

**UCare Medicare Advantage PlansClinical Case Management Requirements** **Updated for January 2024**

UCare supports and follows the guidelines for the standards of practice from the Case Management Society of America (CMSA). The CMSA defines Case Management as “a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes.” (CMSA 2022)

UCare contracts with the following entities to provide case management for UCare Medicare Advantage; UCare Medicare Advantage with M Health Fairview & North Memorial; and EssentiaCare members: Essentia, Fairview Physicians Associates (Fairview Health Network), Fairview Partners, North Memorial and Voyage Health Care.

UCare provides Case Management for all UCare Medicare Advantage members not affiliated with one of the above listed UCare Products and contracted entities. UCare provides NCQA Complex Case Management to eligible members. This function is not delegated outside of UCare.

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| Case Management Documentation Requirements |
| **Focus of Case Management** | The focus of case management is on members with acute, medical/social needs, typically of short-term duration (3-6 months). |
| **Welcome Letter** | CM sends the UCare Welcome Letter\* prior to or immediately upon engaging contact with member. The letter contains information on how the member was identified for case management, the services CM provides and how to opt in/out. \*Letter found on the UCare.org website: [UCare® - Medicare](https://www.ucare.org/providers/care-managers/medicare-resources)  |
| **Screening for Case Management**  | Delegates shall provide Case Management for all UCare members who meet the screening criteria developed by Delegate and approved by UCare.Delegates work with UCare in defining, refining, and using criteria that identifies UCare members that are at high risk for adverse health outcomes. Delegate agrees to cooperate with suggested Predictive Modeling methodology as developed or other identification mechanisms approved by UCare to initially identify UCare members for further screening. Delegate may also initially identify a limited number of UCare members through encounters at the clinic level. |
| **Referral Source and Method** | Referrals for case management services may come from a variety of sources, including but not limited to:w Medical management program referral (DM, BH, Pharmacy, UR, etc.)w Practitioner or clinic referral (PCP/PCC)w Hospital or facility social workers/discharge plannersw Member or caregiver referralw Health Plan referral w Other external sourcesThe CM documents the referral source and the method of referral (report, phone, email, in person, etc.) within the member record. |
| **Member Consent** | Obtain consent for case management services from the member or caregiver. Document in the member record. |
| **Initial Assessment** | The Case Manager (CM) should initiate an assessment for all referred members deemed to be “at risk” of high utilization and/or cost, based on available data, and professional judgment. The CM will complete the UCare General Assessment (2024 update)\* to gather information or completes an assessment form that has been approved by UCare. The assessment should cover medical, behavioral health, substance use and abuse and social determinants of health.\*Assessment found on the UCare.org website [UCare® - Care Coordination Medicare](https://www.ucare.org/providers/care-managers/medicare-resources) |
| **Decline or Unable to Reach** | If the member **declines** case management, the CM will send the *Resources Letter\** which contains the CM contact information and any resource/educational material as appropriate. This is documented= in the member record. The case may then be closed as appropriate (screening closed or closed).If the CM is **unable to reach** the member via phone after two unsuccessful attempts (2 different dates/times of day **OR** invalid contact information after checking two sources), the CM will send the *Unable to Reach Member Letter\** explaining the CM role and request a callback from the member to complete the assessment. These attempts are documented in the member record. The case may then be closed as appropriate (screening closed or closed).\*Letters found on the UCare.org website: [UCare® - Medicare](https://www.ucare.org/providers/care-managers/medicare-resources)  |
| **Plan of Care****(POC)** | If the member agrees to case management, the CM develops a person-centered POC with the member (or caregiver if appropriate). The POC should be developed based on information collected in the assessment, identified care needs/gaps in care and desired member goals. The CM documents the following on the POC:* Person-centered **SMART** goals related to needs/care gaps identified in the assessment.
* Any barrier(s) to member attaining goal
* Priority (low, medium, high) as ranked by the member/caregiver
* Target date for goal (may be modified with supporting documentation in member record)
* Member/caregiver actions/interventions or self-management plan toward reaching goal.
* CM actions/interventions to be taken assisting member to reach their goal. Include any opportunities for collaboration with member, caregiver (if applicable) and members of interdisciplinary care team.
* Documentation member/caregiver participation in the POC (acknowledgement statement)
* Goal achievement date and status of goal (when goal closed)

The Plan of Care is kept in the member record.Delegate CM uses the UCare Care Plan form (on the UCare.org website) or a care plan form that has been approved by UCare.  |
| **Ongoing Assessment &** **Monitoring**  | The CM provides ongoing assessment and follow up with the member to monitor status and progress of POC interventions. The CM revises the plan with the member/caregiver as needed to meet the member’s identified health goals. Generally, members are contacted at least monthly while in Case Management. Contact may occur more frequently if needed. Documentation includes:* Continued assessment of member’s status
* Follow-up plan for next contact (include timespan example – 2 weeks, 1 month, etc.)
* Any communication with member, PCP/Specialist, or other provider, as applicable.
* Progress toward goal (evaluation of member progress toward goal, member response to interventions, resources or education provided by CM, etc.)
* Education of member and/or caregiver on conditions/comorbidities and health/wellness strategies. Education or resources given to members for closure of care gaps.
* Any coordination of services\*\*, **as applicable.**

\*\*Services may include:* Assistance coordinating clinic or specialty appointments
* Medication management and related follow up
* Assistance obtaining Home Care Services
* Assistance with Durable Medical Equipment (DME).
* Referral to services available to member (example: disease management, pharmacy review, etc.)
* Resources for support services, community groups, or associations related to their condition or need (e.g., Stroke or Mental Health support groups, Meals on Wheels, safe driving resources, Diabetes Association).

Documentation is kept in the member record (may be in the POC or member notes). |

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| **Transition of Care**(Discharge to Home) | If a member has been identified for case management due to an admission, once the member discharges home (or to usual care setting), the CM performs the section 1.1 “Four Pillars” on the UCare General Assessment (2024 update)\* along with a medication reconciliation. This also applies to members already in case management who have admissions upon their return home/usual care setting. Delegates complete the UCare General Assessment (2024 update)\* or an assessment form (which contains the “Four Pillars” and med reconciliation) approved by UCare. \*Assessment found on the UCare.org website [UCare® - Care Coordination Medicare](https://www.ucare.org/providers/care-managers/medicare-resources) |
| **Advance****Directives** | The CM ensures advance directive are addressed or discussed with the member. Record of discussion is kept in the member record. |
| **Case Closure** | The CM closes the case when one of the following occurs:* Member goal(s) are met (or partially met and plateaued)
* Member declines further case management services
* Member becomes unreachable (follow unable to reach process above)
* Member transitions to Assisted Living or becomes institutionalized
* Member enrolls in hospice or expires
* Member disenrolls from a Case Management product (or if a Medicare member transitions to a

non-delegated care system)* Member disenrolls from UCare

 Upon closure, document status of any open goal(s) in the POC as well as noting reason case closed in the member record.  |
| **Policies and****Procedures** | All UCare delegates are required to have policies and/or procedures that support all the above stated requirements. |
| **Qualifications** | Current, active, and unrestricted licensure or certification in a health or human service discipline that allows the professional to conduct an assessment independently as permitted within the discipline’s scope of practice. |
|  **Reporting** |  Delegates submit a monthly roster of activity via secure email to nfarmer@ucare.org and jmilner@ucare.org. This includes:**Required Reporting:**1. Number of members with outreach (include UCare ID, First & Last Name, DOB)
2. Number of members actively participating in CM (include UCare ID, First & Last Name, DOB, Start Date,

 Closed date – if applicable) |

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| **Definitions/Acronyms** |
| **Term/Acronym** | **Definition** |
| **Active (case status)**  | Member consents to CM/actively participating in CM, has assessment completed and a plan of care with follow up scheduled. Members remain Active until Closed.  |
| **BH** | Behavioral Health |
| **Closed (case status)**  | Member had been Active, but CM case now closed (see “Case Closure” in Grid for reasons). |
| **DM** | Disease Management |
| **EMR** | Electronic Medical Record |
| **PCC** | Primary Care Clinic |
| **PCP** | Primary Care Provider |
| **Resource Letter** | Product Specific “Resource Letter” is sent upon completion of member contact where resources or information is sent to the member. It contains a recap of what resources were needed/sent and the case manager’s contact information. The “Resource Letter” has been approved by UCare and our regulatory agencies. It is saved in the member record upon use. |
| **Screening Closed (case status)** | Initial outreach attempts completed but CM unsuccessful in reaching member, member declines services, termed/expired or member found to be generally inappropriate for CM. |
| **Screening Open (case status)** | Initial outreach to members for CM. These efforts are generally overview of program and for determining interest to engage in CM |
| **SMART goal** | Specific to the member’s situation/needs, Measurable, Attainable/Realistic to member’s situation, & Timebound |
| **Unable to Reach Letter** | Product specific “Unable to Reach Letter” sent after 2 unsuccessful phone attempts (different days/times of the day) to reach members. The “Unable to Reach Letter” has been approved by UCare and our regulatory agencies. It is saved in the member record upon use. |
| **UR** | Utilization Review |
| **Welcome Letter** | Product specific “Welcome Letter” sent prior to or immediately upon engaging contact with member. Welcome letter is an NCQA requirement (all levels of case management) that lists how members were identified for case management, what services they receive/how to use them, how to opt in/out. The “Welcome Letter” has been approved by UCare and our regulatory agencies. It is saved in the member record. |