>  ○ Send to the new CC entity by the 15th of the month<br>• The transfer must also include:<br>  ○ 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. All documents attached in MnCHOICES, and not sent to the receiving entity, must be referenced on the DHS-6037, indicating where the documents can be found. |

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| **90-Day Requirements After MA Becomes Inactive** | **If a member's Medical Assistance (MA) becomes inactive, the CC is required to:**<br>• 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<br>  ○ **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.<br>  ○ 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<br>• **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:**<br>• Educate member if the new residence will impact care coordination assignment and/or UCare eligibility.<br>  ○ Review DHS-5218, Health Plan Choices by County.<br>• Send the DHS-5181 form to the county of financial responsibility to inform them of the member's new address and date of move<br>  ○ Save a copy of the DHS-5181 in the member record |
| **Behavioral Health Home (BHH) Services** | **The CC is required to:**<br>• Contact BHH provider within 30 business days of notification that the member is receiving BHH. During this call, the CC will:<br>  ○ Provide the BHH provider with the CC's contact information<br>  ○ Share information related to the member's Support Plan<br>  ○ Establish contact frequency between BHH provider and CC and preferred method of communication<br>• Include BHH service on the member's Support Plan<br>• Include BHH provider as ICT<br>• Notify BHH staff of any known ER/hospitalization admission and/or discharge<br>• Notify BHH staff of any transitions of care, post-discharge plans and follow-up plans<br>• Document all contact with BHH provider in the member's record |

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| **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:**<br>• Pre-petition screening<br>• Preadmission screening for HCBS<br>• County case management for HCBS<br>• Court ordered treatment<br>• Case management and service providers for people with developmental disabilities.<br>• Relocation service coordination<br>• Adult protection<br>• Assessment of medical barriers to employment<br>• State Medical Review Team or Social Security disability determination<br>• Working with Local Agency social service staff or county attorney staff for enrollees who are victims or perpetrators in criminal cases<br>• 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.*<br><br>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.<br><br>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.<br><br>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. |

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| **Documentation and Notes** | **The CC is required to document in the member record, all evidence of:**<br>• Care coordination requirements are being met<br>• Care coordination requirements that were attempted but not completed<br>• Communication with members, representatives, providers, and any other ICT members<br>• All care coordination documents that are not found in MnCHOICES |

**Definitions/Acronyms**

| Term/Acronym | Definition |
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| **Assessment Guide** | There are 3 methods for completing assessments/reassessments: in-person, televideo, and by phone. Televideo must be a visual, real-time, interactive, HIPAA-compliant telehealth encounter. See table below for Connect assessment requirements. |

| | Connect |
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| Initial assessment | Offer HRA:<br>• May be conducted via phone, televideo, or in-person |
| Annual assessment | Offer HRA:<br>• May be conducted via phone, televideo, or in-person |
| Institutional initial/annual | In-person required |

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| | **NOTE:** An in-person assessment is required:<br>• Any time a member/representative* requests an in-person assessment<br>If during a televideo or phone assessment, the CC determines an in-person assessment is necessary to complete the assessment |
| **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. |
| **Connect Outreach Attempts** | Connect Outreach requires three outreach attempts to reach the member. These attempts may include phone calls, letters, or secure emails. If all 3 attempts are needed, first attempt must be a phone call and one attempt must be a UTR letter. Outreach attempts do not need to be actionable. Automated phone calls* are acceptable outreach attempts when the member answers the phone, or a voicemail is left on a known working number. Phone calls should be made on different dates and varying times. |
| **CSP/CSSP** | Community Support Plan/Coordinated Services & Supports Plan.<br>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. |

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| **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:<br>• At a minimum includes the care coordinator, the member and/or representative*, PCP, and Waiver Case Manager (as applicable)<br>• 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<br>• 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. |
| **Interactive Voice Response (IVR)** | An Interactive Voice Response (IVR) call is a pre-recorded or computer-generated voice message delivered over the phone without real-time human interaction from the caller. (Not to be used with Connect+). |
| **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.<br>Health Risk Assessment form (HRA-MCO) – replaces the DHS-3428H |

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| | MnCHOICES Assessment form with "Staying Healthy" section – replaces the DHS-3428 for managed care certified assessors<br>MnCHOICES Assessment form – replaces the DHS-3428 for county assessors (NOT used by MCO care coordinators)<br>Support Plan-HRA-replaces My Connect/Connect+ Medicare Support Plan. Use Program Type 'Health Risk Assessment'<br>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:<br><br>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.<br>• UTR Activity Date = date of last outreach attempt to reach member for assessment<br>• Refusal Activity Date = date member verbally refused/declined HRA<br><br>If the initial assessment results in a completed assessment, the reassessment is due within 365 days of the previous assessment activity date. |
| **Representative** | A member's 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 |

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| | of representation. For additional information on alternative decision-makers, refer to the Care Coordination Manual (pt. 1).<br><br>**Some examples of alternative decision makers, but not limited to:**<br>**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)."<br><br>**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.<br><br>**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.<br>• **Durable Power of Attorney** hold the same privileges as POA but maintains their power through incapacities and terminates upon death of the member<br><br>**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.<br><br>**Responsible Party (RP)/participant's representative** is "An individual who is age 18 or older and capable of directing care on behalf of a person receiving PCA/CFSS services when the person is assessed as unable to direct their own care. In PCA, this individual is called the RP. In CFSS, this individual is called the participant's representative. (DHS, PCA Manual, PCA responsible party and participant's representative (CFSS) (state.mn.us)). The participant's representative/RP should be listed in the MnCHOICES assessment. The |

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| | participant's representative/RP must actively participate in planning PCA/CFSS services. " The designated RP is not permitted to act as the PCA. |
| **ROI** | Release of Information.<br>• A signed ROI does not grant decision making powers |
| **SMART Goals** | Specific, Measurable, Attainable, Relevant, Time-bound. |
| **THRA** | Transfer Member Health Risk Assessment.<br>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. |
| **UTR** | Unable to Reach. |

| **eDocs Form Names** | |
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| **eDocs Number** | **Title of Document** |
| **DHS-5181** | *Lead Agency Assessor/Case Manager/Worker LTC Communication Form:*<br>• 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:*<br>• 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:*<br>• 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.* |

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| | • May be used as an additional tool for HRA-MCO forms as applicable |
| **DHS-3428M** | *Mini-Cog© Instructions for Administration and Scoring*<br>• Screening tool to detect possible presence of dementia |
| **DHS-8354** | *MCO Member Address Change Report Form.*<br>• 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) |