Care Coordination Manual Part 3: Connect & Connect + Medicare

Table of Contents

Definitions

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

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

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

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

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

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

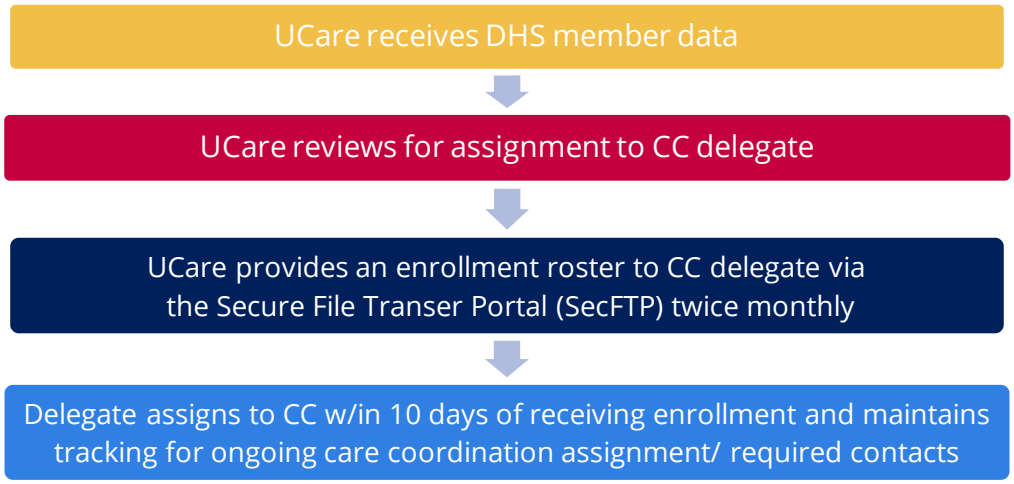
Support Plan: A person-centered document that identifies what is important to the member, what support and care is necessary for the member, and member specific goals and interventions. Information is gathered from consultation with the member, the member's care team, caregivers, and/or member information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

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

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

Care Coordination Enrollment Overview

The Department of Human Services provides UCare with member enrollment updates. UCare reviews enrollment information to determine the delegate that will be assigned for care coordination. Connect (CT) and Connect + Medicare (CT+MED) members are assigned to delegates based on the member's county of residence and contracted agreements with counties and care system partners. Some exceptions may apply based on specific contracted agreements.



Enrollment Rosters

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

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

Reconciling the Enrollment Roster

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

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

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

Primary Care Clinic (PCC) Changes

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

- Updated PCC and care coordination assignment will be reflected on 2nd roster posting.
- If requested after the 12th day of the month, care coordinators are to continue with all care coordination activities to ensure member contact is completed within the regulated timelines and PCC will be honored effectively on the first roster of the next month.
- PCC must be confirmed with the member. Reviewing electronic health records is not sufficient to request a PCC change.

90-Day Grace/Monitoring Period for Medical Assistance

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

CONNECT

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

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

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

CONNECT+ MEDICARE

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

- UCare continues to pay claims for eligible members in the 90-day CMS grace period
- CCs continue all care coordination activities for 90 days following the date MA becomes inactive
- Medical providers may contact the Provider Assistance Center at 612-676-3300 to confirm eligibility prior to providing services
- CCs assist with resolving MA re-enrollment issues. Consider referral to UCare's Keep Your Coverage Team
- Upon notification of disenrollment from UCare via the Enrollment Roster, ensure MnCHOICES documents are in completed status and remove the CC location and assignment

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

Medical Spenddowns

The county financial assistance unit is responsible for determining the financial obligation for UCare members. The member receives a notice if they have a waiver obligation or will be responsible for a spenddown. A spenddown may occur when a person's income/assets are above the criteria to qualify for MA. Similar to an insurance deductible, to get coverage a recipient pays a share of the cost of medical bills before MA begins to pay.

CT/CT+ MED: Members who are enrolled in UCare Connect/Connect + Medicare and incur a Medical Spenddown may stay enrolled in the UCare plan as long as the member pays the spenddown each month. Members pay spenddowns directly to DHS via monthly invoices from DHS. If a member does not pay the spenddown for three consecutive months, DHS will disenroll the member from UCare. Members who have questions about spenddowns should be directed to speak to their county of financial responsibility eligibility worker. CCs do not have access to spenddown information.

Designated Providers

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

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

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

Initial Assignment

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

- Introduce themselves to the member
- Provide the assigned care coordinator's name and contact information
- Answer any questions the member has about their plan and/or benefits
- Identify a date/time within 60 days of the member's enrollment to UCare to complete an HRA

Member Contacts

Actionable Attempts

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

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

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

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

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

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

Using Interpreters

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

Arranging Interpreter Services

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

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

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

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

90-day Monitoring Period for Connect Members and Using Interpreters

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

Assessment and Support Planning Overview

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

Assessment

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

Support Planning

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

Ongoing Caseload Management

Care coordinators maintain the relationship with members throughout the year. Follow-up is a minimum of every 6 months (mid-year review) to review goals as well as during Transitions of Care (aka hospital admit/discharge).

The Assessment

A CT/CT+ MED assessment is completed within 60 days of the member's enrollment date and thereafter reassessed within 365 days. If a member requests an assessment or if there is a significant change in the member's condition, it is best practice to complete it within 20 business days of the request or change.

UTR/Refusal Reassessment Due Dates

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

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

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

Assessment Tools and Methods

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

Assessment Methods

DHS and CMS provide guidance on the method of assessment (e.g., in-person, phone, televideo). In preparation for the assessment, care coordinators must determine the appropriate method based on the member's situation. Documenting the assessment options offered according to the grid below is key to maintaining compliance with DHS and CMS regulations. If a Connect + Medicare member assessment is completed via telephone, a separate in-person or televideo encounter during that same 12-month period is required. Ideally, this is completed by the Care Coordinator. Alternatively, the Care Coordinator can confirm the PCP, Waiver Case Manager, or other ICT Specialty Care Provider has seen the member in person or televideo.

	Offer First: In Person	Offer Second: Televideo	Offer Third: Via Phone
Initial/Annual: Community Member CONNECT	X	X	X
Initial/Annual: Community Member CONNECT+ MED	X	X	X* *Additional ICT encounter requirements and robust documentation – SEE JOB AID BELOW
Initial/Annual: Institutional CT/CT+ MED	X	NA	NA

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

Preparation for Assessment:

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

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

Gaps in Care Report / Quality Action List

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

Reference: Reports

Assessment Tools

MnCHOICES Assessment**	• An option for UCare care coordinators who have a dual role of being the member's county case manager for members on waivers (CADI, DD, BI, CAC) to complete in lieu of completing the HRA-MCO • 4 actionable attempts to schedule assessment • See In-Person Assessment Job Aid for methods and additional encounter requirements
HRA-MCO	• Health Risk Assessment (HRA) for community and nursing home members • Completed when member is on other waivers (CADI, DD,BI,CAC) and county is not providing waiver case management • See In-Person Assessment Job Aid for assessment methods
TRANSFER MEMBER HRA (THRA)*	• Transitional tool for members with a product change or MCO transfer • Must review assessment/support plan completed w/in previous 365 days • Reassessment due 365 days from previous assessment • May be completed in-person or via phone
Additional Assessment Tools	• DHS-6914 Caregiver Assessment (optional when caregiver identified) • DHS-3428M Mini Cognitive Exam (optional) • PHQ9 Depression Screening (optional)

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

**DHS permits UCare care coordinators who are also the disability waiver case manager to utilize the MnCHOICES Assessment tool to meet both UCare care coordination and disability waiver assessment requirements. Dual role CC/CMs are expected to meet all UCare care coordination requirements including but not limited to assessment timelines, in-person assessment requirements, support plan requirements, and submitting the Monthly Activity Log.

Completing the Assessment

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

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

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

Member No Show or Canceled Assessment

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

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

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

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

MMIS Entry

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

Transfer Member HRA

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

Examples of when to use a THRA include:

1. Product Changes: CT/CT+ MED or vice versa
2. Other MCO to UCare transfer

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

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

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

Waiver Case Management Referrals

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

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

Nursing Facility Level of Care Criteria (CADI example)

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

1. Does/would live alone or be homeless without current housing type **and** meets one of the following:
   - Has had a fall resulting in a fracture within the last 12 months
   - Has a sensory impairment that substantially impacts functional ability and maintenance of a community residence
   - Is at risk of maltreatment or neglect by another person or is at risk of self-neglect
2. Has a dependency in four or more activities of daily living (ADLs).
   - ADLs include dressing, grooming, bathing, eating, bed mobility/positioning, transferring, walking, toileting
3. Has significant difficulty with memory, using information, daily decision-making or behavioral needs that require intervention.
4. Needs the assistance of another person or constant supervision to complete toileting, transferring or positioning, and this assistance cannot be scheduled.
5. Needs formal clinical monitoring at least once a day.

Reference: DHS-7028 Nursing Facility LOC Criteria

Consumer Directed Community Support (CDCS)

CDCS is a service option that gives members open to a disability waiver flexibility and responsibility to direct their own services and supports. CDCS may include services, supports and items currently available through the Medical Assistance waivers, as well as additional services. To learn more about CDCS, CCs may view the DHS CDCS Online Learning Module which includes an overview of the CDCS program.

References: DHS CDCS Policy Manual

Non-Waiver HCBS

Moving Home Minnesota (MHM)

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

Reference: DHS Moving Home Minnesota

Housing Stabilization Services (HSS)

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

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

CFSS

On Oct. 1, 2024, DHS transitioned from personal care assistance (PCA) and the Consumer Support Grant (CSG) to a new combined program called Community First Services and Supports (CFSS). CFSS is a Minnesota health care program that provides services to seniors and people with disabilities to help them remain independent in the community. A Certified Assessor completes an in-person MnCHOICES assessment and uses the assessment results to determine eligibility for CFSS.

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

CFSS Eligibility

CFSS Covered Supports

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

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

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

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

Goods and Services and PERS: Support related to an assessed need, for the direct benefit of the member, increases independence or decreases the need for assistance from others, and is included in the service delivery plan.

CFSS Referrals

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

Reference: DHS CFSS Program Info: CFSS Policy Manual

State Plan Home Care Services Authorization

Skilled Nursing Visits and Home Health Aide

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

Who is the Payor?

UCare is the Home Care Services Payor (non-waiver member)

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

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

When a member is open to a community disability waiver, the county waiver case manager faxes the DHS-5841 to 612-884-2499 to authorize state plan services. The waiver case manager may share the DHS-5841 with the care coordinator for collaboration and good communication purposes.

Care coordinators initiating state plan services for members on disability waivers are required to send the DHS-5841 to the county waiver case manager to communicate that services will need to be approved and included in the member's waiver budget.

Medicare Eligible Home Care Services

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

Reference: UCare Authorization & Notification Requirements

Daily Authorizations Report (DAR)

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

Three reports on the DAR:

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

Action by care coordinators:

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

Denial Termination or Reduction (DTR) of UCare Paid Services

Services being denied (based on lack of need), terminated (based on member's request or other reason) or reduced (based on member's request or other reason) require members to be notified of their right to appeal. UCare CT/CT+ MED care coordinators do not complete DTRs. UCare issues any needed DTRs based on member claims.

The Support Plan

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

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

Support Plan Tools

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

Reference: CT/CT+ MED Letters Guide

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

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

Signature Requirements

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

Ongoing Caseload Management

Support Plan Revisions

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

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

UTR/Refusal Members and Support Plan Updates

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

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

Care Coordinator's Support Members in the Following Areas:

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

Collaboration with Other Case Managers

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

Members on Other Waivers

Care coordinators review the waiver case manager's support plan to better understand the member's needs, supports and services and avoid duplication. Care coordinators also share the CC support plan with the waiver case manager

and communicate member updates throughout the year. When initiating State Plan Services, the CC uses the DHS-5841 to communicate with the waiver case manager and request/approve Home Care, Home Health Aide, Physical Therapy, Occupational Therapy, and Speech Therapy.

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

UCare Care Coordinator Responsibilities	CADI/DD/BI/CAC Case Manager (non-dual role) Responsibilities
MnCHOICES Assigned Role: Care Coordinator **Assessment tool:** HRA-MCO	**MnCHOICES Assigned Role:** Certified Assessor **Assessment tool**: MnCHOICES Assessment *Waiver CM determines waiver, CFSS and HSS eligibility*
Care Coordinator: Completes Support Plan - HRA	**Case Manager (CM):** Completes MnCHOICES Support Plan
Areas of Focus	
Assist in accessing medical care, preventative health education and closing Gaps in Care Send 5841 to Waiver CM when initiating State Plan Services	Authorize HCBS, PCA/CFSS, and home care services Sends the DHS-5841 to UCare to authorize State Plan Services
Education on health plan benefits assist with access to supplemental benefits	Education on wavier covered HCBS
Community resource referrals *Both CC and Waiver CM provide support with community resources*	
Collaborate with ICT: CC shared support plan with PCP, waiver CM, BHH (as applicable) and other ICT members	Waiver case manager shares MnCHOICES Support Plan
Coordinate MA-covered medical equipment and supply needs	Coordinate waiver-covered housing, equipment and supply needs
Transportation to UCare covered medical appointments	Transportation to waiver-covered supports
Transition of Care support* *communication/collaboration with PCP, BHH and waiver case manager (as applicable)	Collaborate with CC on waiver-covered support needs
UCare completes PAS for care coordination	Waiver CM completes OBRA II as applicable for UCare members

Behavioral Health Home (BHH)

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

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

Reference: Behavioral Health Home Job Aid

Restricted Recipients

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

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

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

Members on Hospice

For members who have elected hospice, care coordinators continue to be involved, complete all care coordination processes including annual reassessments and corresponding paperwork, and communicate and collaborate with the hospice care team and ICT. Care coordinators should consider asking to participate in Hospice case discussions. Support plans may be adjusted based on new or changes in service providers/payors. For additional information refer to the Hospice Benefit in the UCare Provider Manual keyword HOSPICE.

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

Transition of Care

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

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

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

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

Notification of TOC

Care coordinators may be notified of admissions via:

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

*MN Encounter Alert System (AKA PointClickCare)

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

TOC Log

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

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

TOC Requirements

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

Admission to a Nursing Facility

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

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

CC Responsibilities:

- Monitor MN EAS and the Daily Authorization Report for admissions

- Complete transitions of care activities
- CT+ MED members complete a TOC log
- Determine if an early assessment due to a change in needs is warranted. An assessment is not required solely based upon admission to a nursing facility.
- Complete the member's reassessment based on the member's assessment timeline requirements
- Update the member's support plan as applicable

NOTE: If the enrollment roster displays an incorrect Living Status, the CC should complete the correct assessment according to the actual living status and ensure the address is updated accordingly. To update the Enrollment Roster's Living Status from "community" to "institutional" the nursing facility submits the DHS-1503 to the member's county of residence. To change from institutional to the community, CC sends the DHS-5181 to notify the county of a member address change.

Institutionalized Members

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

Members will appear on the enrollment rosters as "Institutional." Initial outreach, assessment timelines, mid-year reviews and TOC requirements do not differ for institutional members. The HRA and support plan used are the same for community members and are completed within the MnCHOICES application. See Assessment Tools and Support Plan Tools. Additionally, assessments are required to be conducted in person. A signature is required for the Support Plan.

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

In the rare instance that the member is unable to complete the assessment due to being unable to communicate or declining participation, the care coordinator should gather as much information as possible through conversations with facility staff, chart review, and the member's caregivers/family, and member (if able or willing) to complete the assessment and support plan. When unforeseen barriers prevent the completion of the assessment/support plan, follow the refusal process.

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

Medical Assistance Renewals

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

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

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

Change in Care Coordinator

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

Transfer to a New MCO or Between UCare Care Coordination Delegates

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

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

Internal Change in Care Coordinator

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

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

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

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

Reference: Letters Guide

Temporary absence of CC

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

Other Case Closure Responsibilities

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

Member Moves Out of State/Country	• Document in member record • Send DHS-5181 to COFR • Continue care coordination while the member remains on UCare's Enrollment Roster • Follow 90-day grace/monitoring period • Notify providers to stop services	• Upon notification on the UCare Enrollment Roster, remove CC location and assignment and discontinue care coordination
Member Confirmed to be Incarcerated	• Complete four actionable attempts to permanent residence, if known, for the member to act upon if released • Document confirmation in the member record • Follow the process for UTR or refusal (if reached and declined) • Send 5181 to COR	• Upon notification on the UCare Enrollment Roster, remove CC location and assignment and discontinue care coordination
Member moves to FFS MA	• Enrollment Roster informs CC of change • Verify in MN-ITS MA is active • Document in member record • Notify providers of change in payor	• Upon notification on the UCare Enrollment Roster, remove CC location and assignment • Ensure documents are in completed status
Member Changes to Non-UCare Health Plan	• Enrollment Roster informs CC of change • Verify in Mn-ITS MA is active and ID new MCO • Document in member record • Complete the DHS-6037 to transfer to the new MCO	• Upon notification on the UCare Enrollment Roster, Remove the CC location and assignment • Ensure documents are in completed status

Member's Turning age 65

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

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

- Sending DHS-6037 if a member is transferring to a new care coordinator

Documentation

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

Monthly Activity Log

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

Reference: CT/CT+ MED Monthly Activity Log Job Aid

Additional Resources:

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