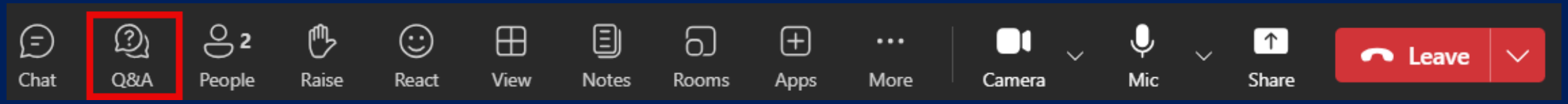
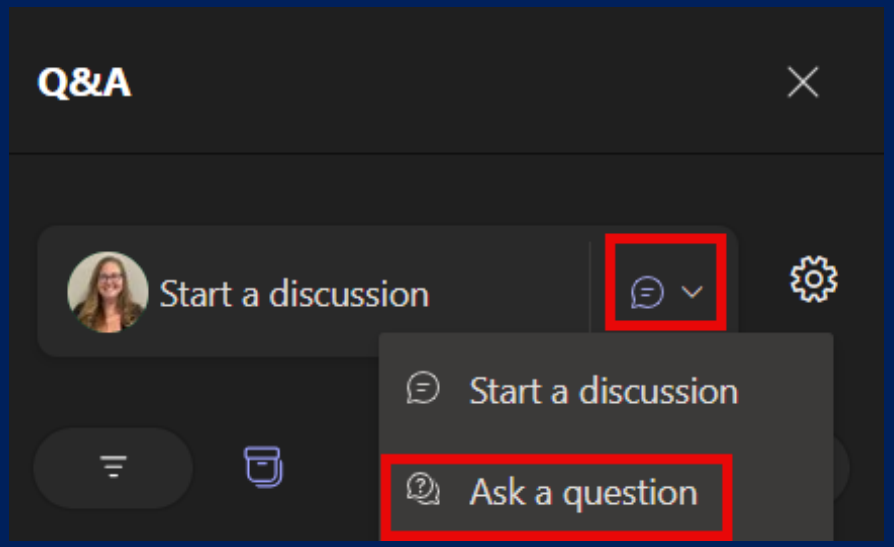

ucare®

UCare Connect/Connect + Medicare & MSC+/MSHO 3rd Quarterly All Care Coordination Meeting

September 11, 2025

Questions welcome!





Quarterly Meeting Announcement

2025 Care Coordination Meeting Schedule

UCare Product	Meeting Type	Date	Time
MSC+/MSHO and Connect/Connect + Medicare	UCare Quarterly All Care Coordination Meeting	December 11	9 am – 11 am
MSC+/MSHO and Connect/Connect + Medicare	CEU Event	November 4 and 6	CC Learning Day
MSC+/MSHO	Office Hours	October 23	11:00 am-12:00 pm
Connect/Connect + Medicare	Office Hours	October 23	12:30 pm – 1:00 pm
MSC+/MSHO and Connect/Connect + Medicare	Housing Office Hours	3rd Wednesday of the month	1:00 pm -1:30 pm

Today's Agenda

Time	Topic	Audience	Presenter
9:00–9:05	Welcome	All	Clinical Liaisons
9:05-9:12	Care Coordination Updates	All	Katie Osborne
9:12-9:22	CC Satisfaction Survey	All	Jennie Paradeis
9:22-9:40	Model of Care Training	All	Dawn Sulland
9:40-10:00	STARS	All	Rachel Sterner
10:00-10:10	Chronic Condition Programs	All	Liz Sperr
5 Minute BREAK			
MSC+/MSHO Presentations (SNBC Optional)			
10:15-10:30	UCare Initiatives Update	MSC+/MSHO	Dee-Ana Farness
10:30-10:40	T2029: Medical vs Elderly Waiver	MSC+/MSHO	Dawn Sulland
10:40-10:45	Initial Assessment Review (IAR)	MSC+/MSHO	Kristen Sagnes
10:45-11:00	CFSS	MSC+/MSHO	Samantha Rue

Care Coordination Updates

Katie Osborne

Enrollment Service Area Freeze – Call to Action

April 2025:
Enrollment freeze for UCare Connect in the 12 counties where HealthPartners left

July 2025:
Changed the current enrollment freeze to a hard freeze for UCare Connect in the 12 counties

September 2025:
UCare Connect hard enrollment freeze expands to additional 37 counties where there is another plan option for SNBC

Membership Freeze and Service Area Reduction

- **4/1/25 Freeze on New Enrollment**
  - **PMAP:** All counties (except Hennepin County)
  - **MinnesotaCare:** Hennepin County
  - **SNBC non-integrated (Connect):** 12 counties where Health Partners exited

- **7/1/25 Hard Freeze on All Enrollment** Hard freeze definition: new and re-enrolled members
  - **PMAP:** All counties
  - **MinnesotaCare:** Added the following counties to freeze: Anoka, Benton, Carver, Chisago, Crow Wing, Dakota, Hennepin, Pennington, Ramsey, Roseau, Scott, Sherburne, Stearns, St. Louis, Wadena, Washington and Wright (counties with 2+ health plan options)
  - **SNBC non-integrated (Connect):** Hard freeze in the 12 counties frozen on 4/1/25

- **9/1/25 Service Area Reduction (SAR) and Hard Freeze Expansion**
  - For **PMAP and MinnesotaCare**, UCare will exit the following counties until the new procurement:
    - Benton, Chisago, Crow Wing, Pennington, Ramsey, Roseau, Sherburne, Stearns, St. Louis, Wadena, and Wright (counties with at least 3 plan choices)
  - **SNBC non-integrated (Connect):** "hard freeze" in an additional 37 counties where there is another plan option for SNBC.

Preventative Care Trainings

Meetings & Trainings

Quarterly meeting schedule and recorded trainings.

View Meetings & Trainings

Other Care Coordination Trainings

Click below to access various care coordination trainings.

View Trainings

Preventative Care and Chronic Condition Management Training and Resources

Annual Wellness Visits
Recorded webinar (coming soon)
Presentation slides
Care Coordination Annual Wellness Visit Information Sheet

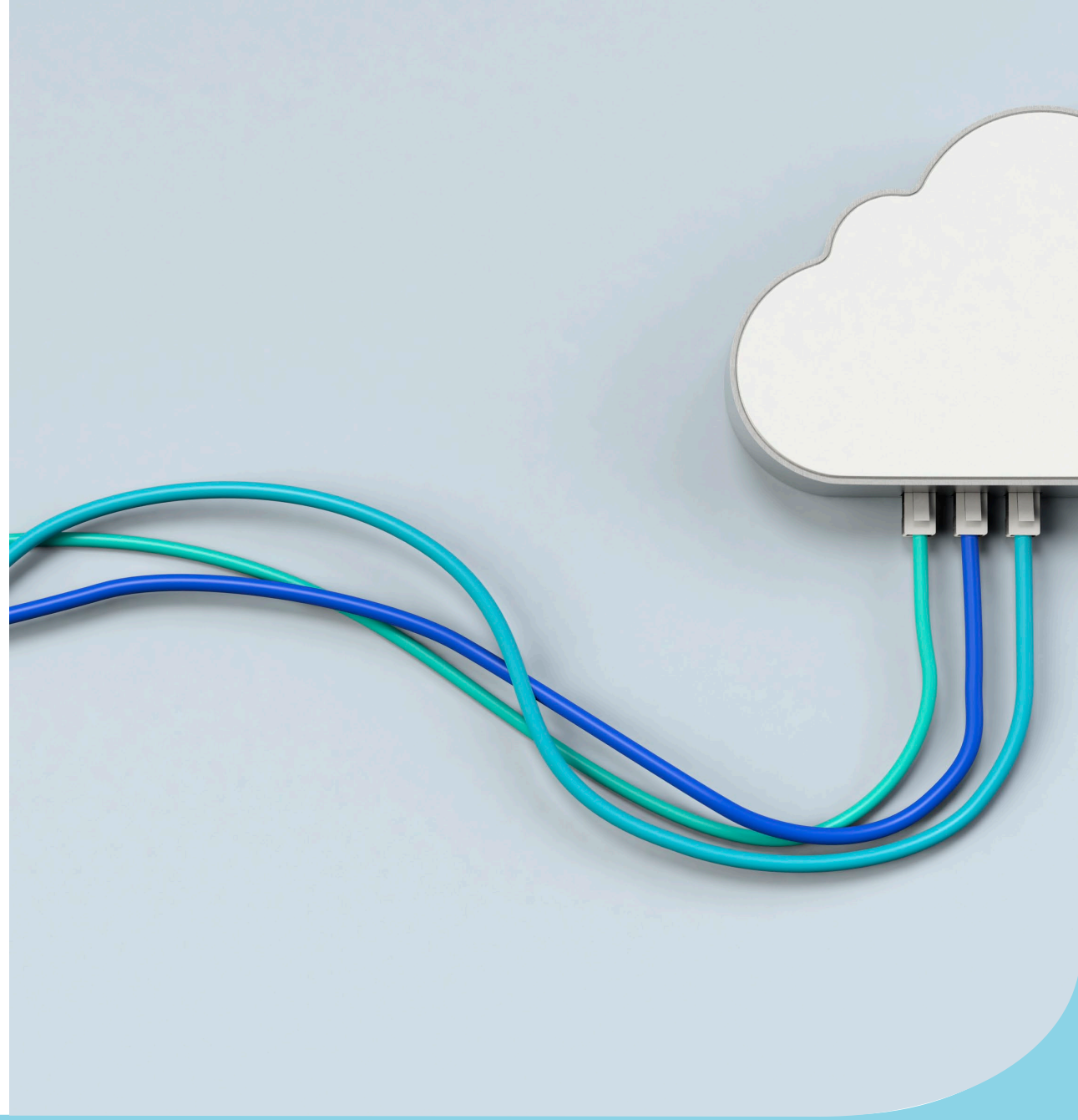
Breast Cancer Screening
Recorded webinar
Presentation slides

Colorectal Cancer Screening
Recorded webinar
Presentation slides

Diabetes Management and Screening Training
Recorded webinar
Presentation slides
Care Coordination Diabetes Information Sheet

SecFTP Portal Reminders

- UCare relies on the secure file transfer protocol (SecFTP) portal to send enrollment rosters and monthly reports to care coordination delegate agencies.
- Files should be downloaded then deleted from the SecFTP portal.
- Please review any files stored in the SecFTP portal and delete them once you have saved a copy to your computer.
- MFA planned to take effect 9/22



Questions?

Inquiring with U!
CC Satisfaction Survey

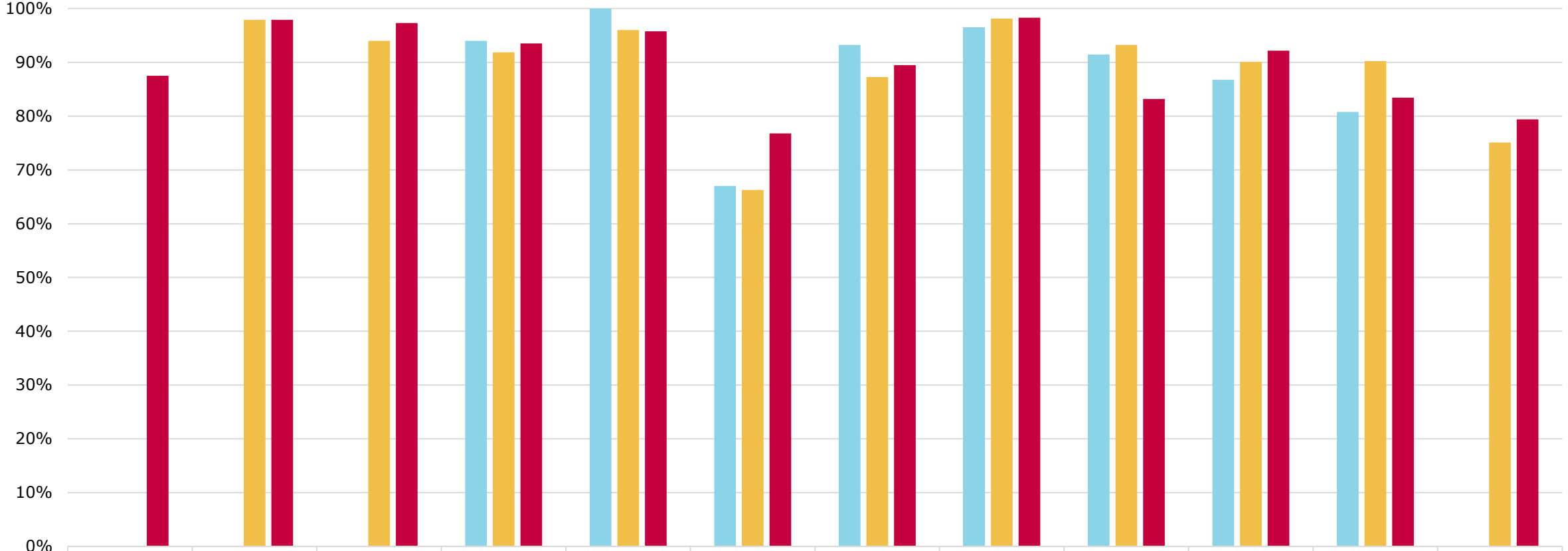
Jennie Paradeis, Delegation and Enrollment Manager

Inquiring with U: 2025 Annual Care Coordination Survey Results

Thank you for your participation in the care coordination survey! Your feedback matters and is incredibly valuable as we continue to grow and improve our care coordination services.

Participation :
242 responses
84% of delegates represented

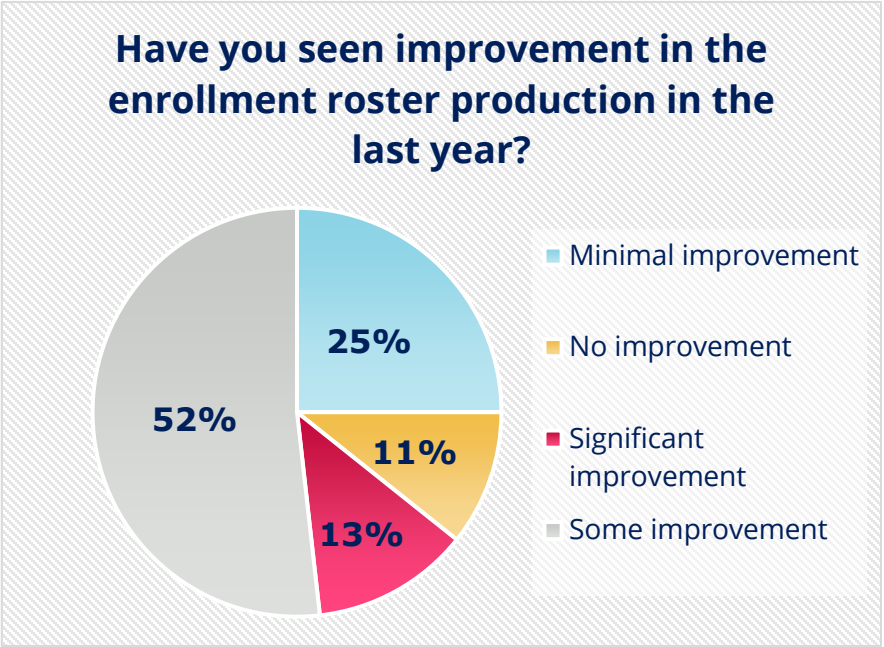
2023-2025 Results



	Access Line	Clinical Liaison Office Hours	Clinical Liaisons (Connect/ MSHO MSC+)	Enrollment Coordinator - CM intake	Enrollment Coordinator- Connect Intake	Enrollment Rosters	MSS triage line	Newsletter	PCA auths	PCC change process	Waiver Service Auths	Website
2023				94%	100%	67%	93%	97%	91%	87%	81%	
2024		98%	94%	92%	96%	66%	87%	98%	93%	90%	90%	75%
2025	88%	98%	97%	94%	96%	77%	89%	98%	83%	92%	83%	79%

2023 **2024** **2025**

Enrollment Rosters



Noteworthy WINS!

- Increase in satisfaction of 11%
- 89% of responders reported minimal or more improvement

Action Items

- Continue the goal of posting to delegates SFTP no later than the 3rd business day for the first roster or the 15th of the month for the second roster.
- Continued focus on data/accuracy
- Enhancements to roster fields
- Follow up with individual delegates

MSC+ & MSHO

CFSS/Waiver Service Authorizations

Noteworthy WINS!

Action Items

Meetings and Trainings/Job Aids

Noteworthy WINS!

- Average of 95% satisfaction rating for recorded trainings
- Average of 98% satisfaction for instructional guides and 97% for job aids

Action Items

- Shorten the duration of quarterlies
- Highlight trainings that are available
- Offering medical/gaps in care topics
- SMART job aid updated
- Continue to offer CEUs

We heard you!

Area	Action Items
Website	• Website navigation – locating resources • Working to move resources to decrease clicks to locate items
PCC verifications	• Identify ways to simplify the submission process to update
Liaisons and Enrollment Team Support	• Overall, very positive • Who to contact – enhanced cheat sheet

Keep it coming!

We welcome you to continue providing feedback.
We want to hear from you!

Some ways your feedback can make an impact:

- Annual CC survey
- Post-meeting surveys
- Open communication with your Clinical Liaisons

Questions?

Model of Care Training

MSHO, Connect + Medicare & I-SNP

Dawn Sulland

Table of contents

UCare Model of Care (MOC)

The purpose of this training is to:

- Provide information about the Model of Care and the annual training requirement for UCare's Special Needs Plans (SNP)
- Outline the importance of your role on the Interdisciplinary Care Team (ICT)
- Explain how to interface with the care coordination team in the provision of care

Powering the Way

We have clear priorities focused on:

- Increasing access to affordable, cost-effective health care like Primary and Specialty Care
- Improving the coordination of care
- Supporting improvements in health outcomes and quality of life for our members
- Ensuring seamless transition of care
- Managing costs

We'll achieve these priorities by:

Sharing our Model of Care with you!

Quality Measurement & Performance Management

Data & Reports

UCare collects and analyzes data and reports from a variety of sources to measure plan performance including but not limited to:

- Claims, utilization, pharmacy, and demographic information
- HEDIS, CAHPS, Stars, predictive modeling, and evidence-based analytic tools

This information helps UCare to:

- Set goals and create health outcome objectives
- Evaluate the Model of Care annually
- Identify improvements

Who We Serve

MSHO, Connect + Medicare and I-SNP

UCare's Special Needs Plans

Minnesota Senior Health Options (MSHO) and Connect + Medicare (D - SNP)

- Parts A, B, and D (pharmacy) plus Medicaid benefits
- Members have one ID card
- One phone number for health plan questions
    - 612-676-6830 or 1-855-260-9707

Institutional Special Needs Plan (I – SNP)

- Parts A, B, and D (pharmacy)
- Members have one ID Card
- One phone number for health plan questions
    - 612-676-6800

Who We Serve

	Serving Members	Age Range	Identified Gender	Living Arrangements	Race/Ethnicity
Connect + Medicare	that have a certified disability who are dually eligible for Medicare and Medical Assistance	18 to 64 years	Female: 55% Male: 45%	Community: 98% Facility: 2%	Asian: 7% Black or African American: 14% Hispanic: 3% Native American: 3% White: 73%
Vulnerabilities: Disabled adults, diagnosed with a physical, developmental, mental illness, or brain injury. Most of the population is diagnosed with serious and persistent mental illness. Most of the population has multiple complex, chronic conditions.					
MSHO	elderly who are dually eligible for Medicare and Medical Assistance	65 to 85+ years	Female: 64% Male: 36%	Community: 41% Facility: 13%	Asian: 16% Black or African American: 20% Hispanic: 3% Native American: 1% White: 60%
Vulnerabilities: Older adults, often frail, are at risk for readmission to the hospital, at risk of multiple chronic conditions and polypharmacy.					
I-SNP	18 and older who are Medicare eligible members who for 90 days or longer have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility (SNF) or an Assisted Living (AL)	65 to 85+ years	Female: 67% Male: 33%	Facility: 100%	Asian: 2% Black or African American: 4% Hispanic: 1% Native American: 1% White: 91%
Vulnerabilities: Older adults that have diseases of aging that are chronic, progressive, or degenerative • Dealing with mobility issues or limitations in ability to function independently that are compounded by the existence of multiple co-morbidities and frailty					

Provider Network

UCare’s provider network meets a wide range of needs

Members may receive care from any contracted provider within 30 miles (primary care) or 60 miles (specialty care) from the member’s primary residence without a referral.

The network includes but is not limited to:

- Primary Care Providers
- Specialists and Specialty Care Clinics
- Dental Providers
- Mental Health Care Providers

Enrolling in SNP

MSHO

Member’s county financial worker or Senior Linkage Line 800-333-2433

MSHO and Connect + Medicare

UCare’s Enrollment: 612-676-3554 or 800-707-1711

I-SNP

UCare’s Sales ISNP team: 612-676-6821 or 877-671-1054

Care Coordination

Connecting members with providers

Care Coordinator (CC)

The CC serves as a primary point of contact for all members of the Interdisciplinary Care Team (ICT)

Care Coordinator qualifications:

- Minnesota Licensure:
  - Nurse Practitioner
  - Independently Licensed Mental Health Professionals (LP, LPCC, LMFT, LICSW) (CT+MED)
  - Public Health Nurse
  - Physician Assistant
  - Physician
  - Registered Nurse
  - Social Worker/County Social Worker

Care Coordination

The Care Coordinator (CC) Supports members by:

Conducting Health Risk Assessments

Closing Gaps in Care

Supporting member's goals and needs

Communicating with the ICT

Individual Support Planning

Improving Quality of Life

Facilitating Transitions of Care

Health Risk Assessment

The annual health risk assessment completed by the care coordinator provides direction and insights into:

1. Determining member needs
2. Understanding how members manage their health
3. Needed supports to manage overall health
4. What's important to and for the member

Empowering our People

Individualized Support Plan

The person-centered information contained in the support plan is used to monitor gaps in the member's medical, psychosocial, cognitive, functional and mental health needs. The focus is on preventative and health care services, disease-specific interventions and service coordination.

The support plan addresses needs identified in the HRA by:

- Prioritizing goals
- Identifying barriers and interventions
- Identifying and coordinating service needs
- Identifying members of the Interdisciplinary Care Team
- Planning for care continuity, transition and/or transfers
- Updating progress made toward goals/plan
- Managing ongoing communication between teams

Transition of Care Protocols

CC role

- Coordinating services and equipment needs to promote health and safety
- Supporting family and caregivers with education and resources throughout transitions
- Ensuring communication between the Interdisciplinary Care Team members
- Sharing the member's support plan updates with the Interdisciplinary Care Team
- Supporting members with arranging transportation to scheduled appointments

CCs support the member's understanding of:

- Any health status changes
- Discharge instructions
- Changes to medication(s)
- Follow-up appointments scheduled

Transition of Care

The key to successful Transition of Care

Transition of care protocols are in place to improve coordination and communication with providers and to improve member outcomes by reducing fragmented care and avoiding re-hospitalizations.

The key to successful transition is:

- Care Coordinators working with Providers before, during and after transition to ensure continuity and coordinated care
- Adhering to transition protocol to reduce readmissions and improve outcomes
- Identifying when a member has new or changing needs because of the transition
- Care Coordinators being available for questions and to assist members with transitions of care needs

Care Coordinator Contacts

MSHO:

612-676-6868 or 1-866-280-7202

Connect + Medicare:

612-676-3310 or 1-855-260-9707

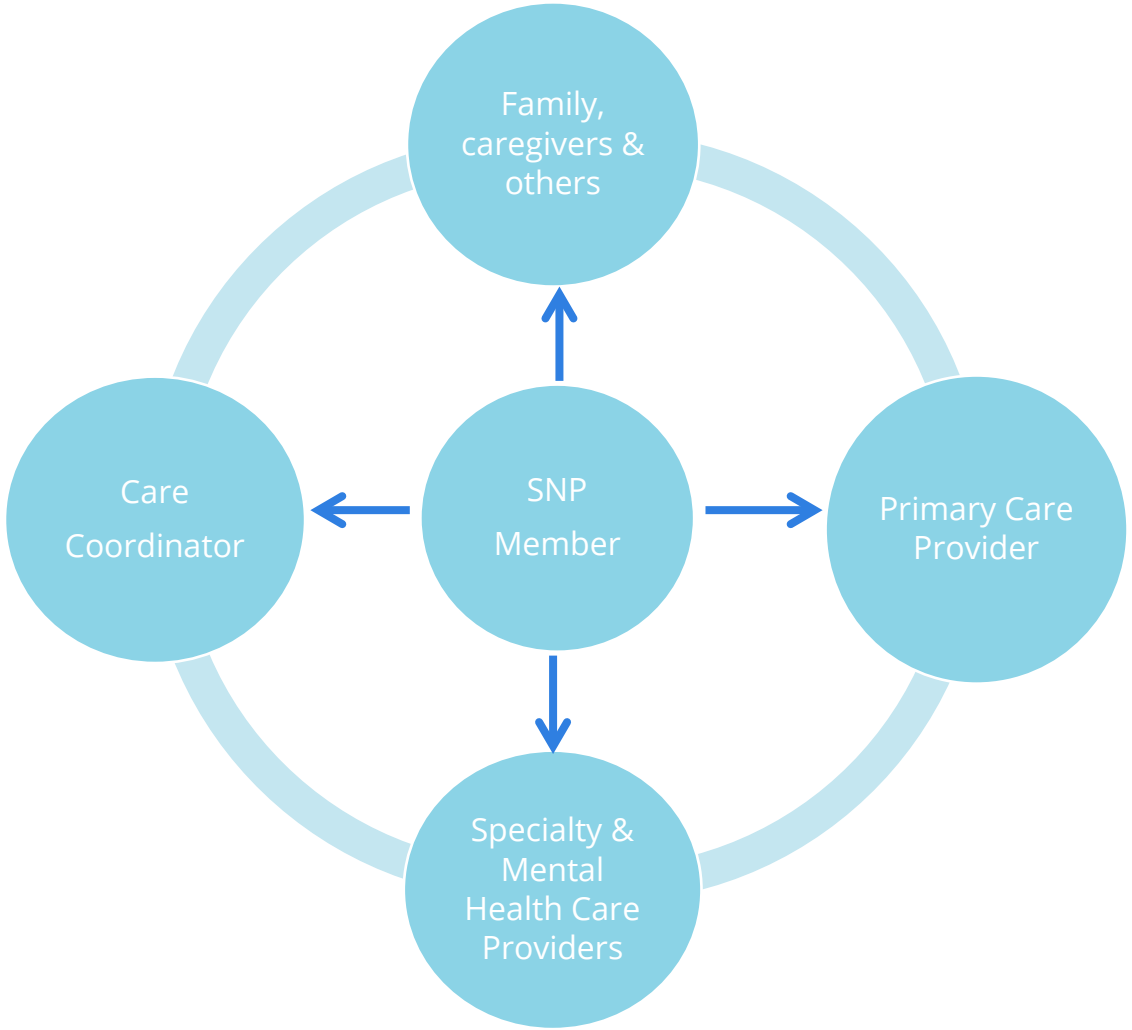
I-SNP:

612-676-3600 or 1-877-523-1515

The Interdisciplinary Care Team

ICT

Interdisciplinary Care Team



Roles on the ICT

Provider Role

- Provide appropriate care
- Review and provide input to the support plan
- Work with members to identify meaningful goals
- Work with the CC to ensure the appropriate level of care for members experiencing transition
- Support members with improving their quality of life

Care Coordinator

- Partner with all members of the ICT
- Serve as the primary point of contact for the ICT
- Facilitate Transition of Care protocols

Providers: Clinical Practice Guidelines

Medical

- Asthma Diagnosis and Management
- Care of Older Adult
- Diabetes: Type 2 Dx and Management
- Management of Heart Failure in Adults
- Obesity for Adults: Prevention and Management
- Prenatal Care
- Preventative Services for Adults
- Preventative services for Children and Adults

Mental Health and Substance Use

- Assessment and Treatment of Children and Adolescents with ADHD
- Assessment and Treatment of Children and Adolescents with Depressive Disorders
- Management of PTSD and Acute Stress Disorder
- Treatment of Opioid Use Disorder
- Treatment of Patients with Major Depressive Disorder
- Treatment of Patients with Schizophrenia
- Treatment of patients with Substance Use Disorders

Link: UCare Clinical Practice Guidelines

Summary & Attestation

Goals of MOC

Summary

The UCare MOC is designed to meet the needs of our unique member population

- Providers play an important role as members of the Interdisciplinary Care Team
- Providers and Care Coordinators work together to improve outcomes and the quality of life for members
- UCare uses data and reports to evaluate the Model of Care annually

UCare Goals

Our goals include preventive HEDIS measures, member satisfaction with the plan, improved access to care, seamless transitions, and improved coordination of care via HRA, support plan, and ICT.

Annual Attestation Required

If you have any questions, please reach out to the Clinical Liaison team

MSC_MSHO_ClinicalLiaison@ucare.org

SNBCClinicalLiaison@ucare.org

Care Coordinator Attestation

Care Coordinator MOC

Star Ratings Update

Rachel Sterner, Stars Program Senior Manager

Stars Programs

CMS Star Ratings (Medicare)	Quality Ratings System (Marketplace)	Quality Ratings System (Medicaid)
• UCare Medicare • Minnesota Senior Health Options (MSHO) • Connect + Medicare • EssentiaCare • Your Choice PPO • Aspirus Health Plan	• Individual & Family Plans (IFP) • Individual & Family Plans with Fairview	• Pre-Paid Medical Assistance Program (PMAP) • MinnesotaCare • Minnesota Senior Care Plus (MSC+) • Connect

Stars Matter

Member Health Outcomes	Reduced utilization & healthier members
Plan Revenue	≥ 4 plans earn quality bonus payments (QBP) & higher % of rebate
Business Development	5 Star plans can enroll year-round Contributes to product growth & retention
Compliance & Regulatory Requirements	CAHPS, HEDIS, HOS
Reputation	Publicly reported CMS low performing flag

Care Coordination Impact on Medicare Stars

Keeping Members Healthy

Care coordinators educate and support scheduling needed preventative services (cancer screenings, vaccinations, annual wellness visits)

Managing Chronic Conditions

Assessments – members that don't complete annual Health Risk Assessment, pain screening, & medication reviews count against Stars

Diabetes & Hypertension – members not managing these chronic conditions (annual exams & medication adherence) count against Stars

Readmissions – a readmission may have been avoidable if member got follow-up care after a hospital stay

Member Experience

Grievances – members may file formal complaints against the plan (CTMs) if care is not appropriated coordinated for the member

CAHPS responses – negative experiences affect member's perceptions of health care quality and satisfaction

Voluntary disenrollment – ongoing or frequent problems with care coordination can lead to members choosing to leave the plan

Care Coordination Q3 / Q4 Efforts

01

Outreach to non-engaged members (no office visits)

- Start with trying to schedule Medicare Annual Wellness Visit
- Ensure primary care provider connection
- If willing, work to schedule other due preventive services
- Help members return in-home screening kits

02

Ensure post-discharge connection to primary care provider within 30 days.

03

Ensure members with diabetes and/or hypertension have adequate support managing their chronic condition.

04

Concentrated effort on addressing members' barriers to care. Members are asked to recall their experience with UCare next spring on survey.

Virtual Care Program Partnership with Cecelia Health

Liz Sperr, Disease Management Manager

Virtual Care Program Overview

Enhanced Cardiometabolic Care Journey, which consolidates our existing programs into one cohesive solution.

Individual programs unified into a single, integrated approach:

- Diabetes Management
- Chronic Kidney Disease Management
- Respiratory Care (COPD and Asthma)
- Cardiovascular Disease

A streamlined approach enables better coordination of care, addressing the interconnected nature of cardiometabolic conditions.

- Clinical, behavioral, and lifestyle interventions
- Driving improved health outcomes
- Promoting member engagement
- Ability to activate single or multiple condition focus area pathways, depending on member health status and assessments completed with a clinical lead

The digital tools offered allow asynchronous support providing guidance in between telephonic coaching appointments

- Bidirectional chatting with their clinician
- Ability to track their progress and upload biometrics

5 Minute Break

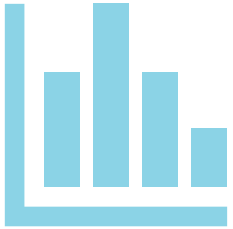
MSC+/MSHO Presentations

UCare Initiatives Updates

Dee-Ana Farness, Care Coordination Associate Director

Updates

Feedback



Reports

CFSS Non-EW

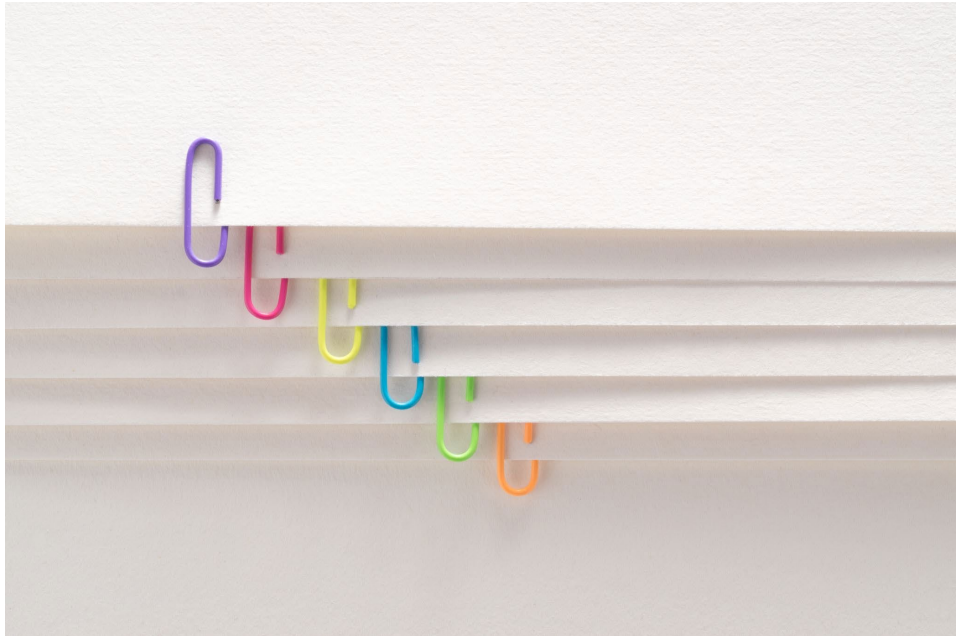
HCBS Utilization

Capitation

CFSS Utilization

CFSS Utilization

- 965 reviews complete
  - July: 435
  - August: 530
- 80% of assessments reviewed had recommended follow up
- Proposed daily units: 19,103
- Proposed daily units AFTER reviews: 9,904



CFSS Review Reminders

01

Email must include member PMI and UCare ID

02

Reviews must be submitted within 5 business days of assessment

03

Assessment must remain “in progress” to allow for recommended changes

04

Reviews must be submitted PRIOR to entering in MMIS

CFSS Assessment – Type of Support

- **Supervision**: Broad range of oversight and instructional support focused on an activity or task that does not include hands-on assistance. Supervision includes supporting the person through:
  - Guidance in the form of set-up
  - Prompting
  - Step-by-step cuing
  - Interactive monitoring responsibilities.
    - (**Note**: If the person does not need instructional support to complete tasks, the person does not require task supervision.)
- **Physical assistance**: Hands-on maneuvering, touching or moving a person to assist them to complete activities and/or any degree of another person's physical participation in the activity is considered physical assistance. This includes hand-over-hand assistance. Supervision is included in physical assistance.
- **Someone else completes**: (Highest level of dependency) Another person must complete activities. (The person may be passively participating in the activity) Supervision is included in assistance where another person needs to complete the task.

Questions

DME: Medical vs Waiver

Dawn Sulland

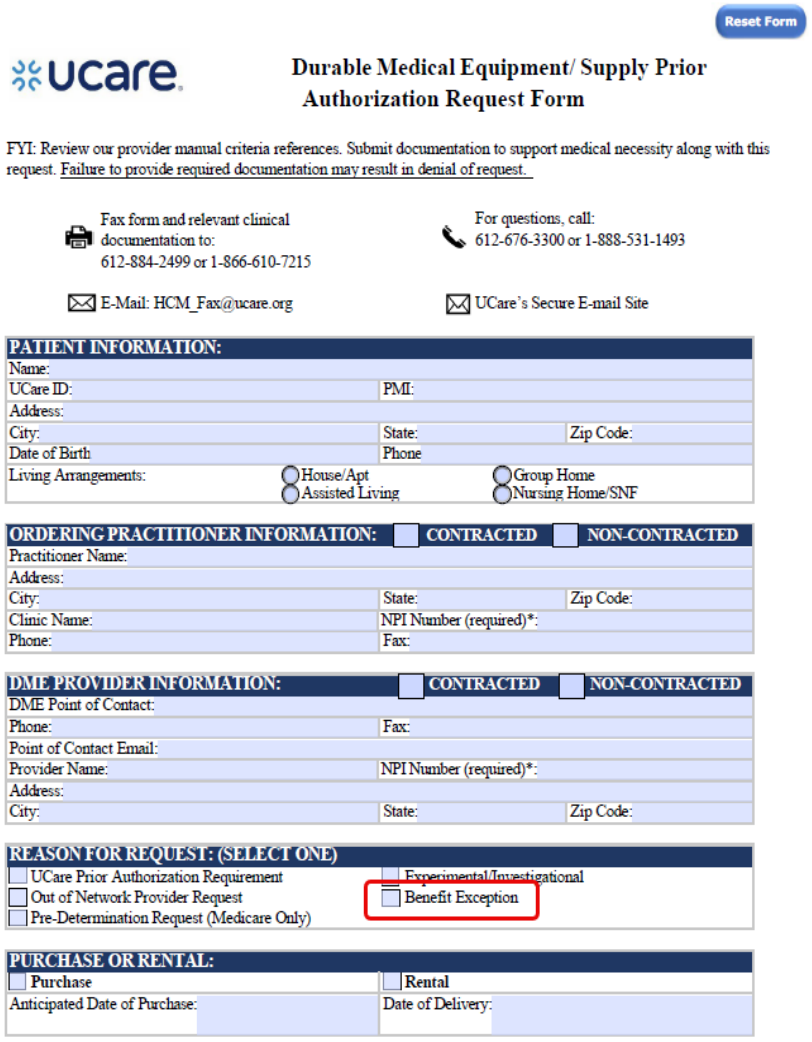
DME Covered by Medical Assistance

- If the item can be covered by Medical Assistance, it must be provided under the Medical Assistance benefit.
  - MHCP Provider Manual – Equipment and Supplies
  - Medical Supply Coverage Guide
- Prior Authorization Requirements
  - MSC+ Authorization and Notification Requirements grid
  - MSHO Authorization and Notification Requirements grid

EW Specialized Equipment and Supplies Overview

- The item must allow the member to do one of the following:
  - Communicate with others
  - Perceive, control or interact with their environment
  - Perform activities of daily living
- Commonly requested non-covered EW DME:
  - MA covered items:
    - Ted hose, shower chair, wheelchair, fully electric hospital bed
  - OTC's, Body soap, etc.
  - Covered doorknob

Durable Medical Equipment PA Form



Reset Form

ucare

Durable Medical Equipment/ Supply Prior Authorization Request Form

FYI: Review our provider manual criteria references. Submit documentation to support medical necessity along with this request. Failure to provide required documentation may result in denial of request.

Fax form and relevant clinical documentation to: 612-884-2499 or 1-866-610-7215

For questions, call: 612-676-3300 or 1-888-531-1493

E-Mail: HCM_Fax@ucare.org

UCare's Secure E-mail Site

PATIENT INFORMATION:

Name:		
UCare ID:	PMI:	
Address:		
City:	State:	Zip Code:
Date of Birth	Phone	
Living Arrangements:	○ House/Apt ○ Assisted Living	○ Group Home ○ Nursing Home/SNF

ORDERING PRACTITIONER INFORMATION: ☐ CONTRACTED ☐ NON-CONTRACTED

Practitioner Name:		
Address:		
City:	State:	Zip Code:
Clinic Name:	NPI Number (required)*:	
Phone:	Fax:	

DME PROVIDER INFORMATION: ☐ CONTRACTED ☐ NON-CONTRACTED

DME Point of Contact:		
Phone:	Fax:	
Point of Contact Email:		
Provider Name:	NPI Number (required)*:	
Address:		
City:	State:	Zip Code:

REASON FOR REQUEST: (SELECT ONE)

- ☐ UCare Prior Authorization Requirement
- ☐ Out of Network Provider Request
- ☐ Pre-Determination Request (Medicare Only)
- ☐ Experimental/Investigational
- ☐ Benefit Exception

PURCHASE OR RENTAL:

☐ Purchase	☐ Rental
Anticipated Date of Purchase:	Date of Delivery:

REPLACEMENT: ☐ YES ☐ NO

Date of Original Purchase/Delivery:	
Original Payer:	
Cost of Replacement:	
Reason for Replacement:	

REPAIR: ☐ YES ☐ NO

Make/ Manufacturer:	
Original Payer:	
Cost of Repair:	
Reason for Repair:	

CPT/HCPC:

CPT/HCPC Code(s)	Description of Request	# of Units Requested	Start Date	End Date

ICD-10 Diagnosis Codes

PLEASE SELECT STANDARD OR EXPEDITED REQUEST BELOW

○ STANDARD REQUEST

- Medicare and Medicaid decision within 10 business days.
- IFP decision within 5 business days.

○ EXPEDITED REQUEST

- Only request an urgent/emergent review if waiting for the standard review timeframe would potentially jeopardize the member's health, life, or ability to regain function.
- Medicare and Medicaid decision within 72 hours.
- IFP decision within 48 hours, including 1 business day.
- Billing and retrospective authorizations are not expedited.

1. Proposed date of service: _____
   - Billing and retrospective authorizations are not expedited.
2. Clinical reason for urgency (unrelated to scheduling issues):
3. Provide a contact name and number available for this request:
   - Due to the expedited processing time, please ensure that the designated contact is readily accessible should further information be required.
4. Clinical notes supporting any of the above have been included in the submission form. (Incomplete submission can delay decision time) Include Physican Order with request

Physician/Practitioner Signature _____ Date _____

NOTE: Description/Additional Information: (Attach manufacturer retail price listing)

DME requesting CC use EW T2029 for MA covered items

- Example: lost, stolen or broken items – for these, a Durable Medical Equipment/Supply Prior Authorization Form is needed.
- If a physician's order (PO) is already in DME possession, an additional provider signature is not needed on the form. The DME provider should include the PO.

Initial Assessment Review (IAR)

Kristen Sagnes

Initial Assessment Review (IAR)

Effective July 1st: Validity of MnCHOICES Assessments extended from 60 to 365 days for initial assessments.

- IAR must take place after an initial assessment, where a delay in opening the waiver takes place
- Can be remote or in person
- Can use more than one IAR if the program didn't open with the last IAR
- Do NOT need to use an IAR when the person meets all eligibility criteria for an HCBS program within the valid 60-day period following the in-person assessment.

Reference: IAR for Home and Community Based Services

Initial Assessment Timelines

Initial Assessment: An assessment completed for a person who is not currently receiving services through a waiver or other program.

Initial assessment review (IAR): An activity that takes place after an initial assessment when there has been a delay in opening to a waiver, Alternative Care (AC), Essential Community Supports (ECS) or Community First Services and Supports (CFSS).

Eligibility Update (EU) no longer effective starting July 1st, 2025

Use the MnCHOICES Help Desk Contact Form, DHS-6979 to request DHS assistance to use an EU for initial assessments completed from May 2, 2025, to June 30, 2025.

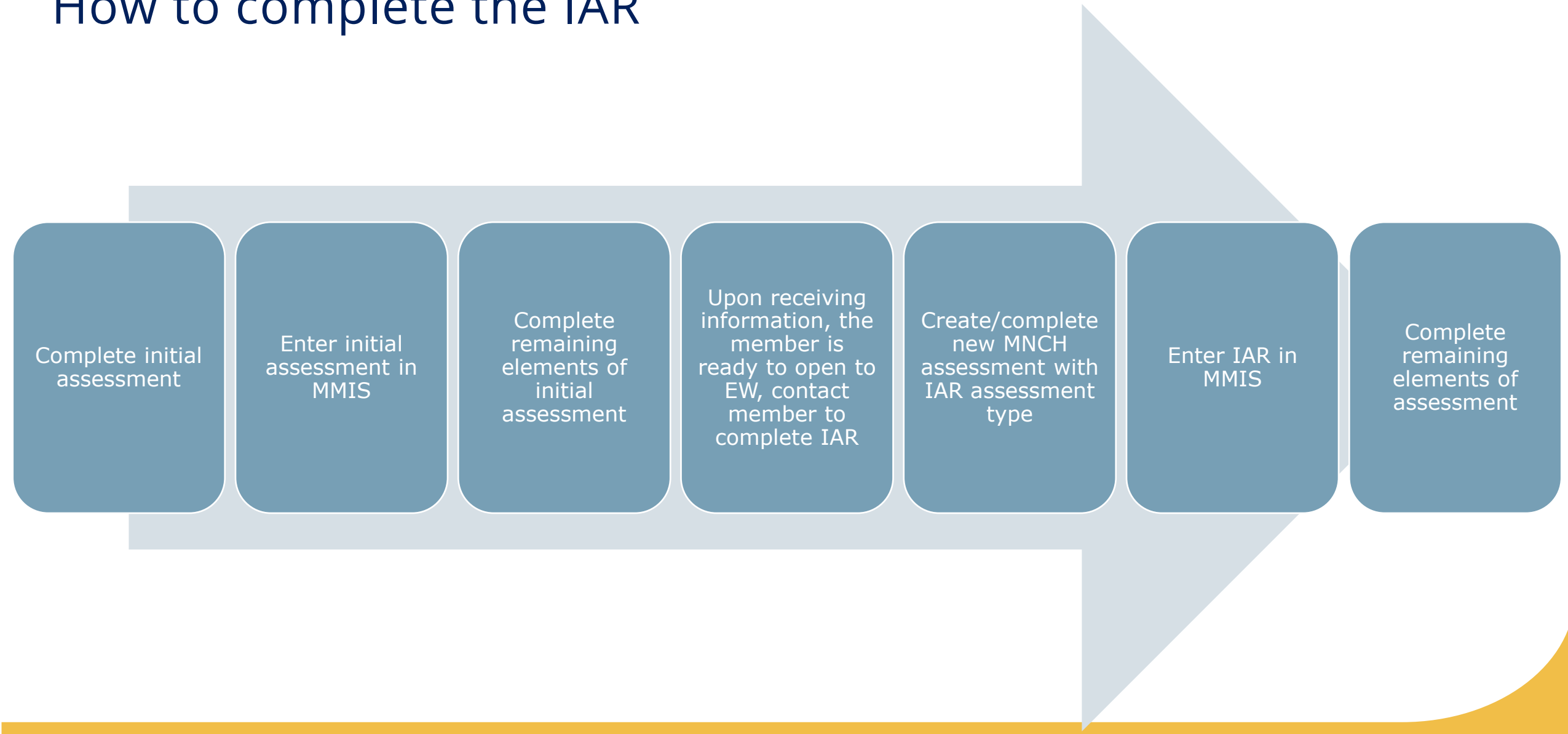
DHS will approve the use of an EU for limited circumstances (e.g., people in an assisted living facility requesting EW funding for services from the day of their initial interview).

Who Completes the IAR

The entity that completes the IAR depends on the person's MCO enrollment and the effective date of the EW or CFSS span.

The entity the member is enrolled with at the time of the IAR effective date completes the IAR screening.

How to complete the IAR



CFSS Updates

Samantha Rue

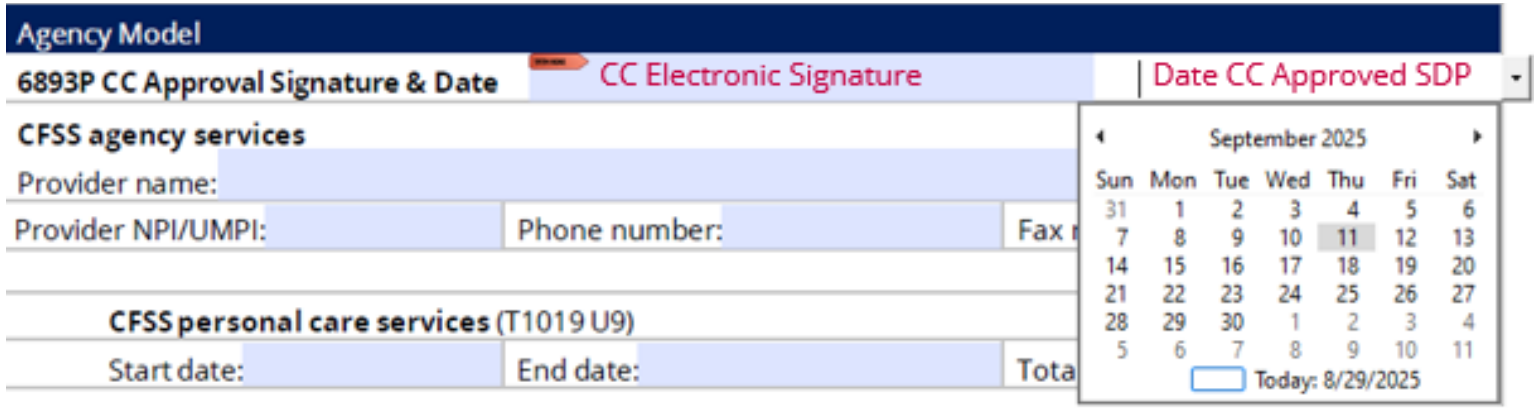
PCA/CFSS Communication Form Trends

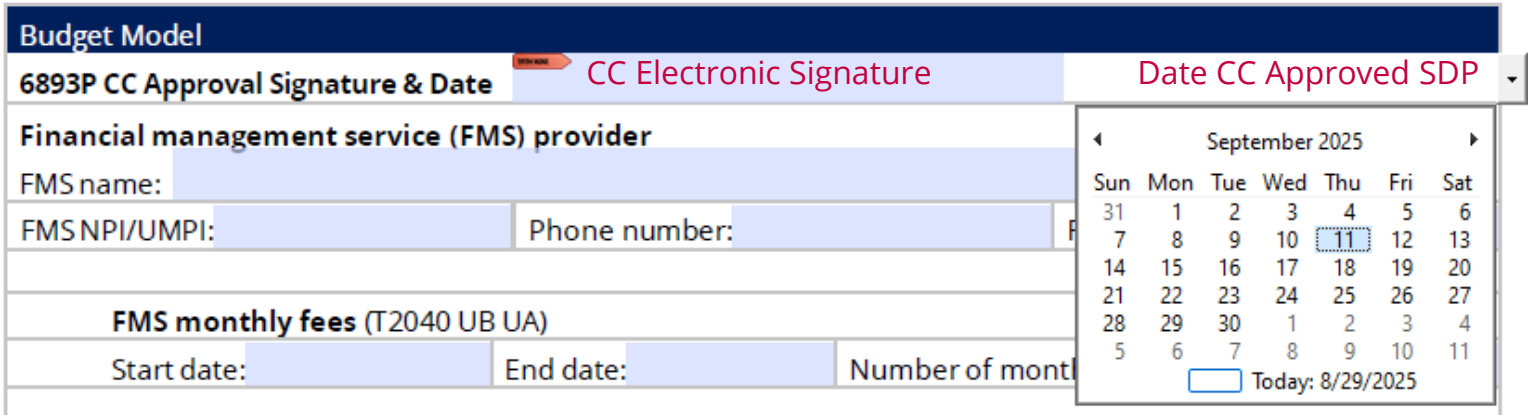
NOTE: If the processing time exceeds 14 calendar days and you are inquiring about status, CCs can call: 612-676-6705 (option 2, then option 4) or email pca_cfss@ucare.org.

Common Issues requiring Intake to return the PCA/CFSS Communication Form for clarification/correction:

- Incorrect/missing provider info
- Start dates for CFSS services before the SDP sign date
- Incorrect CFSS units/dollar amounts for the authorization dates
- Missing or wrong MnCHOICES assessment documents attached
- Lack of relevant documentation/rationale under the "Description of request"
- The outdated PCA/CFSS Comm Form was used

PCA/CFSS Communication Form Signature





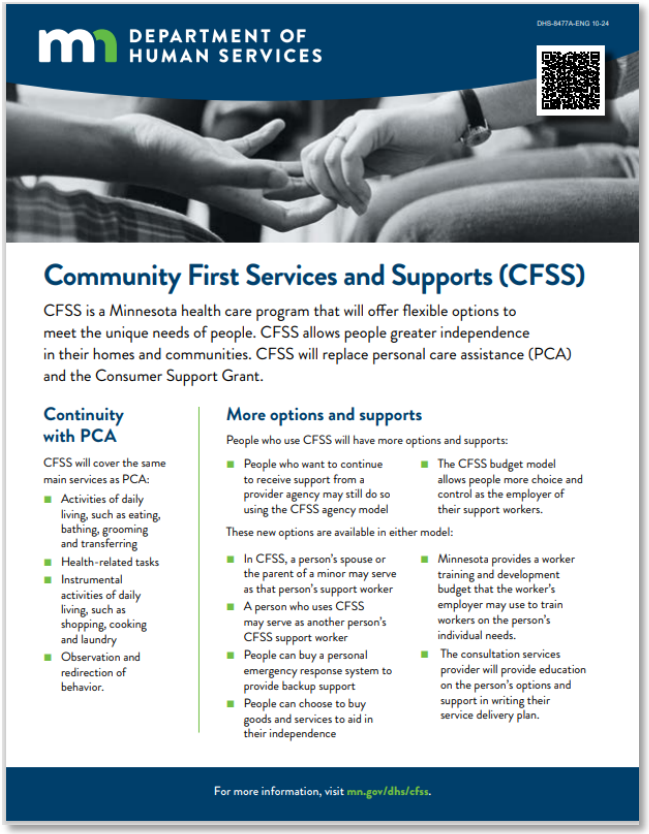
Reference: DSD eList announcement
CFSS service delivery plan development and approval process page

PCA Transition Extension

- Members currently receiving PCA who do not have an approved CFSS service delivery plan before their next assessment will be able to continue receiving PCA services while they continue the transition to CFSS to avoid gaps in service.
- If an assessment occurs before March 31, 2026, the CC may continue to extend PCA services in 6 month increments. After April 1, 2026, the CC authorizes through September 30, 2026.
- All members receiving PCA must transition to CFSS by 9/30/2026.

Reference: AASD and DSD eList: Instructions to avoid gaps in service for people receiving PCA/CSG services

DHS-8477A vs DHS-6893U: When to provide?



DEPARTMENT OF HUMAN SERVICES

DHS-8477A-ENG 10-24

Community First Services and Supports (CFSS)

CFSS is a Minnesota health care program that will offer flexible options to meet the unique needs of people. CFSS allows people greater independence in their homes and communities. CFSS will replace personal care assistance (PCA) and the Consumer Support Grant.

Continuity with PCA

CFSS will cover the same main services as PCA:

- Activities of daily living, such as eating, bathing, grooming and transferring
- Health-related tasks
- Instrumental activities of daily living, such as shopping, cooking and laundry
- Observation and redirection of behavior.

More options and supports

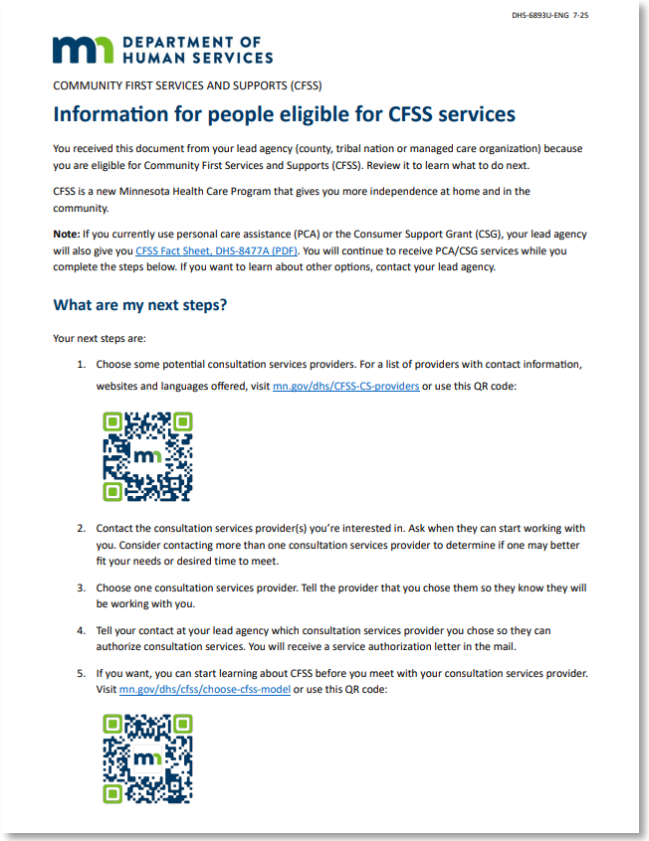
People who use CFSS will have more options and supports:

- People who want to continue to receive support from a provider agency may still do so using the CFSS agency model
- The CFSS budget model allows people more choice and control as the employer of their support workers.

These new options are available in either model:

- In CFSS, a person's spouse or the parent of a minor may serve as that person's support worker
- A person who uses CFSS may serve as another person's CFSS support worker
- People can buy a personal emergency response system to provide backup support
- People can choose to buy goods and services to aid in their independence
- Minnesota provides a worker training and development budget that the worker's employer may use to train workers on the person's individual needs.
- The consultation services provider will provide education on the person's options and support in writing their service delivery plan.

For more information, visit mn.gov/dhs/cfss.



DHS-6893U-ENG 7-25

DEPARTMENT OF HUMAN SERVICES

COMMUNITY FIRST SERVICES AND SUPPORTS (CFSS)

Information for people eligible for CFSS services

You received this document from your lead agency (county, tribal nation or managed care organization) because you are eligible for Community First Services and Supports (CFSS). Review it to learn what to do next.

CFSS is a new Minnesota Health Care Program that gives you more independence at home and in the community.

Note: If you currently use personal care assistance (PCA) or the Consumer Support Grant (CSG), your lead agency will also give you CFSS Fact Sheet, DHS-8477A (PDF). You will continue to receive PCA/CSG services while you complete the steps below. If you want to learn about other options, contact your lead agency.

What are my next steps?

Your next steps are:

1. Choose some potential consultation services providers. For a list of providers with contact information, websites and languages offered, visit mn.gov/dhs/CFSS-CS-providers or use this QR code:
2. Contact the consultation services provider(s) you're interested in. Ask when they can start working with you. Consider contacting more than one consultation services provider to determine if one may better fit your needs or desired time to meet.
3. Choose one consultation services provider. Tell the provider that you chose them so they know they will be working with you.
4. Tell your contact at your lead agency which consultation services provider you chose so they can authorize consultation services. You will receive a service authorization letter in the mail.
5. If you want, you can start learning about CFSS before you meet with your consultation services provider. Visit mn.gov/dhs/cfss/choose-cfss-model or use this QR code:

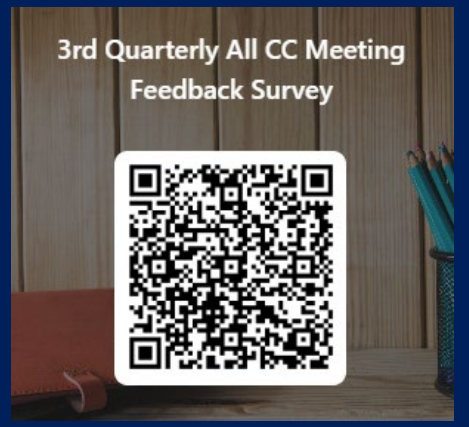
DHS-8477A and **DHS-6893U**: Currently using PCA and not yet transitioned to CFSS

DHS-6893U: Members new to CFSS not previously using PCA or fully transitioned to CFSS

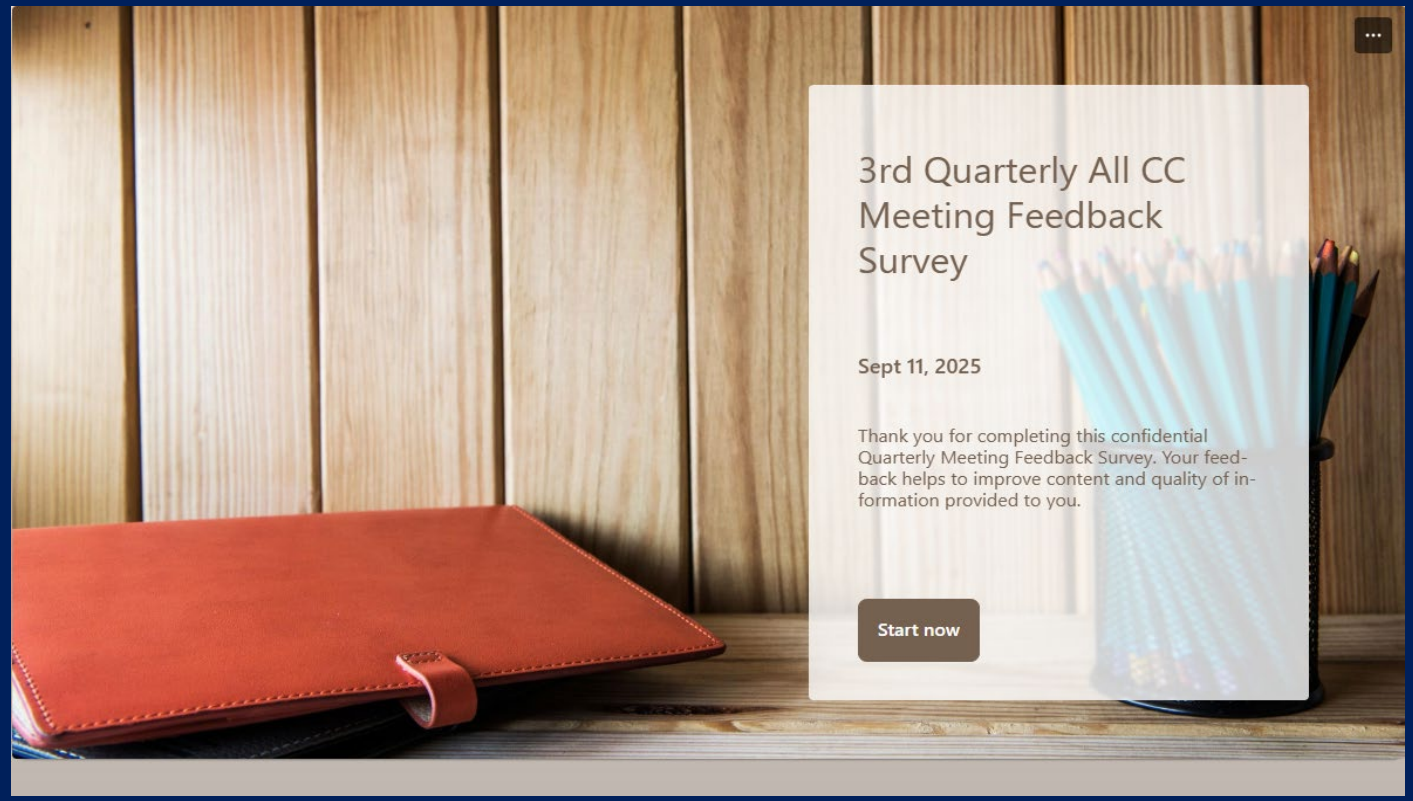
Reference: Assessment for PCA/CFSS services

Questions?

We appreciate your feedback!



Please take some time to complete the



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