Minnesota Senior Care Plus (MSC+) and Minnesota Senior Health Options (MSHO)
Care Coordination Requirements for Community Elderly Waiver Members
Effective 10/1/2024

Contents

Ensure you are using the current version of any document. All related UCare forms can be found HERE; all DHS forms can be found HERE; Care Coordination Manual can be found HERE.

*If asterisk shown, see Definitions/Acronyms section for a further explanation of that term.

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Initial Assignment	Initial assignment* is the first day the care system or county receives the care coordination enrollment roster. **Upon receiving the monthly enrollment roster, the Care Coordinator (CC) is required to:**
	• Provide the member with the name and phone number of the CC within 10 business days of initial assignment.
	  ○ This may be done by phone or letter and must be documented in the member's record. If contact is by letter, the CC must use UCare's approved *Welcome Letter* (for new members) or *Change of Care Coordinator Letter* (for transferred members) found on the UCare website. Note the difference in Welcome Letters, as there is one for Community and Elderly Waiver members, and one for members on CAC/CADI/DD/BI Waivers.
	• Contact the member within 30 days of enrollment* to complete tasks based on if the member is transferring – OR – is in need of an assessment (either New Member/Initial Assessment, Refusal, or Unable to Reach).
	  ○ Make a minimum of 4 actionable attempts* or fewer if member is reached.
	  ○ Contacts may be by phone, in-person, or secure email, and should be on different days, at different times, and by using the *Unable to Reach Letter* on the UCare website.
	  ○ **NOTE:** Sending the *Welcome Letter* is not considered an attempt to contact the member.

ASSESSMENTS	
New Member/Initial Assessment	A member is considered NEW when newly enrolled on UCare MSC+/MSHO *AND* has not had a previous MSC+/MSHO assessment within the last 365 days. Members aging into MSC+/MSHO are considered a New Member and need an assessment, UNLESS the assessment is reflective of determination for opening to Elderly Waiver (65th birthday assessment and must be a full LTCC or full MnCHOICES assessment). Members with previous coverage that experience a gap in coverage due to loss of MA* eligibility (e.g., exceeding 90-day grace period) are treated as a NEW member if re-enrolled.
	The CC is required to: • Conduct an initial in-person assessment* by the end of the month of enrollment, but not to exceed 30 days. Use the MnCHOICES Assessment form for members opening to Elderly Waiver. Ensure 'Yes' is selected for the question "I am the Care Coordinator and need the Staying Healthy section" **NOTE:** If the member/representative* requests an assessment to determine EW* eligibility, the MnCHOICES Assessment form must be completed within 20 business days of the request.

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	Complete tasks listed below within 30 days of assessment. • All MnCHOICES Assessment form questions and sections must be completed or noted as not applicable. • If the member will receive PCA/CFSS services, send a copy of MnCHOICES supplemental summary charts to member/representative* within 10 business days • Send the PCA/CFSS Communication Form, Assessment Results, and Supplemental Summary Chart to the Intake Auth Coordinator Team at PCA_CFSS@ucare.org within 10 business days. • If member is accepting PCA, complete a DHS-4690 *Communication to Physician* and send it to the PCP* (not applicable for CFSS). • Send MnCHOICES Assessment Summary to member. • Have Safe Disposal of Medications* conversation and complete follow up tasks. • Complete *OBRA Level I* screening. • Develop a person-centered Support Plan – MCO MnCHOICES Assessment. • Submit WSAF*. • Approve the assessment data in MMIS* before choosing "Approved by MMIS" in MnCHOICES. **Assessments should be entered into MMIS prior to the 1st Capitation Date*.** • Enter the assessment on the Monthly Activity Log. **NOTE:** If the member indicates during the assessment that they want to/must move under 'Choice About Housing' and requires assistance, complete a Transition Plan using DHS-3936 *My Move Plan Summary*. (Found within 'Living Environment', under 'Housing Satisfaction', question 'Choice About Housing' *and then* indicates needs assistance with housing goals). **NOTE:** If a new member is Unable to Reach or Refusal, refer to the respective sections.
Transferred Member between UCare Delegates	**Transferred Members from a UCare Delegate:** A member who previously received care coordination from a UCare delegate and had an assessment within the last 365 days. For example, the transfer is between one delegate to another within UCare and the member was on MSC+/MSHO with the previous delegate. The enrollment roster will indicate "care coordinator change" in the status column to notify of a UCare delegate change (e.g., UMP to UCare, Olmsted County to UMP, etc.). **The previous (sending) CC is required to:**

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	• Thoroughly complete all areas of the DHS-6037 *Transfer Form* and send via secure email or fax to the new (receiving) CC when confirmed via enrollment roster.
	  ○ *Care Coordination Contact List* is located on the UCare website.
	• The transfer must also include:
	  ○ The most recent HRA, Support Plan, Support Plan Signature Sheet with member signature, relevant case notes, and other applicable case documents if not found in MnCHOICES.
	  ▪ This includes UTR/Refusal Support Plans as applicable.
	  ○ **NOTE:** If a CC has completed an assessment and is notified of a member transfer, the CC must complete all assessment paperwork PRIOR to transfer, including but not limited to: Support Plan and EW paperwork (e.g., 3543, 5181, WSAF).
	• Unassign location and staff assignment in MnCHOICES.
	• Ensure MnCHOICES forms are left in a completed status.
	
	The new (receiving) CC is required to:
	• Provide the member with the name and phone number of the new CC within 10 business days of transfer.
	  ○ This may be done by phone or letter and must be documented in the member's record. If contact is by letter, the CC must use UCare's approved Change of Care Coordinator Letter found on the UCare website.
	  ○ Document the review of transfer documents
	  ▪ Fill in any missing information with member if necessary.
	  ▪ If Signature Sheet not received, CC ensures evidence in transfer documentation of at least 2 attempts to obtain member signature. If not present, CC completes any remaining attempts to obtain (up to 2 attempts).
	  ○ **NOTE:** If the Member was previously an UTR or Refusal, treat as a New Member. Four outreach attempts are due.
	  ○ Assign staff and location in MnCHOICES
	  ○ Enter change of CC in MMIS for EW members only.
	  ○ No Monthly Activity Log entry required.

	Transferred Member from FFS* or a Different MCO*: A member who is new with UCare or re-enrolled with UCare, coming from Fee-For-Service (FFS) or a different Managed Care Organization (MCO). The assessment following a transfer from FFS/MCO is considered an initial assessment and must follow in-person requirements.

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Transferred Member to/from FFS or a Different MCO	**NOTE:** Members aging into MSC+/MSHO are considered a New Member and need an assessment, UNLESS the assessment is reflective of determination for opening to Elderly Waiver (65th birthday assessment and must be a full MnCHOICES assessment) OR a member on a disability waiver that has a 65th birthday assessment and chooses to switch to EW within 60 days of 65th birthday assessment. **Transferred Member from UCare to a Different MCO**: A member has been confirmed to be with another MCO. **Transferred Member from UCare to FFS:** A member has been confirmed to be active with MA* but without an MCO.
	The enrollment roster does not indicate a change of MCO. Member will have a status of "New Member/Termed Member". Notification of enrollment in a new health plan may come in the following forms when reconciling your roster: • Verifying eligibility in MN-ITS • Notifications from new health plan • Member communication • **NOTE:** After identifying a member is no longer with UCare but is not showing the change on the roster, notify CMIntake@ucare.org. CM Intake will verify and confirm discontinuation of care coordination. **The previous (sending) UCare CC is required to:** • Thoroughly complete all areas of the DHS-6037 *Transfer Form* and send via secure email to the new (receiving) CC when confirmed via enrollment roster. The transfer must also include documents not available in MnCHOICES including: the current assessment (3428, 3428H), OBRA Level I, Care Plan/Support Plan *with* the signed Signature Page, DHS-3428D *PCA Assessment* with signature page, and other applicable documents. ○ Evidence of 2 attempts to obtain the signature page made by the previous (sending) CC is acceptable. ○ **NOTE:** If a CC has completed an assessment and is notified of a member transfer, the CC must complete all assessment paperwork PRIOR to transfer, including but not limited to: Support Plan and EW paperwork (e.g., 3543, 5181, WSAF). • **NOTE:** For transferred members from UCare to a different MCO* or FFS*: The CC should work with the member and receiving entity to ensure a smooth transfer process. CC should not continue to provide Care Coordination once enrollment has been confirmed via MN-ITS. • Refer to DHS-6037A *Communication Form Scenarios*. • Unassign location and staff assignment in MnCHOICES. • Ensure MnCHOICES forms are left in a completed status.

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	The new (receiving) CC is required to:
	• Conduct an assessment* within the month of enrollment*/month of assignment* but not to exceed 30 days.
	  ○ Determine type of assessment using criteria listed below (THRA, Functional Needs Update, or an initial assessment).
	  ○ Make and document 4 actionable attempts to reach member.
	
	A Transitional Member Health Risk Assessment (THRA) is used when: The previous (sending) case management/care coordination entity provided the new (receiving) CC with the most recent copy of the assessment, the most recent /Support Plan *with* the signed Signature Page.
	• If unable to obtain the signed Signature Page from the previous (sending) CC, follow the Support Plan Signature Sheet section to obtain a member signature on a new Signature Page.
	• If unable to obtain a Support Plan in the transfer, the new CC may create one with the member, using "Support Plan – MCO MnCHOICES Assessment". Obtain signature.
	  ○ Share new Support Plan with member and PCP within 30 days of THRA.
	• The recent assessment can be either DHS-3428 or MnCHOICES*, or verification of a face-to-face assessment entered into MMIS* within the past 365 days using Activity Type 02 or 06. **NOTE:** If MMIS is being used, the full MMIS entry must be in the member's record, not just the first page.
	  ○ A THRA includes a verbal review of the assessment and Support Plan by the CC *with* the member (by phone, televideo, or in-person). The review must include pertinent areas of the assessment (at a minimum, review the areas that are required for a MMIS entry) and include questions necessary for the completion of an effective Support Plan. Fill in any missing areas.
	  ○ Complete the THRA in MnCHOICES by opening a Health Risk Assessment-MCO form and using 'Transitional HRA' for the 'HRA Type'. Enter 'Transitional HRA type' and 'Referral Date'.
	  ○ Complete the THRA form from UCare's website and attach in MnCHOICES.
	  ○ If applicable, submit WSAF* for new or ongoing services.
	  ○ Do NOT enter THRA in MMIS.
	  ○ Enter change of CC in MMIS.
	  ○ Enter the THRA on the Monthly Activity Log.

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	○ **NOTE:** If the member is unable to be reached or refuses the THRA, document the final outcome in member record. Do not revise the MnCHOICES Support Plan. Do not complete an Unable to Reach Support Plan or Refusal Support Plan. The assessment timeline does not start over. MnCHOICES THRA type/date entry still required. A Functional Needs Update is in lieu of a THRA activity/form and required when: an EW member transfers from FFS with/without a Support Plan OR when a member has had a qualified 65th birthday assessment and is opening to EW. • Complete the Functional Needs Update (FNU) in MnCHOICES by initiating a new MnCHOICES Assessment, identifier current recipient change, with assessment type: Functional Needs Update. ○ Ensure 'Yes' is selected for the question "I am the Care Coordinator and Need the Staying Healthy Section." ○ The FNU can be completed in-person, televideo, or by phone. ○ Enter change of CC in MMIS. ○ Enter FNU into MMIS. ○ Send MnCHOICES Assessment Summary to member. • Complete a person-centered Support Plan – MCO MnCHOICES Assessment with new and ongoing goals within 30 days of FNU. ○ Obtain a Support Plan signature. ○ Send Support Plan to member and PCP. • MSC+/MSHO: If the member was unable to be reached or refused the FNU, complete an Unable to Reach or Refusal Support Plan. Attach in MnCHOICES. ○ If there was a previous Support Plan, carry over the goals. ○ Attempt to complete the FNU at the next successful contact. • Submit WSAF* for new or ongoing services. • Enter the FNU on the Monthly Activity Log. • **NOTE:** The FNU does not replace an annual reassessment and it does not reset or extend a waiver eligibility span. A member may choose to receive a reassessment instead of a FNU. • **NOTE:** If the previous assessment was completed in MnCHOICES 1.0, and a CSP/CSSP was also received, a THRA may be completed. If CSP/CSSP or rate tool requires significant changes, create a new Support Plan and obtain signature. Share Support Plan with member and PCP within 30 days of THRA.

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	An assessment* is required when: The new (receiving) CC does NOT receive the most recent assessment. The missing recent assessment is either DHS-3428 or MnCHOICES, and/or the CC cannot verify that an in-person assessment has been conducted within the past 365 days by checking MMIS. ▪ This scenario requires a full in-person assessment. ○ Enter the assessment data in MMIS within 30 days of the assessment. ○ Develop a new person-centered Support Plan using "Support Plan – MCO MnCHOICES Assessment". ○ Enter the assessment on the Monthly Activity Log. ○ If the member requires a full assessment but is Unable to Reach or is a Refusal, follow the respective sections.
Annual Reassessment	**The CC is required to:** • Complete final revision of previous Support Plan. • Complete a reassessment* within 365 days of the prior assessment using the MnCHOICES Assessment form and complete tasks listed below within 30 days of reassessment. ○ Ensure 'Yes' is selected for the question "I am the Care Coordinator and need the Staying Healthy section" ○ All MnCHOICES Assessment form questions and sections must be completed or noted as not applicable. **NOTE:** When a reassessment is following an initial UTR/Refusal, the Reassessment Due Date* is based on member's initial enrollment date. This is only applicable to the first reassessment following an initial UTR/Refusal. • If the member will receive PCA/CFSS services, send a copy of MnCHOICES supplemental summary charts to member/representative* within 10 business days. • Send the PCA/CFSS Communication Form, Assessment Results, and Supplemental Summary Chart to the Intake Auth Coordinator Team at PCA_CFSS@ucare.org within 10 business days. • If member is accepting PCA, complete a DHS-4690 *Communication to Physician* and send it to the PCP* (not applicable for CFSS). • Send MnCHOICES Assessment Summary to member. • Have Safe Disposal of Medications* conversation with member and complete follow up tasks. • Complete an *OBRA Level I* screening. • Develop a new person-centered Support Plan – MCO MnCHOICES Assessment with new and ongoing goals. • Submit WSAF*.

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	• Approve the assessment data in MMIS* before choosing "Approved by MMIS" in MnCHOICES. **For members on Elderly Waiver, assessments should be entered into MMIS prior to the 1st Capitation Date*.** • Enter the assessment on the Monthly Activity Log. **NOTE:** If the member is open to EW*, or will be opened to EW, and indicates during the assessment that they want to/must move under 'Choice About Housing' and requires assistance, complete a Transition Plan using DHS-3936 *My Move Plan Summary*. (Found within 'Living Environment', under 'Housing Satisfaction', question 'Choice About Housing' *and then* indicates needs assistance with housing goals). **NOTE:** If member is Unable to Reach or Refusal for their annual reassessment, refer to the respective sections.
Caregiver Support	A caregiver is a non-paid person that, without their help, paid services would have to be put into place for the member. If the member already has services in place, a caregiver is someone who provides care beyond reimbursed hours/services.

	If a caregiver is identified during the assessment, then the CC is required to:
	• Complete the DHS-6914 *Caregiver Questionnaire*. Document if the caregiver declines the questionnaire.
	• Upload the *Caregiver Questionnaire* to MnCHOICES when completed.
	• If caregiver needs are identified, incorporate them into the Support Plan.
	• If a caregiver is identified, the CC must document at least two attempts to complete the *Caregiver Questionnaire*.
	  ○ It can be done during the in-person visit; a paper copy can be left after the in-person visit and returned to CC; it can be completed over the phone; or mail/email it to the caregiver.
	  ○ Conduct a second attempt to complete the Caregiver Questionnaire within 2 weeks of the first attempt. Document the date of the follow up.

OBRA Level I Screening	**The CC is required to**: • Complete a *OBRA Level I* screening for all members at the time of the MnCHOICES Assessment.
Product Changes	A Product Change is when an existing UCare member changes product from MSC+ to MSHO, or MSHO to MSC+ only. **NOTE:** A SNBC member aging into MSC+/MSHO will show as a Product Change on the Care Coordination enrollment rosters but MUST be considered a New Member. CC is required to follow the steps in the New Member section. **NOTE:** The first assessment following a Product Change THRA is considered an Initial Assessment and should follow the in-person requirements.
	The CC is required to: • Provide the member with the name and phone number of the CC within 10 business days of Product Change.

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	○ This may be done by phone or letter and must be documented in the member's record. If contact is by letter, the CC must use UCare's approved *Welcome Letter* found on the UCare website. Note the difference in Welcome Letters, as there is one for Community and Elderly Waiver members, and one for members on CAC/CADI/DD/BI Waivers. • Complete the THRA* within 30 calendar days of enrollment and attach it to the most current assessment. This may be conducted via phone, televideo, or in-person. • Make 4 actionable attempts* to reach the member. • Complete the THRA form from UCare's website and attach in MnCHOICES. • Review the Care Plan/CSSP*/Support Plan and update/revise as necessary. • Complete the THRA in MnCHOICES by opening a Health Risk Assessment-MCO form and using 'Transitional HRA' for the 'HRA Type'. Enter 'Product Change' for the 'Transitional HRA type' and 'Referral Date'. Requirements are fulfilled after completing Assessment Information. Review all additional areas applicable. • Enter the THRA on the Monthly Activity Log. • If the member is unable to be reached for the THRA or refuses the THRA, document final outcome in member record. Do not revise the MnCHOICES Support Plan. Do not complete an Unable to Reach or Refusal Support Plan. MnCHOICES THRA type/date entry still required. ○ **NOTE:** The annual reassessment date does not change. If there is **no previous** DHS-3428/3428H or MnCHOICES* completed within 365 days a new assessment* is required by the end of the month of enrollment of the product change, not to exceed 30 days. Meaning, the member was previously Unable to Reach or Refusal and remains Unable to Reach or Refusal for this assessment, refer to the respective sections. **NOTE:** The annual reassessment date changes to the first day of the enrollment month.
Unable to Reach	**Initial Enrollment and/or Assignment: If member is unable to be reached** within the month of enrollment and/or assignment but not to exceed 30 days, **the CC is required to:** • Make and document 4 actionable attempts* to reach the member. Document all activities to obtain a working phone number for the member. ○ **NOTE:** Investigative research* is not considered an actionable attempt. • Document the final outcome in member record. Do not revise the MnCHOICES Support Plan. Do not complete an Unable to Reach Support Plan. Do not make MnCHOICES entry. • Enter Change of CC in MMIS. • Enter the Unable to Reach in the Monthly Activity Log. Include dates of all attempts in provided columns.

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	• Send *Provider Engagement Letter* to member's PCP within 30 calendar days of last outreach.
	
	Annual Assessment: If member is Unable to Reach within 365 days from the date of last assessment, the CC is required to:
	• Make and document 4 actionable attempts* to reach the member. Document all activities to obtain a working phone number for the member.
	  ○ **NOTE:** Investigative research* is not considered an actionable attempt.
	• Complete Health Risk Assessment-MCO form indicating assessment results as 'Person not located for health risk assessment', and then save as completed.
	• Enter the Unable to Reach in the Monthly Activity Log. Include dates of all attempts in provided columns.
	• Send *Provider Engagement Letter* to member's PCP within 30 calendar days of last outreach.
	• Close Elderly Waiver and terminate waivered services:
	  ○ Exit member from Elderly Waiver in MMIS*. The Activity Date and Effective Date will be the last day of the month the member was eligible for Elderly Waiver.
	  ○ Follow DTR* process by terminating Elderly Waiver and terminating any waivered services.
	• MSHO Members: Complete the UCare Unable to Reach Support Plan and attach in the member's record within 30 days of the Activity Date. Attach in MnCHOICES.
	  ○ The UTR Support Plan must have at least one high priority goal. All questions and sections must be completed or marked as not applicable.
	• MSC+ Members: Document outreach attempts and outcomes in member record.
	• Complete final revision of previous Support Plan, if applicable.
	
	Mid-Year Review: If the member is unable to be reached at their mid-year review, the CC is required to:
	• Contact the member mid-year following the assessment date.
	• Make 4 actionable attempts* to reach the member. Document all activities to obtain a working phone number for the member.
	  ○ **NOTE:** Investigative research* is not considered an actionable attempt.
	• Update the Support Plan to show that member was unable to be reached, in lieu of creating an Unable to Reach Support Plan.
	• See section Mid-Year Review and Ongoing Support Plan Updates for more instruction.

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Refusal	**Initial Enrollment and/or Assignment:** The CC is required to reach the member within the month of enrollment* or month of assignment*, but not to exceed 30 days. **If the member/representative* refuses, the CC is required to:**
	• Document all actionable attempts* to reach the member.
	• Document the conversation with the member regarding the refusal.
	• Do not revise the MnCHOICES Support Plan. Do not complete a Refusal Support Plan. Do not make MnCHOICES entry.
	• Enter Change of CC in MMIS.
	
	Annual Assessment: If a member/representative* refuses an assessment within 365 days from the last assessment, the CC is required to:
	• Document all actionable attempts* to reach the member.
	• Complete Health Risk Assessment-MCO form indicating assessment results as 'Person declines health risk assessment', and then save as completed.
	• Close Elderly Waiver and terminate waivered services:
	  ○ Exit member from Elderly Waiver in MMIS*. The Effective Date will be the last day of the month the member was eligible for Elderly Waiver.
	  ○ Follow DTR process by terminating Elderly Waiver and terminate any waivered services.
	• Send *Refusal Letter* to member within 30 calendar days of member refusal.
	• Send *Provider Engagement Letter* to member's PCP within 30 calendar days of member refusal.
	• Enter the Refusal on the Monthly Activity Log.
	• MSHO Members: Complete the UCare Refusal Support Plan reflecting completed attempts within 365 days of the last assessment and attach it in the member's record within 30 days of the Activity Date. Attach in MnCHOICES.
	  ○ The Refusal Support Plan must have at least one high priority goal. All sections must be completed or marked as unknown.
	• MSC+ Members: Document outreach attempts and outcomes in member record.
	• Complete final revision of previous Support Plan, if applicable.
	
	Mid-Year Review: If the member refuses to complete mid-year review, the CC is required to:
	• Contact the member mid-year following the assessment date.
	• Revise the Support Plan to show that member refused, in lieu of creating a Refusal Support Plan.
	• Document all actionable attempts* to reach the member.

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	NOTE: See section Mid-Year Review and Ongoing Support Plan Updates for more instruction.
SUPPORT PLAN	
Support Plan	A Support Plan is required for all MSC+ and MSHO members. The Support Plan is located within the MnCHOICES application. It is a living document that should be created annually and updated throughout the year. Note the additional requirements for those on Elderly Waiver, including Provider Signature Requirements, changes in services, and Case Mixes. Unable to Reach/Refusal Members meet the Support Plan requirement with their Unable to Reach Support Plan or Refusal Support Plan and do not need an additional Support Plan. The title of the MnCHOICES Support Plan is "Support Plan – MCO MnCHOICES Assessment".

	The CC is required to:
	• Develop a person-centered Support Plan with the member at the time of the initial and annual assessment using the Support Plan located within the MnCHOICES application. Ensure all questions and sections are completed.
	  ○ Use "Support Plan – MCO MnCHOICES Assessment"
	• The Support Plan must include the names and disciplines of members' Interdisciplinary Care Team (ICT)* as applicable.
	• Develop person-centered, prioritized goals on the Support Plan for identified areas noted in the assessment. The CC is not required to develop a goal for identified areas that are not currently active. For example, it is not required to develop goals for identified chronic conditions that are well managed and/or stable. Clearly document in the 'My Plan to Address Safety Needs' section any areas of identified risks that the member has declined or prefers no intervention.
	  ○ Goals should be written based on needs identified with the member during their assessment.
	  ○ Goals should be written as SMART goals (Specific, Measurable, Attainable, Relevant, and Time-bound).
	  ○ Goals should be ranked by priority, indicated by high, medium, or low. At least one goal is ranked as high priority.
	  ○ Interventions should include the necessary steps to achieve the goal (for example, who will provide assistance, and resources/referrals needed to meet the goal).
	• The Support Plan is shared within 30 calendar days of the assessment. Day 1 is the date of the assessment.
	  ○ Document the date the Support Plan is shared with applicable ICT* members:
	  ▪ Member and/or representative*. Include UCare *Care Plan Letter*.
	  ▪ PCP*
	  ▪ Elderly Waiver Providers per member's choice (see EW* Provider Signature Requirements section).

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	• As applicable, address each previously established goal by updating the "Status Date" and "Status of Goal" by selecting one of the following:
	  ○ Achieved (goal met; Goal may or may not continue onto new Support Plan)
	  ○ In progress (goal is not met and goal continues over to new Support Plan)
	  ○ Discontinued (goal no longer relevant; member no longer wants goal)
	• Add additional comments or updates under "Monitoring Progress" section with a date.

Support Plan Signature Sheet	**The CC is required to:**
	• Obtain a Support Plan signature from the member/representative* using the e-signature within MnCHOICES (as able). This signature demonstrates that the CC has discussed the Support Plan with the member/representative.
	  ○ **NOTE:** Only use the MnCHOICES Support Plan Signature Sheet when unable to use the offline function of MnCHOICES.
	  ○ The Support Plan is not valid unless signed and dated by the member/representative.
	• Sign Support Plan Signature Sheet using the e-signature within MnCHOICES and include CC's credentials.
	• If the assessment was not in-person, and the Support Plan is mailed to the member to obtain the signature, document the date of when the Signature Sheet was sent, and corresponding *Care Plan Signature Letter* found on the UCare website.
	  ○ Conduct at least one follow up attempt by phone or letter within 2 weeks of the Signature Sheet being sent to the member if the Signature Sheet has not been returned to the CC. Document the dates of the follow up.
	  ○ Attach Signature Sheet to MnCHOICES when obtained from member.

Mid-Year and Ongoing Support Plan Updates	**The CC is required to:**
	• Maintain ongoing contact or check-in with the member mid-year at a minimum to update the Support Plan.
	  ○ Document all actionable attempts* to reach the member.
	  ○ The contact may be by phone, televideo, or in-person and the contact is allowed any time 5-7 months from the last assessment date.
	  ○ If the assessment was not in-person, continue to offer an in-person visit for the mid-year review. One encounter must be in-person within the 12-month period.
	• Document the "monitoring of progress" by revising the Support Plan within MnCHOICES, found under the 'My Goals' section of the Support Plan, and any sections open to update status of a goal.
	  ○ **NOTE**: If member's active Support Plan is a Collaborative Care Plan, update sections "Monitoring Progress/Goal Revision" and any sections titled "Update".

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	• If the member is unable to be reached or refuses the mid-year review, the CC must revise the existing Support Plan in the Monitoring Progress section, and any other applicable areas. This scenario does not require an Unable to Reach Support Plan or Refusal Support Plan. Additionally, if the member is unable to be reached, the CC must document the 4 actionable attempts* to reach the member. • Communicate with the PCP* at least annually, and more as needed. This communication may include updates and changes to the member's condition. Document all communication or attempted communication. **NOTE:** Document every time services or goals are modified. Make an entry on the Monthly Activity Log under the appropriate columns to represent the Support Plan changes. • If a member is unable to be reached or refuses the mid-year review, do not add to the Monthly Activity Log. **NOTE:** If services/providers have changed, follow process in Change in Elderly Waiver Services and/or Providers section.

Elderly Waiver Provider Signature Requirement	**The CC is required to:**
	• Give the member a choice of sending the full Support Plan, a summary of the Support Plan, or not sending the Support Plan to each of their service providers.
	  ○ When sending a full Support Plan, it is accompanied with the *Elderly Waiver Provider Care Plan Cover Letter*.
	  ○ When sending a Support Plan summary, use the *Elderly Waiver Provider Care Plan Summary Letter.*
	• Document member choice(s) on the Support Plan Signature Sheet.
	• For providers receiving a full Support Plan or summary, the CC is required to obtain signatures from the providers within 60 days.
	• Attach Provider Signature in MnCHOICES.
	• **NOTE:** Two attempts to obtain the signature within 60 days meets the requirement also. Document these attempts.
	• If there are multiple services in place within one provider entity, only one letter is needed per provider. **NOTE:** If there are multiple providers, member has option to choose a different option for each provider.
	NOTE: Affected providers are DHS Enrollment Required Services (formerly called Tier 1) and Approval Option; Direct Delivery Services (formerly called Tier 2) providers, as well as PCA providers only if the member is open to the waiver.
	NOTE: The signed ICLS planning form can be used to meet the provider signature requirements.

Change in Elderly Waiver Services and/or Providers	**If there is a change to a service or a provider in between the annual Support Plans, the CC is required to follow these Elderly Waiver Provider Signature requirements:** • Update the Support Plan with the change in all appropriate areas. • Send the member a *Member Elderly Waiver Service Change Letter* which requests the member's signature. Send a copy of the new Support Plan.

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	• Offer the member a choice of sending the provider the full Support Plan, the Support Plan Summary Letter, or not sending the Support Plan at all. ○ Document member choice in member record. • Make 2 attempts to obtain a signature from the provider, if applicable, and document these attempts. The first attempt must be within 30 days of the change and second attempt must be within 60 days of the first notification. • If there are multiple changes within one provider entity, only one letter needs to be sent to the member total, and one letter to the provider total. • Attach Provider Signature in MnCHOICES. **NOTE:** This requirement includes all change scenarios. For example, but not limited to adding a service, reducing units, or starting with a new provider. If there is a Denial, Reduction, or Termination, follow the DTR* process as well.
Case Mix Service Caps	The Case Mix is determined using the MnCHOICES Assessment form. All state plan home care and Elderly Waiver services must be based on member's assessed need and the total cost cannot exceed the Case Mix monthly cap amount. **This includes UCare's monthly Care Coordination fee of $180**. See DHS-3945 *Long-Term Services and Supports Service Rate Limits* for service rates and Case Mix amounts.
OTHER REQUIRED CARE COORDINATOR ACTIVITIES	
Monthly Activity Log	**The CC is required to:** • Enter all MSC+ and MSHO assessments and reassessments on the Monthly Activity Log, including Unable to Reach and Refusals. • Enter MSC+ and MSHO THRA's and Functional Needs Updates on the Monthly Activity Log, upon Product Changes and transfers from FFS/Other MCOs.. • Enter MSC+ and MSHO Support Plan modifications on the Monthly Activity Log **when there are changes or updates to member's services, goals, and/or needs**, including at the time of the mid-year review and as a result of a transition of care. ○ If a member is unable to be reached or refuses the mid-year review, do not add to the Monthly Activity Log. • Submit the Monthly Activity Log to assessmentreporting@ucare.org by the 10th calendar day of the following month. • See the UCare website for tips and instructions.
EW Encounter Requirements	Care Coordinators are to ensure an in-person encounter is completed at least once in a 12-month period (see 4/4/2023 DHS e-list announcement). If the member declines to meet in-person for the assessment, Care Coordinators may opt to conduct a separate in-person encounter during the same 12-month period. It is best practice to complete the annual reassessment in-person. Care Coordinators must track and document compliance of this requirement. Enter Care Coordinator's encounter on the Monthly Activity Log under Support Plan Update using the appropriate drop down. **NOTE:** All assessments that result in PCA services must be completed in-person.

	Community Elderly Waiver Members
	NOTE: All initial EW assessments must be in-person. EW services cannot be started until an in-person assessment has been completed.
Transitions of Care	Transition of care (TOC) is when a member transitions from one care setting (e.g., member's home, hospital, or skilled nursing facility) to another care setting, whether planned or unplanned. Each transition, when due to a change in the member's health status, is considered a separate transition.
	The CC is required to: • Monitor EAS for admissions on business days. • Monitor the Daily Authorization Report for out-of-state and out-of-network admissions. • Assist with care transitions. • Follow steps below. **MSHO MEMBERS:** • Assist with the member's planned and unplanned transitions from one care setting to another care setting. • Complete the **TOC* Log**, found on the UCare website along with TOC Log instructions. o Contact member/representative* to assist with transition. ▪ When reaching out to the member/representative* for TOC Log tasks, make and document at least 2 actionable attempts*. o Share CC contact information and Support Plan/services with receiving setting within one business day of notification of transition. o Notify PCP* of transition via fax/phone/EMR/secure email (if PCP was not admitting physician) within one business day of notification of transition o Document reason for admission and all other relevant information on TOC Log. o Continue to log subsequent transitions (transition #2, and if applicable, #3, #4, and #5) until member returns to usual setting. • In addition, the below tasks should be completed when the member discharges TO their usual care setting. This includes situations where it may be a 'new' usual care setting for the member (i.e., a community member who decides upon permanent nursing home placement).

	Community Elderly Waiver Members
	○ Communicate with member/representative about care transition process, changes to the member's health status, and support plan updates within 1 business day of notification of transition. ○ Provide education about transitions and how to prevent unplanned transitions/readmissions. ○ Complete 4 Pillars for Optimal Transition ▪ Indicate if the member has a follow-up appointment scheduled with primary care or specialist. If not, provide explanation in comments. • For mental health hospitalizations, indicate if the member has a follow-up appointment scheduled with a mental health practitioner within 7 days of discharge. ▪ Indicate if the member can manage their medications or has a system in place to manage medications. If not, provide explanation in comments. ▪ Indicate if member can verbalize warning signs and symptoms and how to respond. If not, provide explanation in comments. ▪ Indicate if the member uses a Personal Health Care Record. If not, provide explanation in comments. ○ Indicate whether the member's Support Plan has been updated following this transition. If not, provide explanation in comments. ○ Indicate whether you have reviewed the discharge summary with the member. If not, provide explanation in comments. • Conduct a Functional Needs Update* if appropriate. • If the TOC resulted in a change to member's services, goals, and/or needs, enter the Support Plan modifications on the Monthly Activity Log. **NOTE:** If the CC is notified of the transition(s) 15 days or more after the member has returned to their usual care setting, the CC is not required to complete a TOC Log. However, the **CC is still required to:** ○ Follow-up with the member to discuss the care transition process, any changes to their health status, and their Support Plan. ○ Provide education about how to prevent a readmission and document this discussion in the case notes. ○ When reaching out to the member/representative*, make and document at least 2 actionable attempts*. ○ The 15-day exception only applies if the CC finds out about *all* the transitions after the member has returned to their usual care setting.

	Community Elderly Waiver Members
	MSC+ MEMBERS • Upon return to usual setting, follow-up with the member to discuss the transition, any changes to their health status, and/or changes to their Support Plan. Use Transition of Care Talking Points on the UCare website. ○ When reaching out to the member/representative*, make and document at least 2 actionable attempts*. • Provide education about how to prevent a readmission and document this discussion in the case notes. • If the TOC resulted in a change to member's services, goals, and/or needs, enter the Support Plan modifications on the Monthly Activity Log. • Conduct a Functional Needs Update* if appropriate. • Use professional judgement to determine additional care coordination intervention.

Admissions over 30 Days	UCare completes ALL telephonic Nursing Facility (NF) OBRA/Pre-admission Screening and Resident Review (PASRR) activity internally. If an assessment is needed to determine level of care, the care coordinator will be notified.
	
	If the member admits to a hospital for 30 days or more, the CC is required to follow these steps on day 31:
	  ○ Send the DHS-5181 *Communication Form* to the county Financial Worker and indicate the date the member was admitted to the hospital.
	  ○ If the member is on Elderly Waiver and plans to return the community, **temporarily** exit the waiver in MMIS* using the **date of the member's hospital admission.**
	  ○ Complete a DTR* for each waiver service the member is receiving.
	
	If the member admits to a nursing facility for 30 days or more, the CC is required to follow these steps on day 31:
	  ○ Send the DHS-5181 *Communication Form* to the county Financial Worker and indicate the date the member was admitted to the nursing facility.
	  ○ If the member is on Elderly Waiver and plans to return the community, **temporarily** exit the waiver in MMIS* using the **date of the member's nursing facility admission.**
	  ○ Complete a DTR* for each waiver service the member is receiving.
	
	If the member admits to a hospital and transitions to a nursing facility. Once the member has been in the nursing facility for 30 days or more, the CC is required to follow these steps on day 31:

	Community Elderly Waiver Members
	○ Send the DHS-5181 *Communication Form* to the county Financial Worker and indicate the date the member was admitted to the nursing facility. ○ If the member is on Elderly Waiver and plans to return the community, **temporarily** exit the waiver in MMIS* using the **date of the member's nursing facility admission.** ○ Complete a DTR* for each waiver service the member is receiving. **If the member returns to the community between 30-121 days and was previously on a waiver:** ○ Send the DHS-5181 to the county as notification member returned to the community. ○ Restart the member to their previous waiver program. A new assessment is not due until the normally scheduled assessment, unless a Functional Needs Update* is needed. ○ Submit a new WSAF* to restart waiver services for the partial waiver eligibility span. **If the admission stay is longer than 121 days and they discharge back to community:** ○ Complete a DTR for Elderly Waiver eligibility on day 122. ○ A reassessment is needed to re-open Elderly Waiver. **NOTE:** An Institutional Health Risk Assessment (IHRA) is not needed upon a Transitional Care Unit admission nor a Long Term Care admission. A new assessment is only needed upon a significant change of condition. **NOTE:** Members determined to be long term can be transferred to the appropriate care system/county as applicable by day 100 of a nursing facility admission. If CC is aware that nursing facility placement will be permanent, CC may initiate the transfer prior to day 100 via the *PCC Change Form*. The confirmation of long-term care status must come from the member/representative*.
Member Death	**The CC is required to:** • Submit a *Member Death Notification Form* to UCare. • Close the Elderly Waiver span in MMIS* effective date of death. • Submit the DHS-5181 *Communication Form* to the County of Financial Responsibility (CFR). • Unassign location and staff assignment in MnCHOICES.
Advance Directives	The CC is required to: • Document on an annual basis that Advance Directives was discussed with the member. • If Advance Directives were not discussed, document the reason.

	Community Elderly Waiver Members
Annual Preventive Care	The CC is required to: • Document on the MnCHOICES Assessment form that a conversation was initiated with the member regarding preventive health care (e.g., pneumovax, flu shot, dental visit, vision evaluation).

DTR* Requirements	**CC requirements for a Denial, Termination, Reduction (DTR):**
	• A *DTR Notification Form* is for when a member initiates the termination or reduction of a waiver service.
	• If a member is exiting the waiver for any reason, a DTR must be completed for each waiver service they are currently receiving. A separate DTR is required for waiver eligibility.
	• If a member is receiving home health care services (e.g., PCA/CFSS, HHA, SNV), and the CC or member initiates a termination or reduction of those services.
	  ○ For PCA DTRs, use the Personal Care Assistance (PCA) and Community First Services and Supports (CFSS) Communication Form. For other home health care services, use the *Home Health Communication* form. Both forms are found on the UCare website.
	  ○ Fax form to UCare.
	• The CC is required to submit a *completed DTR Notification Form* to UCare within 1 business day of the decision date to initiate UCare's DTR letter generation process. The *DTR Notification Form* must be sent to UCare Clinical Intake team via email or fax at least 14 days prior to the ending of services.
	NOTE: See the UCare website for additional resources on DTR determination and process.

Safe Disposal of Medications	**If the member is taking any medications, the CC is required to:** complete the below tasks at time of the member's Initial Assessment or Annual Reassessment (not required for UTR*/Refusals): • Complete the *Dispose of Medications Safely* form and provide to member. CC must manually add two community drop-off sites closest to the member's location. • Discuss the information from the *Dispose of Medications Safely* form with the member. ○ Document discussion and that the form was provided on the MnCHOICES Signature Sheet under 'Materials shared: Other information'.
Change in CC within the Same Entity	• The new CC must notify the member of the CC's name and phone number within 10 business days of change in assignment. This can be done by phone or letter. The contact must be documented. If contact is made by letter, the CC must use UCare's approved *Change in Care Coordinator Letter* found on the UCare website. • Transfer staff assignment to new CC in MnCHOICES.

	Community Elderly Waiver Members
	• Enter change of CC in MMIS. • No Monthly Activity Log entry required.

Primary Care Clinic Change	**If a member changes their Primary Care Clinic resulting in a change of care coordination entities, the current (sending) CC completes the following tasks:**
	• Confirm PCC* with the member.
	  ○ Confirmation needs to be a verbal discussion with the member/representative*.
	  ▪ Reviewing EMR* or Internal Systems to see if the member has established care is NOT sufficient.
	  ○ If the member states they plan to establish care with a new clinic, UCare expects the new (receiving) CC to work with the member in scheduling the appointment to establish care. Ensure the desired clinic is in UCare's provider network, if not, the current CC will work with the member to establish care at an in-network provider, prior to completing a *Primary Care Clinic Change Request* form.
	• Ensure the member does not have a future MA* end date as these members cannot be transferred.
	• **All required assessments and corresponding paperwork/documentation must be fully completed prior to a transfer. Members cannot be transferred the month their annual assessment is due. The current (sending) CC must complete all assessment paperwork PRIOR to transfer, including, but not limited to, all EW paperwork (e.g., 3543, 5181, WSAF*).**
	• **CC's should not initiate the PCC Change during a TOC*.**
	• If the member is new or is a member with a Product Change: Complete the *Primary Care Clinic (PCC*) Change Request* form and submit to UCare no later than the 12th of the month for a retro assignment.
	• If this is an ongoing member (NOT New or had a Product Change), complete the *Primary Care Clinic (PCC*) Change Request* form and submit to UCare no later than the 24th of the month prior to the transfer effective date.
	• UCare will notify the current (sending) CC if the transfer has been denied.
	• The current (sending) CC/entity is responsible for care coordination until the transfer effective date indicated on the PCC Change Request form.
	• The current (sending) CC completes the DHS-6037 *Transfer Form* and sends to the new (receiving) CC/entity, along with all pertinent documents.
	• Care coordination entities and delegates are strongly encouraged to reconcile their care coordination enrollment rosters monthly.

	Community Elderly Waiver Members
Financial Eligibility for Elderly Waiver Services	**The CC is required to:** • Verify member's financial eligibility for Elderly Waiver services prior to initiating the services. • Complete the DHS-3543 *Request for Payment of Long-Term Care Services* and the DHS-5181 *Communication Form* and send to the county to determine eligibility. • Maintain a copy of the DHS-5181 and DHS-3543 in the member's record.
Medical Assistance Eligibility Renewals	**The CC is strongly encouraged to:** • Remind members when they are at risk of losing MA* eligibility due to incomplete or unprocessed paperwork. • Assist members with the completion of renewal paperwork as appropriate. **NOTE:** The UCare Keep Your Coverage Team reaches out to members to offer additional assistance with maintaining eligibility. The CC may collaborate with the Keep Your Coverage Team for support.
90 Day Monitoring After MA* Becomes Inactive	**If a member's Medical Assistance*becomes inactive, the CC is required to:** • MSC+: Track the status of the member, support efforts to reinstate MA, and complete any assessments and supporting documents that are needed in the following 90 days. ○ **NOTE**: If a CC is able to document confirmation from a member or member's Financial Worker that MA will not be reinstated, care coordination may end. Examples may include: member moved out of state, incarcerated, no longer financially eligible for MA per Financial Worker. ○ If a mid-year review comes due during the 90 Day inactivity period, complete the mid-year review once MA has been reinstated and document why it is late. • MSHO: Members will remain on the enrollment roster during the initial 90 day inactivity and all care coordination activity continues. ○ **NOTE:** If member's 90 day grace period ends early, the member will fall off roster and CC may discontinue Care Coordination. • Submit PCA/CFSS Assessments and WSAFs when MA is reinstated. Make note of the MA inactivity/reinstatement on the forms. • Enter EW assessment data into MMIS* when the member's MA is reinstated to UCare MSC+/MSHO. • Enter the assessment data on the Monthly Activity Log once MA is reinstated. • EW* MEMBERS ONLY: Refer to DHS-6037A *Communication Form Scenarios*. ○ If the member's MA is not reinstated by the 60th day, the CC is required to complete the DHS-6037 and send with all pertinent transfer documents to the County of Residence on the 60th day. • **NOTE:** This section applies to MA-inactive members only. If the member terms from UCare but is active with MA, follow Transferred Member section.

	Community Elderly Waiver Members
	NOTE: If member's 90 Day grace period ends and member did not reinstate: • Unassign location and staff assignment in MnCHOICES. • Ensure MnCHOICES forms are left in a completed or discarded status.
Member Change of Address	**The CC is required to:** • Send the DHS-5181 *Communication Form* to the County of Financial Responsibility (CFR) as notification of the member's new address and the date they moved. ▪ Maintain a copy of the form and document the action in the member's record.
HCBS* Modification to Member Rights	A member's rights may be modified if living in settings where they receive customized living, foster care, or supported living services. **The CC is required to:** • Complete Part A and Part B of the DHS-7176H *HCBS Rights Modification Support Plan*. • Once completed, the CC sends the DHS-7176H form to the provider via fax or secure email. The provider will complete Part C and send back to the CC. • The CC will review and confirm that the provider documented how the modification of the member's right(s) will be implemented in Part C and reviews the modification plan with the member. • Once the form is completed and signed by the member or Authorized Representative, the CC incorporates the member's decision in their Support Plan. • Attach a signed copy to the Support Plan. Also maintain a copy in the member's record.
Behavioral Health Home (BHH) Services	**The CC is required to:** • Contact BHH provider within 30 business days of notification that the member is receiving BHH. During this call, the CC will: o Provide the BHH provider with the CC's contact information. o Share information related to the members Support Plan. o Establish contact frequency between BHH provider and CC and preferred method of communication. • Include BHH service on the member's Support Plan. • Include BHH provider as ICT. • Notify BHH staff of any known ER/hospitalization admission and/or discharge. • Notify BHH staff of any transitions of care, post discharge plans and follow up plans.

	Community Elderly Waiver Members
	• Document all contact with BHH provider in the member's record.

Coordination With Local Agencies	**The CC is required to:**
	• Make referrals and/or coordinate care with county social services and other community resources per member's needs, including but not limited to:
	  ○ Pre-petition Screening.
	  ○ Spousal Impoverishment Assessments.
	  ○ Adult Foster Care.
	  ○ Group Residential Housing Room and Board Payments.
	  ○ Substance Use Disorder room and board services covered by the Consolidated Chemical Dependency Treatment Fund.
	  ○ Adult Protection.
	  ○ Local Human Service Agencies for assessment and evaluation related to judicial proceedings.

MSHO Model of Care Training	UCare requires that all CCs complete the Model of Care training within three months of hire and annually thereafter. CCs may access this training via WebEx located on the UCare Care Management/Care Coordination website (titled MSHO & UCare Connect + Medicare MOC Training). UCare will also provide Model of Care training to CCs on an annual basis. • Each CC will need to submit the electronic attestation form following the completion of training located on the UCare Care Management/Care Coordination website.
Documentation and Notes	**The CC is required to document in the member's record all evidence of:** • Care coordination requirements are being met. • Care coordination requirements that were attempted but not completed. • Member documents including, but not limited to, assessments, Support Plans, and TOC* Logs. • All communication with members, representatives, providers, and any other ICT* members.
Policies and Procedures	• UCare and all care coordination delegates are required to have policies and procedures that support all the above stated requirements. • All EW services must follow criteria and policies outlined in the DHS CBSM.

*DEFINITIONS/ACRONYMS	
Term/Acronym	**Definition**
Actionable Attempts	Successful communication that the member can act upon. For example, a voicemail left at a known working number, mailing a letter to a known address, or sending a secure email to a verified email address. When mailing UTR* letters, allow at least 2 days in between mailings to allow time for member to respond. When calling or emailing, the attempts are made on different dates and varying times. Ideally, attempts are 3 calls and one letter. If calls are not actionable (e.g., number unconfirmed/not working), then additional letters are acceptable. **NOTE:** Investigative research* is not considered an actionable attempt.

Assessment Guide	There are 3 methods for completing assessments/reassessments: in-person, televideo, and by phone. Some assessments require in-person, as explained below. Televideo requires robust documentation that member has been given an informed choice of in-person first. Phone assessments must have robust documentation that member has been given an informed choice of in-person first, then televideo second, before completing a phone assessment. **See job aid and decision tree on CC website for more guidance**. Televideo must be a visual, real time, interactive telehealth encounter.
	
	Alternate Year (EW, non-PCA only) = Remote reassessments may be substituted for one reassessment if followed by an in-person reassessment. CC provides information to make an informed choice between a remote and in-person assessment and documents informed choice.
	• **NOTE:** All MSC+/MSHO members on EW must have at least one in-person visit per 12-month period.
	  ○ If a member chooses a remote reassessment, the CC must complete a separate in-person visit within the same 12-month period.
	• All initial EW assessments must be in-person.
	
	NOTE: An in-person assessment is required for:
	• All PCA Assessments.
	  ○ **NOTE:** PCA refers to assessments that result in PCA services. Does not apply to community members that have PCA through their CAC/CADI/DD/BI waivers.
	• All initial EW assessments.
	• Any time a member/representative* requests an in-person assessment.

	• If during a phone or televideo assessment, the CC determines an in-person assessment is necessary to complete the assessment.
Assignment Date	Date the member is assigned to a care coordination delegate via the monthly enrollment roster.
CAC/CADI/DD/BI	Home and Community-Based Waiver Types: Community Alternative Care (CAC)/Community Access for Disability Inclusion (CADI)/Developmental Disabilities (DD)/Brain Injury (BI)
Capitation Date	Or "Cap" Date. These are outlined on Managed Care Key Dates published by DHS and are updated annually.
EAS	Encounter Alert Services – allows providers throughout the state to receive member encounter alerts, for individuals who have been admitted to, discharged, or transferred from, an EAS-participating hospital, emergency department, long-term care facility, or other provider organization in real time.
EMR	Electronic Medical Record
Enrollment Date	First day of the month the member enrolls to the current health plan product.
EW	Elderly Waiver. A Medical Assistance program for people aged 65 and older who require the level of care provided in a nursing facility and choose to reside in the community.
FFS	Fee-For-Service. A person that remains on traditional Medical Assistance without a Managed Care Organization. Services not authorized or paid through managed care organizations.
Functional Needs Update	A remote assessment used by lead agencies to document a change to a person's assessed needs any time during the service year for EW members. Certified assessors can use a functional needs update to update a person's assessment prior to reassessment when the person has a change in functional needs, including changes that will affect their EW case mix budget or establish eligibility for 24-hour customizing living for EW. A functional needs update does not replace an annual reassessment, and it does not reset or extend an EW eligibility (service agreement) span. A person may choose to receive a reassessment instead of a functional needs update.
HCBS	Home and Community-Based Service: Refers to support/programs/supplies and/equipment paid for by a waiver and not covered by Medical Assistance. The member must qualify for a waiver to be eligible for HCBS support.
HHA	Home Health Aide
ICT	Interdisciplinary Care Team: • At a minimum includes the Care Coordinator, the member and/or representative*, PCP, and Waiver Case Manager (as applicable). • ICT members may also include any and all other health and service providers (including Managed Long Term Supports & Service providers/Home & Community Based Service providers) as needed, if they are involved in the member's care for current health conditions.

	○ These may include but are not limited to: family, caregiver, specialty care providers, social workers, mental health providers, nursing facility staff, and others performing a variety of specialized functions designed to meet the member's physical, emotional, and psychological needs.
Investigative Research	A good faith effort should be documented to locate a member's contact information. Investigative research is not considered an actionable attempt*. Examples may include: • Contact Financial Worker for correct contact or a number for an Authorized Representative • Call PCC* • Contact Waiver Case Manager • Review historical information – check to see if previous number is now working • As available – utilize other electronic health records accessible to the County or Care System (MIIC, EPIC, EHR)
MA	Medical Assistance
MCO	Managed Care Organization. A health plan that manages Medical Assistance for eligible members. UCare is an MCO.
MMIS	Medicaid Management Information System: Minnesota's automated system for payment of medical claims and capitation payments for Minnesota Health Care Programs (MHCP).
MnCHOICES	A single, comprehensive, web-based application that integrates assessment and support planning for all people who seek access to Minnesota's long-term services and supports. Health Risk Assessment form (HRA-MCO) – replaces the DHS-3428H MnCHOICES Assessment form with "Staying Healthy" section – replaces the DHS-3428 for managed care certified assessors MnCHOICES Assessment form – replaces the DHS-3428 for county assessors (NOT used by MCO care coordinators) Support Plan-HRA-replaces Collaborative Care Plan for CAC/CADI/DD/BI members OR community members not receiving PCA services. Use Program Type 'Health Risk Assessment' Support Plan-MCO-MnCHOICES Assessment-replaces Collaborative Care Plan for Elderly Waiver members or community members receiving PCA services Support Plan-MnCHOICES Assessment-replaces the CSSP for county assessors (NOT used by MCO care coordinators)
MN-ITS	DHS system care coordinators use to verify member MA status, Medicare, Waiver, MCO and Restricted Recipient eligibility. MN-ITS is also the DHS billing system for providers enrolled in Minnesota Health Care Programs (MHCP). UCare suggests checking MN-ITS to verify member's eligibility status upon initial assignment and at least once mid-year.
PCC	Primary Care Clinic
PCP	Primary Care Physician
Rate Cell	The pricing data attributed to a member to determine the monthly prepaid capitation payment.

	Rate Cell A = Community, non-Elderly Waiver Rate Cell B = Community, Elderly Waiver Rate Cell D = Institutional
Reassessment Due Date	Reassessment timelines differ based on the outcome of the initial assessment. If the initial assessment results in a UTR/Refusal the reassessment due date is within 365 days of the original enrollment date*. Subsequent reassessments need to be within 365 days of the last Activity Date. UTR Activity Date = Date of last actionable attempt* to reach member for assessment. Refusal Activity Date = Date member refused/declined the assessment.

Representative	**A members verified legal alternative decision maker. For example: court appointed guardian/conservator, health care agent. Obtain a copy of guardian/conservator or Health Care Directive documents to verify level of representation.** **Examples of alternative decision makers, but not limited to:** **Guardian** is "A person with the legal authority and duty to act on behalf of another person. The legal guardian can make decisions for the person about where to live, medical treatment, training and education, etc. Decision-making is limited to the specific powers the court assigns to the legal guardian (dhs.state.mn.us)." **Health Care Agent** is the person listed on a Health Care Directive that can make health care decisions if the individual is unable to make those decisions (MDH, Health Care Directives - Minnesota Dept. of Health (state.mn.us)). A designated health care agent may sign ROI, only if the principal is unable to sign for themselves, unless explicitly directed in the Health Care Directive. **Power of Attorney (POA)** "is a written document often used when someone wants another adult to handle their financial or property matters (Minnesota Judicial Branch, Power of Attorney, Minnesota Judicial Branch - Power of Attorney (mncourts.gov))." POA will cease when a person becomes incapacitated. • **Durable Power of Attorney** hold the same privileges as POA, but maintains their power through incapacities and terminates upon death of the member. **Authorized Representative (A-Rep)** is "a person or organization authorized by an applicant or enrollee to apply for a MHCP and to perform the duties required to establish and maintain eligibility (DHS, Eligibility Policy Manual, 1.3.1.2 MHCP Authorized Representative (state.mn.us)." This type of representative is exclusive to financial eligibility such as Medical Assistance eligibility and MHCP Eligibility. **Responsible Party (RP)** is "A person who is at least 18 years old and capable of providing the support necessary to help the person receiving PCA services to live in the community when the person is assessed as unable to direct their own care (DHS, PCA Manual, PCA responsible party (state.mn.us))." This type of representative is exclusive to PCA. The designated RP is not permitted to act as the PCA.
ROI	Release of Information • A signed ROI does not grant decision-making powers.
SMART Goals	Specific, Measurable, Attainable, Relevant, and Time-bound. Find more information on the UCare website.
SNBC	Special Needs Basic Care, a type of health plan for people with disabilities who are 18–64 years old and qualify for Medical Assistance.
SNV	Skilled Nurse Visit
THRA	Transfer Member Health Risk Assessment

TOC	Transition of Care
UTR	Unable to Reach
WSAF	Waiver Service Approval Form. Ensure all Provider information is accurate prior to submitting.

DHS eDocs	
eDocs Number	**Title of document and short descriptions**
DHS-3426	*OBRA Level I Criteria – Screening for Developmental Disabilities or Mental Illness* This form should be completed during all assessments. It specifically is for when a person seeks admission to a Medical Assistance-certified nursing or boarding care facility or as part of a community assessment. **NOTE:** This is not required for members on a CAC/CADI/DD/BI waiver.
DHS-3427	*LTC Screening Document – EW, MSC+, MSHO* This screening document form is used by lead agencies to record LTC screenings.
DHS-3427H	*Health Risk Assessment Screening Document-MSC+, MSHO and SNBC Form* This form is used by managed care organizations to record the health risk assessments for data entering into the MMIS*.
DHS-3428	*Minnesota Long Term Care Consultation (LTCC) Services Assessment Form* This form is used by lead agencies to record LTC assessments. **NOTE:** When completing the LTCC, all questions and sections must be completed or marked as "Not Applicable". This includes: • Informal Caregiver Assessment if section "E" demonstrates need for a caregiver. • My Move Plan Summary, if "Prefer to live somewhere else" or "Don't know" on question E.13 (EW* only, see form).
DHS-3428D	*Supplemental Waiver PCA Assessment and Service Plan* Lead agencies use this form when assessing for PCA services for people on HCBS* waiver and the Alternative Care Program. After completing the PCA Assessment, send a copy to the member/representative*.
DHS-3428H	*Minnesota Health Risk Assessment Form* This is a companion form to DHS-3427H. Health plan care coordinators use it to record the health risk assessments that are entered into the MMIS*.
DHS-3428M	*Mini-Cog© Instructions for Administration and Scoring*
DHS-3428Q	*Person's Evaluation of Foster Care, Customized Living or Adult Day Service Form*

	This form collects feedback from managed care members eligible for the Elderly Waiver program and who receive customized living, foster care and/or adult day services.
DHS-3543	*MHCP Request for Payment of Long-Term Care Services* Application sent when an enrollee begins receiving waivered services must complete this form. Should be completed and returned within 10 days.
DHS-3936	*My Move Plan Summary Form* When a person who receives long-term services and supports is moving to a new residence, he or she completes the My Move Plan Summary form with case manager/support planner.
DHS-4690	*Communication to Physician of Personal Care Assistance Services* This form is used to communicate with member's PCP following a PCA Assessment that was completed by the UCare CC.
DHS-5181	*Lead Agency Assessor/Case Manager/Worker LTC Communication Form* This form is to be used by lead agency case managers and workers to ensure that the process to determine if applicants or enrollees are eligible to receive MA payments for services received through the HCBS* waiver program is initiated promptly. It is also used to communicate change of member's address, member death, and care coordinator changes.
DHS-5841	*Managed Care Organization, County Agency and Tribal Nation Communication Form - Recommendation for State Plan Home Care Services* Health plans, counties and tribes use this form to make initial or modified requests for authorization of home care services or provide information about changes in services authorized by a health plan. This form is used for members in MSC+, MSHO, SNBC and MA-Families and Children. This form is used to facilitate communication between waiver case managers and MCO staff (care coordinators).
DHS-6037	*HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form* This form assists health plan, county and tribal care coordinators and case managers to share information.
DHS-6037A	*HCBS Waiver, AC and ECS Case Management Transfer and Communication Form: Scenarios for People on EW and AC* Instructional form for using DHS-6037 for the Alternative Care, Elderly Waiver and Essential Community Supports programs.
DHS-6914	*Caregiver Questionnaire* This form is to assess the needs of a family or friend caregiver, to guide support planning, and identify resources to assist with the caregiving role.
DHS-6791D	*Coordinated Services and Supports Plan Signature Sheet*
DHS-7028	*Nursing Facility Level of Care Criteria Guide*

	Determines institutional level of care (including nursing facility NF-LOC). A member must meet the criteria to be eligible for Elderly Waiver. Use as a resource to determine level of care and Elderly Waiver eligibility if appropriate.
DHS-7176H	*HCBS Rights Modification Support Plan Attachment* Care coordinators use this form when a person requires a modification to their rights based on specific and individualized assessed needs that are necessary to ensure his/her health, safety, and wellbeing. If the person agrees to the changes, the license holder/provider implements the modification as identified and agreed to in this form.
DHS-8354	*MCO Member Address Change Report Form* **Online portal only:** https://edocs.mn.gov/forms/DHS-8354-ENG Link for care coordinators to report address changes to the county. For care coordination use only.