Care Coordination News

May 2025

Issues of **Care Coordination News** often refer to different UCare forms. All UCare Care Coordination forms are on the UCare website under the Care Coordination and Care Management page. Care Coordination-related questions can be directed to the Clinical Liaison at:

- **MSC+/MSHO** MSC_MSHO_Clinicalliaison@ucare.org or by phone: 612-294-5045 or 1-866-613-1395
- **Connect/Connect + Medicare**: SNBCClinicalliaison@ucare.org or by phone: 612-676-6625 or 1-833-951-3190

Enrollment-related questions can be directed to:

- **MSC+/MSHO enrollment** by email CMIntake@ucare.org
- **UCare Connect/Connect+ Medicare enrollment** by email at connectintake@ucare.org

2025 UCare Care Coordination Meetings

UCare All Care Coordination Meetings are provided every quarter. These meetings are intended to provide ongoing education, benefit updates and topical information to support successful care coordination presented live or by viewing the recorded WebEx. When viewing the recorded Quarterly All Care Coordination Meeting, an electronic verification is needed. CEU events and office hours are optional.

UCare Product	Meeting Type	Date & Time (Subject to change)
MSC+/ MSHO and Connect/Connect + Medicare	Live Quarterly All Care Coordination Meeting	June 12, 2025, 9 am-12 pm September 11, 2025, 9 am-12 pm December 11, 2025, 9 am-12 pm
MSC+/MSHO and Connect/Connect + Medicare	CEU Event (optional)	May 29, 2025, 11:30 am-1 pm August (Dates to come) November (Dates to come)
MSC+/MSHO	Clinical Liaison Office Hours (optional)	July 24, 2025, 11 am-12 pm October 23, 2025, 11 am-12 pm
Connect/Connect + Medicare	Clinical Liaison Office Hours (optional)	July 24, 2025, 12:30 pm-1:30 pm October 23, 2025, 12:30 pm-1:30 pm
MSC+/MSHO and Connect/Connect + Medicare	Housing Office Hours (optional)	3rd Wednesday of every month from 1 pm-1:30 pm

Click here to register for the May CEU: Understanding the Diversity Within – AAPI: Voices on Culture, Care & Mental Health

Click here to register for the May Housing Office Hours

ALL CARE COORDINATION NEWS

New on the Care Coordination and Care Management Website

All products

- SMART Carte (Revised 4/10/25)
- MnCHOICES Guidance (Revised 4/7/25)
- AA/NA Transportation Request Form (Revised 4/14/25)
- When to Contact Your Care Coordinator (Revised 4/9/25)
- TOC Log Instructions (Revised 4/9/25)
- CLI: Interpreting Services Pre-Scheduling Instructions (Revised 4/18/25)

MSC+/MSHO

- Assessment Checklist (Revised 4/4/25)
- Member Elderly Waiver Service Change Letter (Revised 4/10/25)
- Institutional Health Risk Assessment (Revised 4/7/25)
- PCC Change Form (Revised 4/9/25)
- CDCS Post Assessment Communication Form (New 4/3/25)
- CFSS Care Coordination Guidelines (Revised 4/16/25)
- CFSS FAQ (Revised 3/25/25)
- Waiver Service Authorization Form (Revised 4/16/25)
- EW DTR Form (Revised 4/16/25)

Connect/Connect+ Medicare

- Assessment Checklist (Revised 4/8/25)
- Primary Care Clinic Change Request (Revised 4/9/25)

SMART Goals

All Support Plan goals are required to be written in SMART goal format. SMART goals offer a clear objective to set the member up for success. SMART stands for:

Specific: What needs to be accomplished, who is responsible for it, and what steps need to be taken to achieve it?
Measurable: Quantifying the objective allows for tracking progress and identifying completion.
Attainable: Goals should be realistic and reasonable to accomplish.
Relevant: What is the big picture? Why set this goal? Is this goal relevant to the "why?"
Time-bound: Goals should include time-related parameters. Ask, "When will the member achieve this goal?"

Looking for more help writing SMART goals? Care coordinators can reference multiple resources, including the SMART goals job aid, SMART Carte, and the SMART goals recorded training.

Keeping Support Plans Compliant

Care coordinators create support plans annually with members. Support plans are completed based on the member's requests, identified risks, and needs. Support Plans are revised at a minimum of biannually, and goals are updated at that time. Upon review, goals are updated as Achieved, In Progress, or Discontinued. Support Plans must always have at least one in-progress goal and at least one high-priority goal. A new high-priority goal is created when all goals are achieved or discontinued during an update.

All members, including those unable to reach or refusing the annual assessment, require a mid-year review. At the mid-year review, the care coordinator completes four actionable attempts to reach the member. If the member was unable to reach or refused at the annual assessment and was reached for the mid-year check-in, an assessment should be offered.

Upcoming Changes to the Daily Authorizations Report (DAR)

With the full transition to PointClickCare (PCC), starting 6/1/25, the DAR will be reduced to only include the following notifications:

- Substance Use Disorder Inpatient and Residential Stay
- Detox Admission
- Mental Health Residential Stay
- Skilled Nursing Facility Admission
- Swing Bed Admission
- Long Term Acute Care Admission
- Acute Inpatient Rehabilitation
- Authorized Services (ILOS, EW, CFSS, etc.)

For all other admissions and discharge notifications, care coordinators will review PCC to receive updates and begin the Transition of Care process.

Pre-Admission Screening Updates

As part of UCare's ongoing efforts to enhance collaboration and care coordination, UCare is providing a small but meaningful update to the Pre-Admission Screening (PAS) process.

What's New?

Moving forward, the UCare PAS Coordinator will be sharing PAS documents with delegate agencies whenever a member managed by a delegate is admitted to a Nursing Facility (NF). UCare will continue to manage the PAS process internally. Unless this is the care coordinator's first transition of care notification, these documents will be shared for informational purposes only.

Why This Matters

This update is designed to support and streamline care coordination efforts by providing timely, relevant information at a critical point in the member's transition. The PAS documents often include valuable insights, such as:

- Updated member address and phone number
- Key facility contact details
- A snapshot of the member's status at admission

While this can serve as a secondary notification about a member transition, no additional work or tasks related to the PAS process are required. UCare hopes that receiving these documents will offer another helpful layer of visibility into the member journey, enhancing the care coordinators' ability to plan and coordinate care effectively.

Lutheran Social Services: Healthy Transitions Program

MSHO and Connect + Medicare members

This program provides individualized support, education and resources for eligible members during the critical first 30 days after a hospital or short-term rehabilitation center stay. When the member returns home from the hospital or rehabilitation center, the member is paired with a specially trained

and certified community health worker. The community health worker provides two in-home and two phone visits during the 30 days.

These visits cover:

- Discharge documentation
- Home safety and fall risks
- Nutrition
- Medications
- Socialization
- Appointment setting and transportation
- Short-term goal setting
- Resources and referrals to other providers

The community health worker collaborates with the member and care coordinator to ensure all needs are met. Members may contact care coordinators to learn more and verify eligibility.

Coaching and Education for Healthy Living

UCare's Disease Management team provides member education and coaching programs for Asthma, Chronic Kidney Disease (CKD), Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Hypertension, Heart Failure, Migraines, and Weight Management.

Health coaches and educators help members adapt their lifestyle choices, such as sleep habits, diet, exercise routines, and stress management techniques, to help them improve their health and better manage their chronic condition. Disease Management programs aim to promote healthy living, improve quality of life, encourage self-care, and support provider treatment plans to help members better manage their conditions. Coaching and education empower members to recognize how their thoughts, emotions, and behaviors can improve their symptoms, identify their triggers, improve perceptions of their health, and develop sustainable condition management tools.

Our team works closely with Case Management, Pharmacy, Health Improvement, Health Promotion and provider teams to assist members in self-management of their chronic condition.

For more information, please visit: Managing Health Conditions | Programs and Support | UCare.
To send us a referral, please contact us at:

- **DM Email:** Disease_mgmt2@ucare.org
- **DM Voicemail:** 612.294.6539 or 866.863.8303
- **DM Referral Forms:** https://www.ucare.org/providers/policies-resources/disease-management

Chronic Care Improvement Program (CCIP)

Medicare Advantage plans are required to conduct Chronic Care Improvement Program (CCIP) initiatives. The intent is to promote effective chronic disease management and improvement of care. UCare implements the CCIP program via a quarterly newsletter mailing to members diagnosed with 2-6 chronic conditions based on the Johns Hopkins Adjusted Clinical Group system. Newsletters are sent to EssentiaCare, UCare Medicare, MSHO, and Connect + Medicare members. An estimated 70,000 members receive a newsletter each quarter.

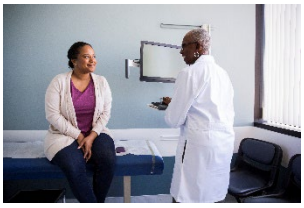
The newsletters provide education and resources to assist members in managing their chronic conditions. Education topics are chosen based on population health data, annual education opportunities, and member claims data. In 2025, the quarterly newsletter topics include Preventive Health, Medication Adherence, and education customized to members based on their diagnosed chronic conditions. Each newsletter includes resources such as Healthy Benefits, fitness, transportation help, Brook Health Companion, health coaching, nurse line, and the Mental Health and Substance Use Disorder access lines.

World No Tobacco Day

May 31 is World No Tobacco Day, and all UCare members are eligible for the Quit for Life tobacco cessation program. Nicotine patches, gum, or lozenges are also available to eligible members.

- Call the tobacco and nicotine quit line toll-free 1-855-260-9713 (TTY 711), available 24 hours a day, seven days a week
- Visit myquitforlife.com/ucare
- Download the Rally Coach Quit for Life mobile app

Everlywell Diabetic Testing Kits: Key Details and New Features



UCare is beginning its third year partnering with vendor Everlywell to engage members who may benefit from diabetic HbA1c testing and/or diabetic kidney disease testing kits. This benefit allows our members to complete all recommended screenings conveniently in the home with no out-of-pocket cost. Everlywell also offers a combination diabetic kit that includes both kidney disease and HbA1c testing in one easy-to-use package, making it more convenient for members to stay on top of their health. Eligibility is determined via claims, pharmacy, or other records.

The 2025 campaign is set to launch in May through an opt-out program. Eligible members will receive a letter from Everlywell letting them know that screening kits will be mailed to them. Opt-out instructions will be outlined in the letter.

Completed screening results can be accessed through an online portal and will also be mailed to members. If there are abnormal or positive screening results, Everlywell's clinical staff will follow up with members to recommend next steps, including consulting their primary care provider. The Kidney Health Evaluation (KED) screening is valid for one year and should be repeated annually. As part of our current partnership with Everlywell, A1C testing may be completed twice a year.

New in 2025, Everlywell kits will include primary care provider (PCP) identification cards. If the card is completed and returned with the sample, a copy of the results will be shared with the designated provider. Additionally, a new SMS feature will be implemented as part of this campaign to prompt and encourage timely kit completion.

UCare members receiving Everlywell kits that need assistance can call Everly's customer service team at 1-855-923-2678 from 8 am – 8 pm ET, Monday–Friday. Members can also chat with a member from Everly's customer service team at membersupport.everlywell.com.
Program-related questions can be directed to ucarequality@ucare.org.

Cologuard Kits Ship This Month: What You Need to Know

As of this month, eligible UCare members will receive a Cologuard screening kit from Exact Sciences, which will be directly mailed to their homes. The opt-out campaign is now live, and members will be notified of their eligibility by mail. Letters include details about the screening and instructions on how to opt out before kits ship. Screening is voluntary and available at no extra cost to the members.

Eligibility is determined through claims data and applies to average-risk members in Medicaid, Medicare, and Exchange plans. Cologuard is not recommended for those with a history of adenomas (a type of polyp), inflammatory syndromes, a personal or family history of colon cancer, or anyone current with a colonoscopy screening test.

Kits arrive at the member's doorstep with pre-paid UPS return postage. Completed kits are typically processed within two weeks of arriving at the lab. Members will receive kit results via certified letter from Exact Sciences. If results are positive or abnormal, a medical professional will attempt to follow up by phone to discuss next steps with the member. A colonoscopy following an abnormal screen is covered as a preventive benefit with no out-of-pocket cost. Negative Cologuard results are valid for three years.

With the campaign now underway, this is a great opportunity to encourage eligible members to complete their kits and return them promptly. Early screening can save lives. Let's help ensure more members take this important step in protecting their health.
The Exact Sciences Customer Care Team is available 24 hours a day, seven days a week by calling 1-844-340-1594 or chat with a member of their care team at Cologuard.com/why.
Program-related questions can be directed to ucarequality@ucare.org.

Job Aid Highlight

Assessment Checklists

UCare has a Connect/Connect + Medicare Assessment Checklist and an MSC+/MSHO Assessment Checklist, which are located in the Job Aids drawer on the Job Aids and Resources page. These checklists are updated frequently, including when the Requirements Grids are updated and when DHS shares updates/clarifications to DHS policies, such as CFSS and CDCS changes. In the most recent update to the MSC+/MSHO Assessment checklist, a tab was added specific to members opened to the Elderly Waiver CDCS.

As a reminder, the assessment checklists are unlocked Excel spreadsheets. Delegates may add their internal processes to the checklists to help care coordinators complete all required tasks during assessments and mid-year reviews. When doing so, it is recommended that the Job Aids and Resources page be monitored for revisions to ensure the most up-to-date checklist is being used.

CONNECT AND CONNECT + MEDICARE NEWS

Connect to Wellness Kit

Connect and Connect + Medicare members can order a Connect to Wellness Kit to help improve their health and wellness. Each kit includes engaging tools at no additional cost. Members may choose one of the following kit options:

- Fitness Kit:
  - Activity Tracker watch
  - Resistance band
  - Extendable massage roller

- Sleep Aid Kit:
  - Aromatherapy diffuser with sound machine and night light
  - Essential Oil

- Stress Relief Kit:
  - Therapy lamp
  - Putty
  - Push pop

- Dental Kit:
  - Electric toothbrush
  - Toothpaste
  - Floss picks

- ADHD and Autism Support Kit (New for 2025):
  - Planner
  - Metal roller
  - Phone cord bracelet
  - Fidget toy
  - Teething tube

- Smart Home Device Kit (CT+ members only):
  - Amazon Echo
- Weighted Blanket Kit (CT+ members only):
  - 5-pound weighted blanket

To order a kit*, members can log in or create an online member account at member.ucare.org. Then, navigate to Health & Wellness, then Wellness, Rewards & Allowance, to place an order. Members or care coordinators can also call UCare Customer Service at the number on the back of the member ID card to order by phone.

*Must be an eligible UCare member at the time of the order. Limit one kit per year per member. Kit contents may be subject to change. Please allow 4 – 6 weeks for delivery.

IMPORTANT CONNECT ALERT: All care coordinators were notified of changes to the Connect requirements effective 5/1/25 in the most recent UCare ALERT. These changes will be reflected on the upcoming Connect/Connect + Medicare Requirements grid that will be posted 7/1/25. The Connect/Connect + Medicare Care Coordination Manual has been updated to reflect these immediate changes. Click here to view the ALERT.

MSC+ AND MSHO NEWS

Good News: Update to Waiver Service Authorization Form (WSAF) and EW DTR

Currently, the Home Health Communication Form is used to authorize and deny, terminate, or reduce (DTR) extended home care services. To streamline Elderly Waiver service authorizations and DTRs, the Home Health Communication Form has been discontinued, and these Elderly Waiver (EW) services have been added to the current WSAF and the EW DTR form. Please begin utilizing the revised forms posted to the MSC+ and MSHO Resources page.

Primary Care Clinic Changes

UCare recently updated the Primary Care Clinic (PCC) Change Form to add instructions around the timeliness of submission and effective dates. PCC must be confirmed with the member. Reviewing electronic health records is not sufficient to request a PCC change. If a member's primary care provider is verified and requires an update, complete a PCC Change Request Form by the 12th day of the month to reassign to the appropriate delegate to be reflected on the 2nd roster posting.

- If requested after the 12th and before the 24th 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.
- If requested after the 24th day of the month, the change will not be effective until the subsequent month
    - Example: PCC form submitted 4/25/25 will be effective 6/1/25

Updates to CFSS Policy

The UCare CFSS Care Coordination Guidelines continue to be updated regularly as CFSS evolves and when DHS policy and guidance change.

Refer to the MSC+/MSHO Care Coordination page for the most up-to-date resources and links to support daily care coordination work during this transition from PCA to CFSS!

QUALITY REVIEW CORNER

Care Coordination Trends & Tips

The Quality Review Team analyzes overall trends in the quality reviews. Quarterly, an opportunity for improvement trend will be presented to care coordinators to provide guidance on improving care coordination compliance.

"My Backup Plans" (Writing an Essential Services Plan)

The care coordinator must discuss and develop a backup plan with the member or representative if the member is receiving essential services or needs a 24-hour plan of care. The care coordinator should use professional judgment and knowledge about the member's situation to determine what is

considered an essential service. An essential service is services, supports, supplies, or equipment that are necessary to the health and safety of the member. The backup plan can include support through providers, informal caregivers, family, friends, community organizations, or assistive technologies. A backup plan should be agreed upon by the member, provider, and/or family/caregiver.

Examples:

- Cleo receives daily CFSS. If CFSS staff are not available, Cleo will call the CFSS agency for backup staff. Niece Shawn would assist informally in the interim if needed.
- Joe resides in a 24-hour customized living and receives essential services from CL. CL will ensure a safe staffing ratio to meet Joe's needs. CL staff will contact the care coordinator if Joe's needs cannot be met in a safe manner.
- If Joan's husband was not available for an extended period, she may need additional formal services and supports, such as a home health aide for bathing or potentially a homemaker or home-delivered meals. The care coordinator could be contacted if her husband were not available.
- Robert is not requiring essential services currently. If Robert's needs change, Robert will contact the care coordinator to discuss services to address their needs.

For additional information, refer to the DHS resource: CBSM Guide for emergency backup planning.

DHS NEWS AND UPDATES

Care Coordinator Workflow in MnCHOICES Training Recording

DHS has posted the March Recorded Care Coordinator Workflow in MnCHOICES Training and PowerPoint to their DSD Training Handouts Archive website.

MnCHOICES Enhancements

Description: A new response option, Anxiety-related behaviors, is being added to Level II [2] behaviors in the MnCHOICES assessment.

- **Changes made:** Anxiety-related behaviors will only display if the person presents one or more level II [2] behavior(s) for which behavioral support interventions are needed.
  Anxiety-related behaviors: A response to perceived stress or uncertainty that involves heightened alertness or attempts to regain a sense of control, which requires a lot of reassurance and/or redirection.
  Examples:
  - Hypervigilance (scanning the environment, easily startled, jumpy, or restless)
  - Perseveration (repetitive and uncontrolled continuation of a thought, behavior, or response)
  - Freezing (temporarily unable to move or act in a situation).

  (Additional details regarding the new response option and instructions were provided in the email communication sent to mentors on March 31.)

MnCHOICES assessment: Assessment results- Description: When a person has a score of "00" for behavior on the LTC Screening Document, the system shows they met Level I [1] or Level II [2] behavior criteria for BI—NF level of care. Policy says to meet the criteria for BI—NF level of care, the behavior

score on the LTC Screening Document must be "01" or higher. [DHS ID 180028 – **This is a critical functionality item.**]

- **Directions:** The agency MnCHOICES mentor must submit a MnCHOICES Help Desk Contact Form, DHS-6979, asking for help if a person meets the behavior criteria for BI—NF level of care with a behavior score of "00" on the LTC Screening Document.

Support plan: Services and supports, Service type — Services that support me-Description: When a user creates a new EW customized living and foster care worksheet, the customized living and foster care daily and monthly rate limits are outdated. They still show 2024 rate caps. This workaround only applies to individuals who have not had a MnCHOICES assessment in the revised application and are using an assessment from MnA 1.0. [DHS ID 180042]

- **Directions:** Follow the steps below for the appropriate scenario:
    - Customized living: If 24-hour customized living eligibility for a person is unknown, use the EW customized living and foster care worksheet to figure out eligibility in a support plan where transition is the reason for the new plan. Then, use Long-Term Services and Supports Rate Limits effective Jan. 1, 2025, DHS-3945 (PDF) to figure out daily and monthly rate limits based on the last case mix determined by an assessment and the start date of the EW transition plan.
        - If a person is eligible for 24-hour customized living based on the last assessment, do not use the EW customized living and foster care worksheet. Use Long-Term Services and Supports Rate Limits effective Jan. 1, 2025, DHS-3945 (PDF) to determine 24-hour customized living daily and monthly rate limits based on a person's last case mix determined by an assessment and the start date of the transition plan.
    - Foster care: Use Long-Term Services and Supports Rate Limits effective Jan. 1, 2025, DHS-3945 (PDF) to figure out case mix limits based on a person's last case mix determined by an assessment and the start date of the transition plan.

For more information, go to the rate determination in a support plan with the transition plan reason section of the support plan and the transition plan reason practice guide in the MnCHOICES Help Center.

Practice Guide: Support Plan v. 4 (Anticipated load date: 4/7/2025. Check the Help Center for actual load date.)

- **Transition Plan**: Do not use the support plan reason "Transition plan" when a MnCHOICES Assessment exists in the system.

REMINDERS

Keep Your Coverage Team

Keep Your Coverage (KYC) specialists are dedicated to helping members maintain Medical Assistance (MA) eligibility and health plan enrollment. KYC specialists work with members on UCare Connect, Connect + Medicare, MSC+, and MSHO plans. Additional details are located in the Keep Your Coverage Program Referral Guide. Refer a member to the KYC team by calling 612-676-3438 or emailing KeepYourCoverage@ucare.org.

Forms Frequently Change

Forms are updated regularly. Please remember to download forms directly from UCare's website. This will ensure the most up-to-date versions are being used.

Updating Primary Care Clinic

All Care Coordinators should confirm members' primary care clinics and complete the Primary Care Clinic Change Request form located on the UCare website in the Care System or County PCC/Care Coordination Change Process drawer. This will ensure members (MSC+/MSHO) are correctly assigned for care coordination while in the program and when they age in. Although SNBC does not make delegate assignments based on PCC, it is equally important to ensure accuracy for continuity of care and initial assignment if/when they transition to MSC+/MSHO.

Care Coordination Questions?

The Clinical Liaisons are a great resource when care coordinators have questions. For us to help you best, please include as much detail as possible when submitting a question(s): e.g., member name and ID number, date of birth, product, details about the situation, and care coordinator name, phone number, and email address.

All emails sent to UCare that include private member information **must** be sent using secure messaging**. There may be times when UCare is unable** to open secure third-party emails. If your agency does not have a secure messaging system or UCare is unable to open the third-party secure message, care coordinators can create a secure email account using UCare's Secure email Message Center.

UCare Care Coordination Contact Numbers

Please refer to the Care Coordination Contact List for delegate contact information.

Newsletter Article Requests

Is there a topic that should be covered in this newsletter? Please send all suggestions to MSC_MSHO_Clinicalliaison@ucare.org & SNBCClinicalLiaison@ucare.org.