Minnesota Senior Care Plus (MSC+) and Minnesota Senior Health Options (MSHO)
Care Coordination Requirements for Community Members
Effective 01.01.2023

All Minnesota Senior Care Plus (MSC+) members and Minnesota Senior Health Options (MSHO) members are automatically assigned a Care Coordinator and receive care coordination until disenrollment. The assigned Care Coordinator (CC) must meet the definition of a Qualified Professional*. Care coordination services incorporate case management and consist of a comprehensive assessment of the member's condition, the determination of available benefits and resources, the development and implementation of an individualized Support Plan with performance goals, monitoring, and follow-up, as described in the grid below.

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; and all DHS Bulletins can be found HERE.

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

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<tr><th></th><th>Community Non-Elderly Waiver Members
Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI*</th><th>Community Elderly Waiver Members</th></tr>
<tr><td>Initial Assignment</td><td colspan="2">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 calendar days of initial assignment.
This may be done by phone or letter and must be documented in the case record. If contact is by letter, the CC must use UCare's approved MSHO/MSC+ 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, and one for members on CAC/CADI/DD/BI.
Contact the member within 30 days of enrollment*/assignment* to complete tasks based on if the member is transferring (either Transferred from FFS*/Different MCO* or Transferred Members from a UCare Delegate) – 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, face-to-face, 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.</td></tr>
<tr><td colspan="3">ASSESSMENTS</td></tr>
<tr><td rowspan="2">New Member / Initial Assessment</td><td colspan="2">A member that is newly enrolled on UCare MSC+/MSHO AND has not had a previous MSC+/MSHO assessment entered in MMIS* within the last 365 days. SNBC members aging into MSC+/MSHO are considered a New Member and need a DHS-3428 or DHS-3428H 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.</td></tr>
<tr><td>The CC is required to:
Complete an assessment, following one of the two scenarios.
For CAC/CADI/DD/BI members OR community members not receiving PCA services: Conduct an initial face-to-face by the 30th day of the month of enrollment, using the DHS-3428H Health Risk Assessment.(Phone HRA is acceptable for MSC+ only.)</td><td>The CC is required to:
Conduct an initial face-to-face assessment by the 30th day of the month of enrollment, using the DHS-3428 Long-Term Care Consultation (LTCC) for members on Elderly Waiver.
All DHS-3428 fields must be completed entirely or noted as not applicable.</td></tr>
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	Community Non-Elderly Waiver Members Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI*	Community Elderly Waiver Members
	NOTE: If the member is CAC/CADI/DD/BI, contact the Waiver Case Manager to request current MnCHOICES* and CSSP*. **-OR-** For community members receiving only PCA services: Conduct an initial face-to-face by the 30th day of the enrollment month, using the DHS-3428 *Long-Term Care Consultation (LTCC)* and DHS-3428D *PCA Assessment*. **Both scenarios require these tasks:** • All DHS-3428/3428H fields must be completed entirely or noted as not applicable. • Have Safe Disposal of Medications* conversation and complete follow up tasks. • Complete DHS-3426 *OBRA Level I* assessment. • Develop a person-centered Care Plan. • Enter the assessment data in MMIS* within 30 calendar days of the assessment date. • If the CC completed a PCA Assessment, complete a DHS-4690 and send it to the PCP. • Enter the assessment on the Monthly Activity Log. • If the member or member's representative* requests a LTCC to determine EW* eligibility, the LTCC must be completed within 20 calendar days of the request. **NOTE:** If a new member is Unable to Reach or Refusal, refer to the respective sections.	• Use DHS-3428D *PCA Assessment* if member requests or is receiving PCA services. ○ If the CC completed a PCA Assessment, complete a DHS-4690 and send it to the PCP. • Reference DHS-7028 *Nursing Facility Level of Care Criteria Guide* to determine institutional level of care (LOC) and Elderly Waiver eligibility. • Have Safe Disposal of Medications* conversation and complete follow up tasks. • Complete DHS-3426 *OBRA Level I* assessment. • Develop a person-centered Care Plan. • Enter the assessment data in MMIS* within 30 calendar days of the assessment date. Be mindful of entering by 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 "Prefer to live somewhere else" or "Don't know" on question E.13 of the LTCC, complete a Transition Plan using DHS-3936 *My Move Plan Summary*. **NOTE:** If a new member is Unable to Reach or Refusal, refer to the respective sections.

	Community Non-Elderly Waiver Members Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI*	Community Elderly Waiver Members
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). SNBC members aging into MSC+/MSHO are considered a New Member and need a DHS-3428 or DHS-3428H assessment.	

	The CC is required to:
	• Conduct an assessment by the 30th day of the month of enrollment*.
	  ○ Determine type of assessment using criteria listed below (THRA or initial assessment).
	• If the member is CAC/CADI/DD/BI and does NOT have a 3428H and Care Plan, follow New Member/Initial Assessment section.
	
	A Transfer 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 Care Plan/Support Plan *with* the signed Care Plan/CSP Signature Page. The THRA may be completed face-to-face or by phone. The recent assessment can be either DHS-3428, DHS-3428H, or MnCHOICES*, or verification of a face-to-face assessment entered into MMIS* within the past 365 days using Activity Type 02 or 06 indicating a face-to-face assessment. **NOTE:** If MMIS is being used, the full MMIS entry must be in the member's file, not just the first page.
	  ○ A THRA includes a verbal review of the assessment and Care Plan by the CC *with* the member. The review must include pertinent areas of the DHS-3428 or DHS-3428H form, or MnCHOICES (at a minimum, review the areas that are required for a MMIS entry). The review should also include any questions that are pertinent to completion of an effective care plan. (The DHS-3427T *Telephone Screening* is NOT appropriate because it does not include review of ADLs).
	  ○ Enter data in MMIS within 30 days of the assessment.
	  ○ Enter the THRA on the Monthly Activity Log.
	  ○ **NOTE:** If the member is unable to be reached or refuses the THRA, the existing Care Plan/Support Plan can still be updated in lieu of completing a full Unable to Reach Support Plan or Refusal Support Plan.
	
	A DHS-3428 or DHS-3428H is required when: The new (receiving) CC does NOT receive the most recent assessment OR does not receive the most recent Care Plan/Support Plan *with* the signed Care Plan Signature Page. The missing recent assessment is either DHS-3428, DHS-3428H, or MnCHOICES, and/or the CC cannot verify that a face-to-face assessment has been conducted within the past 365 days by checking MMIS.	

<table>
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Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI*</th><th>Community Elderly Waiver Members</th></tr>
<tr><td></td><td colspan="2">○ This scenario requires a full face-to-face assessment. (If completing an MSC+ assessment for non-waivered, non-PCA, a 3428H can be conducted via face-to-face or by phone).
○ Enter the assessment data in MMIS within 30 days of the assessment.
○ Develop a new person-centered Care Plan.
○ 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.</td></tr>
<tr><td rowspan="2">Transferred Members from a UCare Delegate</td><td colspan="2">A member that previously received care coordination from a UCare delegate and had an assessment entered into MMIS* within the last 365 days. For example, the transfer is between one delegate to another within UCare (Genevive to UCare; UCare to Fairview; Catholic Charities to Genevive) and the member was on MSC+/MSHO with the previous delegate.</td></tr>
<tr><td colspan="2">The previous (sending) 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: the current assessment (MnCHOICES*, 3428, 3428H), OBRA Level I, Care Plan/Support Plan with the signed Care Plan Signature Page, DHS-3428Q Evaluation (if applicable), DHS-3428D PCA Assessment with signature page, and other applicable documents.
• Care Coordination Contact List is located on the UCare website.

Upon receipt of all applicable transfer paperwork, the new (receiving) CC is required to complete the following steps by the 30th day of the month of assignment:
• Ensure that the member had an assessment within 365 days.
• Review the Care Plan/Support Plan and provided assessment (or MMIS* screen) with the member over the phone or face-to-face.
• Complete the Transfer Member Health Risk Assessment (THRA) form and attach to the most current assessment.
• Update CC information in MMIS* within 30 days of activity date.
• Enter the assessment on the Monthly Activity Log.
• If the member is CAC/CADI/DD/BI, contact the Waiver Case Manager to request current MnCHOICES and CSSP* (if not already provided in the transfer).
NOTE: If the member is unable to be reached or refuses the THRA, the active Care Plan can still be updated in lieu of completing a full Unable to Reach Support Plan or Refusal Support Plan. The assessment timeline does not start over.</td></tr>
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	Community Non-Elderly Waiver Members Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI*	Community Elderly Waiver Members
	A DHS-3428 or DHS-3428H is required when: The new (receiving) CC does NOT receive the most recent assessment OR does not receive the most recent Care Plan/Support Plan *with* the signed Care Plan Signature Page. The missing recent assessment is either DHS-3428, DHS-3428H, or MnCHOICES, and/or the CC cannot verify that a face-to-face assessment has been conducted within the past 365 days by checking MMIS. • Complete a full face-to-face assessment. (If completing an assessment for non-waivered, non-PCA a 3428H can be conducted via face-to-face or by phone). • Enter the assessment data in MMIS* within 30 days of assessment. • Develop a new Care Plan. • Enter the assessment on the Monthly Activity Log. • If the member requires a full assessment but is Unable to Reach or is a Refusal, refer to the respective sections.	
Annual Reassessment	**The CC is required to:** • Complete reassessment, following one of the two scenarios. **NOTE:** When a reassessment is following an initial UTR/Refusal the Reassessment Due Date* is based on member initial enrollment date. This is only applicable to the first reassessment following an initial UTR/Refusal. For CAC/CADI/DD/BI members or community members not receiving PCA services: • Conduct a face-to-face or phone assessment within 365 days of the prior assessment using the DHS-3428H. ○ If the member is CAC/CADI/DD/BI, contact the Waiver Case Manager to request current MnCHOICES* and CSSP*. **-OR-** For community members receiving PCA services: • Conduct a face-to-face assessment within 365 days of the prior assessment using the DHS-3428.	**The CC is required to:** • Conduct a face-to-face assessment within 365 days of the prior assessment using the DHS-3428. **NOTE:** When a reassessment is following an initial UTR/Refusal the Reassessment Due Date* is based on member initial enrollment date. This is only applicable to the first reassessment following an initial UTR/Refusal. ○ All DHS-3428 fields must be completed entirely or noted as not applicable. • For members attending an adult day center or residing in a customized living or foster care facility, complete the DHS-3428Q *Evaluation* with the member and enter data into MMIS*. • Use DHS-3428D *PCA Assessment* if member requests or is receiving PCA services. ○ If the CC completed a PCA Assessment, complete a DHS-4690 and send it to the PCP. • Reference DHS-7028 *Nursing Facility Level of Care Criteria Guide* to determine institutional level of care (LOC) and Elderly Waiver eligibility.

	Community Non-Elderly Waiver Members Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI*	Community Elderly Waiver Members
	• Complete DHS-3428D *PCA Assessment*. **Both scenarios require these tasks:** • All DHS-3428/3428H fields must be completed entirely or noted as not applicable. • Have Safe Disposal of Medications* conversation with member and complete follow up tasks. • Complete a DHS-3426 *OBRA Level I*. • Close out the previous year's Care Plan (or UTR*/Refusal Support Plan and THRAs) by updating the column "Date Goal Achieved/Not Achieved," including a month and year. Retain in member record. • Develop a new Care Plan with new and ongoing goals. • If the CC completed a PCA Assessment, complete a DHS-4690 and send it to the PCP. • Enter the assessment data into MMIS* within 30 calendar days of reassessment. • Enter the reassessment on the Monthly Activity Log. **NOTE:** If member is Unable to Reach or Refusal for their annual reassessment, refer to the respective sections.	• Have Safe Disposal of Medications* conversation with member and complete follow up tasks. • Complete an DHS-3426 *OBRA Level I*. • Close out the previous year's Care Plan (or UTR*/Refusal Support Plan and THRAs) by updating the column "Date Goal Achieved/Not Achieved," including a month and year. Retain in member record. • Develop a new Care Plan with new and ongoing goals. • Enter the assessment data into MMIS* within 30 calendar days of reassessment. **For members on Elderly Waiver, assessments should be entered into MMIS prior to the 1st Capitation Date*.** • Enter the reassessments on the Monthly Activity Log. **NOTE:** If the member is open to EW*, or will be opened to EW, and indicates "Prefer to live somewhere else" or "Don't know" on question E.13 of the LTCC, complete a Transition Plan using DHS-3936 *My Move Plan Summary**. **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/service. NOTE: Completing a Caregiver Assessment is applicable to members who require a DHS-3428 assessment.	

	Community Non-Elderly Waiver Members Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI*	Community Elderly Waiver Members
	If a caregiver is identified in the DHS-3428 Section "E" caregiver supports/social resources, then the CC is required to: • Complete the DHS-3428 Section "O" Informal Caregiver Assessment section. • If caregiver needs are identified, incorporate them into the Care Plan. • Document if the caregiver declines the assessment. • Indicate "Not Applicable" in Section "O" if a caregiver is not identified. • Ensure the Informal Caregiver Assessment section is complete at the next annual reassessment if the DHS-3428 is received during a transfer. • If a caregiver is identified, the CC must document at least two attempts to complete the Informal Caregiver Assessment. It can be done during the face-to-face visit, a paper copy can be left after the face-to-face visit to be completed and returned to CC, it can be completed over the phone, or mail/email another copy to the caregiver. A follow up phone call or email is encouraged if the initial paper copy was left or mailed, or a copy was emailed.	
OBRA Level I Assessment	**The CC is required to**: • Complete a DHS-3426 *OBRA Level I* assessment for all members at the time of a DHS-3428 and DHS-3428H. **NOTE:** This is not required for members on a CAC/CADI/DD/BI waiver.	
Product Changes	An existing UCare member has a Product Change from MSC+ to MSHO, or MSHO to MSC+. 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.	
	The CC is required to: • If the CC has changed, provide the member with the name and telephone number of the new CC within 10 calendar days of initial assignment. Initial assignment is the first day the care system or county receives the enrollment list. This may be done by phone or letter and must be documented in the case record. If contact is by letter, the CC must use UCare's approved MSC+/MSHO *Welcome Letter* found on the UCare website. • Complete the THRA* within 30 calendar days of enrollment and attach it to the most current DHS-3428/3428H or MnCHOICES*. This may be conducted via phone or in person. • Make 4 actionable attempts to reach the member. • Review the Care Plan and update as necessary. • Enter the assessment into MMIS* within 30 days of assessment.	

	Community Non-Elderly Waiver Members Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI*	Community Elderly Waiver Members

	• Enter the Product Change assessment on the Monthly Activity Log.
	• If the member is unable to be reached or refuses the THRA, the current Care Plan/Support Plan can still be updated in lieu of completing a full Unable to Reach Support Plan or Refusal Support Plan.
	  ○ **NOTE:** The annual reassessment date does not change. The MMIS Entry is still needed to represent the change of product.
	• If there is **no previous** DHS-3428, DHS-3428H, or MnCHOICES* completed within 365 days, a new DHS-3428 or DHS-3428H is required by the 30th day of the month of enrollment for the new product. If this is the case and the member is 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. The MMIS Entry would be entered per the UTR/Refusal requirements.	

Unable to Reach	**Initial Enrollment and/or Assignment: If member is unable to be reached within 30 days of initial enrollment and/or assignment, the CC is required to:**
	• 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.
	• If the member has an existing Care Plan (including an existing UTR/Refusal Support Plan), update it in lieu of completing a new Unable to Reach Support Plan. If the member has no existing Care Plan/Support Plan, complete an Unable to Reach Support Plan and attach it in the member's file within 30 days of the Activity Date.
	  ○ The UTR Support Plan must have at least one high priority goal. All sections must be completed or marked as not applicable.
		Initial Enrollment and/or Assignment: If member is unable to be reached within 30 days of initial enrollment and/or assignment, the CC is required to:
		• Make 4 actionable attempts* to reach the member within 30 days of the enrollment date. Document all activities to obtain a working phone number for the member.
		  ○ **NOTE:** Investigative research* is not considered an actionable attempt.
		• Update the Care Plan to show that member was unable to be reached, in lieu of creating an Unable to Reach Support Plan.
		• 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 primary care physician.
		
		Annual Reassessment: If member is Unable to Reach within 365 days from the date of last assessment, the CC is required to:
		• Make 4 actionable attempts* to reach the member. Document all activities to obtain a working phone number for the member.

	Community Non-Elderly Waiver Members Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI*	Community Elderly Waiver Members

	• Enter data into MMIS* within 30 days of the Activity Date. The Activity Date and Effective Date will be the date of the 4th attempt CC made to reach the member.
	• 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 primary care physician **IF** known/confirmed.
	
	Annual Reassessment: If the member is Unable to Reach for their annual assessment, the CC is required to:
	• Complete assessment within 365 days from the original enrollment date and every 365 days thereafter.
	  ○ Example: Member enrolls new to UCare 01/01/22 and is Unable to Reach after 4 attempts on 01/27/22, member's annual assessment is due PRIOR to 12/31/22 (all 4 contact attempts must be completed by 12/31/22).
	• Make 4 actionable* contact attempts to reach the member. Document investigative research*.
	• Complete an Unable to Reach Support Plan and attach it in the member's file.
	  ○ The UTR Support Plan must have at least one high priority goal. All sections must be completed or marked as not applicable.
	• Enter data into MMIS* within 30 days of the Activity Date. The Activity Date and Effective Date will be the date of the 4th attempt CC made to reach the member.
		• Complete an Unable to Reach Support Plan and attach in the member's file within 30 days of the Activity Date.
		  ○ The UTR Support Plan must have at least one high priority goal. All sections must be completed or marked as not applicable.
		• Send *Provider Engagement Letter* to member's primary care physician.
		• Enter the Unable to Reach in the Monthly Activity Log. Include dates of all attempts in provided columns.
		• 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.
		
		6 Month Review: If the member is unable to be reached at their 6 Month Review, the CC is required to:
		• Contact the member 6 months following the assessment date.
		• Make 4 actionable attempts* to reach the member.
		  ○ Update the Care Plan to show that member was unable to be reached, in lieu of creating an Unable to Reach Support Plan.
		• See section 6 Month Review and Ongoing Care Plan Updates for more instruction.

	Community Non-Elderly Waiver Members Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI*	Community Elderly Waiver Members
	• Send *Provider Engagement Letter* to member's primary care physician **IF** known/confirmed. • Enter the Unable to Reach in the Monthly Activity Log. Include dates of all attempts in provided columns. **6 Month Review for a member that was Unable to Reach for their annual and currently have an active Unable to Reach Support Plan, the CC is required to:** • Contact the member 6 months following the Unable to Reach assessment date. • Make 4 actionable attempts* to reach the member. • If reached, offer an Initial Assessment, and follow the respective steps. If the member cannot be reached again, update their current Unable to Reach Support Plan. ○ If the member is reached at the 6 Month Contact, and refuses the assessment, update the current Unable to Reach Support Plan. A new Refusal Support Plan is not needed. No new MMIS* Entry is needed. **6 Month Review for a member that had an assessment at their annual and currently have an active Care Plan, the CC is required to:** • Contact the member 6 months following the assessment date. • Make 4 actionable attempts* to reach the member. • Update the existing Care Plan to show that member was unable to be reached, in lieu of creating an Unable to Reach Support Plan.	

	Community Non-Elderly Waiver Members Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI*	Community Elderly Waiver Members
	NOTE: See section 6 Month Review and Ongoing Care Plan Updates for more instruction.	

Refusal	**Initial Enrollment and/or Assignment: If the member verbally refuses within 30 days of enrollment and/or assignment, the CC is required to:**
	• Document the conversation with the member regarding the refusal.
	• Document all attempts to reach the member within 30 days of the assignment.
	• If the member has an existing Care Plan (including an existing UTR/Refusal Support Plan), update it in lieu of completing a new Refusal Support Plan. If the member has no existing Care Plan/Support Plan, complete a Refusal Support Plan with as much information as possible (mark what is unknown) and attach it in the member's file within 30 days of the Activity Date.
	  ○ The Refusal Support Plan must have at least one high priority goal.
	• Enter MMIS* data within 30 days of Activity Date. The Activity Date is the date the CC spoke to the member.
	• Enter the Refusal on the Monthly Activity Log.
	• Send *Refusal Letter* to member.
	• Send *Provider Engagement Letter* to member's primary care physician **IF** known/confirmed.
	
	Annual Assessment: If a member verbally refuses an assessment, the CC is required to:
		Initial Enrollment and/or Assignment: If the member verbally refuses within 30 days of enrollment and/or assignment, the CC is required to:
		• Document the conversation with the member regarding the refusal.
		• Document all attempts to reach the member within 30 days of the enrollment and/or assignment.
		• Update the Care Plan to show that member refused, in lieu of creating a Refusal Support Plan.
		
		Annual Assessment: If a member verbally refuses an assessment within 365 days from the last assessment, the CC is required to:
		• Document all attempts to reach the member.
		• Complete a Refusal Support Plan reflecting completed attempts within 365 days of the last assessment and attach it in the member file within 30 days of the Activity Date.
		  ○ The Refusal Support Plan must have at least one high priority goal. All sections must be completed or marked as unknown.
		• 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.

	Community Non-Elderly Waiver Members Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI*	Community Elderly Waiver Members

	• Complete tasks within 365 days from the original enrollment date and every 365 days thereafter. For annual reassessments of members who have never had an assessment, all 4 contact attempts/outreach/refusal need to be completed within 365 days from the original enrollment date.
	  ○ Example: Member enrolls new to UCare 01/01/22 and is Refusal on 01/27/22, member's annual assessment is due PRIOR to 12/31/22 (all 4 contact attempts/outreach/refusal must be completed by 12/31/22).
	• Document the conversation with the member regarding the refusal.
	• Document all attempts to reach the member within 30 days of the enrollment and/or assignment.
	• Complete a Refusal Support Plan with as much information as possible (mark what is unknown) and attach in the member's file within 30 days of the Activity Date.
	  ○ The Refusal Support Plan must have at least one high priority goal.
	• Enter MMIS* data within 30 days of Activity Date. The Activity Date is the date the CC spoke to the member.
	• Send *Refusal Letter* to member.
	• Send *Provider Engagement Letter* to member's primary care physician **IF** known/confirmed.
	• Enter the Refusal on the Monthly Activity Log.
		• Send *Provider Engagement Letter* to member's primary care physician.
		• Enter the Refusal on the Monthly Activity Log.
		
		6 Month Review: If the member refuses to complete a 6 Month Review, the CC is required to:
		• Contact the member 6 Months following the assessment date.
		• Update the Care Plan to show that member refused, in lieu of creating a Refusal Support Plan.
		NOTE: See section 6 Month Review and Ongoing Care Plan Updates for more instruction.

	Community Non-Elderly Waiver Members Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI*	Community Elderly Waiver Members
	6 Month Review for a member that was a Refusal for their annual and currently have an active Refusal Support Plan, the CC is required to: • Contact the member 6 months following the Refusal assessment date to offer the Initial Assessment again. If member agrees, follow the Initial Assessment steps. • If member continues to refuse, update the current Refusal Support Plan. If a Refusal member is Unable to Reach at the 6 Month Review, update the current Refusal Support Plan. No new MMIS* Entry is needed. **6 Month Review for a member that had an assessment at their annual and currently have an active Care Plan, the CC is required to:** • Contact the member 6 months following the assessment date. • Update the Care Plan to show that member refused, in lieu of creating a Refusal Support Plan. **NOTE:** See section 6 Month Review and Ongoing Care Plan Updates for more instruction.	
CARE PLAN		
Care Plan	A Care Plan is required for all MSC+ and MSHO members regardless of Rate Cell* or waiver status. The CC creates, implements, and updates the Care Plan annually and completes a 6 Month Review. CC can find additional directions on the Care Plan Instructions located on the UCare website. 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 Care Plan requirement with their Unable to Reach Support Plan or Refusal Support Plan and do not need an additional Care Plan.	
	The CC is required to: • Close out the previous year's Care Plan (or UTR*/Refusal Support Plan) by updating the column "Date Goal Achieved/Not Achieved," including a month and year and if the goal will carry over to new Care Plan. Retain in member record.	

	Community Non-Elderly Waiver Members Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI*	Community Elderly Waiver Members

	• Develop a person-centered Care Plan with the member at the time of the initial and annual assessment using the My Care Plan and Community Support Plan form. Ensure all sections are completed.
	  ○ Care Plan must include the names and disciplines of members' Interdisciplinary Care Team (ICT)* as applicable.
	• Develop person-centered, prioritized goals on the Care 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 member safety plan 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 prioritized using high, medium, or low. At least one goal is ranked as high priority.
	• The Care Plan is shared within 30 calendar days of the assessment. Day 1 is the date of the assessment.
	  ○ Share with applicable ICT* members:
	  ▪ Member and/or representative*.
	  ▪ Primary Care Physician by fax or EMR*.
	  ▪ Waiver Case Manager (if CAC/CADI/DD/BI).
	  ▪ Elderly Waiver Providers per member's choice (see EW* Provider Signature Requirements section).	

Care Plan Signature Page	**The CC is required to:** • Obtain a signature from the member/representative* on the Care Plan to document that they have discussed their Care Plan with their CC. • The Care Plan is not considered valid unless signed and dated by the member/representative*. • Sign Care Plan Signature Page and include CC's credentials. • If the signature page is mailed to the member to obtain the signature, document the date of when the signature page was sent. ○ The CC is required to conduct at least one follow up attempt by phone within 2 weeks of the signature page being sent to the member if the signature page has not been returned to the CC. Document the dates of the follow up.	
6 Month Review and Ongoing Care Plan Updates	**The CC is required to:** • Maintain ongoing contact or check-in with the member at a minimum of every 6 months to update the Care Plan. This includes the Care Plan sections "Monitoring Progress/Goal Revision" and any sections titled "Update". ○ The contact may be by phone or face-to-face.	

	Community Non-Elderly Waiver Members Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI*	Community Elderly Waiver Members
	○ There is a 30-day leeway to complete the 6-Month Review of the Care Plan. Meaning, the 6-month contact is allowed any time 5-7 months from the last assessment date. ○ If the member is unable to be reached or refuses the 6 Month Review, the CC can update the existing Care Plan. 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 in the member's record. • 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 in the member's record. **NOTE:** Update the Care Plan every time services or goals are modified. Make an entry on the Monthly Activity Log under the appropriate columns to represent the Care Plan changes.	
Elderly Waiver Provider Signature Requirement	Not Applicable. **NOTE:** Community Non-EW members do not have this requirement, regardless of receiving PCA services, or services provided by their CAC/CADI/DD/BI waivers.	**The CC is required to:** • Give the member a choice of sending the full Care Plan, a summary of the Care Plan, or not sending the Care Plan to each of their service providers. ○ When sending a full Care Plan, it is accompanied with the *Provider Care Plan Cover Letter*. ○ When sending a Care Plan summary, it is accompanied with the *Provider Care Plan Summary Letter.* • Document member choice(s) on the Care Plan. • For providers receiving a full Care Plan or summary, the CC is required to obtain signatures from the providers within 60 days. **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

	Community Non-Elderly Waiver Members Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI*	Community Elderly Waiver Members
		(formerly called Tier 2) providers, as well as PCA providers only if the member is open to the waiver.
Change in Elderly Waiver Services and/or Providers	Not Applicable. **NOTE:** Community Non-EW members do not have this requirement, regardless of receiving PCA services, or services provided by their CAC/CADI/DD/BI waivers.	**If there is a change to a service or a provider in between the annual Care Plans, the CC is required to follow these Elderly Waiver Provider Signature requirements:** • Update the Care Plan with the change in all appropriate areas. • Send the member a *Member Change Letter* which requests the member's signature. • Offer the member a choice of sending the provider the full Care Plan, a summary of the Care Plan, or not sending the Care Plan at all. • Document member choice on the Care Plan. • 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 assessment 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. **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	Not Applicable.	The Case Mix is determined using the DHS-3428 assessment and used to complete the Care Plan Budget Worksheet. 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

	Community Non-Elderly Waiver Members Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI*	Community Elderly Waiver Members
		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 on the Monthly Activity Log, upon Product Changes and transfers from FFS/Other MCOs and between delegates. • Enter MSC+ and MSHO Care 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 6 Month Review and as a result of a Transition of Care. • 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.	
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.	

	MSHO MEMBERS - the CC is required to:
	• Assist with the member's planned and unplanned transitions from one care setting to another care setting.
	• **Within one business day of notification**, complete the **TOC* Log**, found on the UCare website along with TOC Log instructions.
	  ○ When reaching out to the member/representative* for TOC Log tasks, make and document 4 actionable attempts*.
	• Conduct a Change in Condition* assessment in the event of a care transition when a member experiences significant health changes, repeated or multiple falls, recurring hospital readmissions, or recurring emergency room visits.
	• If the TOC resulted in a change to member's services, goals, and/or needs, enter the Care 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 Care Plan.
	  ○ Provide education about how to prevent a readmission and document this discussion in the case notes.	

	Community Non-Elderly Waiver Members Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI*	Community Elderly Waiver Members
	○ 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. **MSC+ MEMBERS - the CC is required to:** • Follow-up with the member to discuss the transition, any changes to their health status, and/or changes to their Care Plan. Use Transition of Care Talking Points on the UCare website. • 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 Care Plan modifications on the Monthly Activity Log. • Conduct a Change in Condition* assessment in the event of a care transition when a member experiences significant health changes, repeated or multiple falls, recurring hospital readmissions, or recurring emergency room visits.	
Admissions over 30 Days	UCare completes **ALL Nursing Facility (NF)** OBRA/Pre-admission Screening and Resident Review (PASRR) activity internally. **The CC is required to:** • Monitor the Daily Authorization Report for admissions. • Assist with care transitions. • If the member is MSHO, complete a TOC* Log. • **If the member is admitted to a hospital or nursing facility longer than 30 days, 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. ○ 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 admission.** ○ Complete a DTR* for Elderly Waiver eligibility and 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 Change in Condition* is needed. ○ Submit a new WSAF* to restart waiver services for the partial waiver eligibility span.	

	Community Non-Elderly Waiver Members Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI*	Community Elderly Waiver Members
	• **If the admission stay is longer than 121 days and they discharge back to community:** ○ 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*. NOTE: 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. • Submit the DHS-5181 *Communication Form* to the County of Financial Responsibility (CFR).	**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).
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.	
Annual Preventive Care	The CC is required to: • Document on the Care Plan 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):** • If Elderly Waiver is requested and member does not meet Nursing Facility Level of Care (NF-LOC), complete a *DTR Notification Form* using reason code 1114.	**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.

	Community Non-Elderly Waiver Members Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI*	Community Elderly Waiver Members
	• If a member is receiving home health care services (e.g., PCA, HHA, and SNV) and the CC or member initiates a termination or reduction of those services. ○ For PCA DTRs, use the *PCA 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 within one business day of decision.	• If a member is receiving home health care services (e.g., PCA, HHA, SNV), and the CC or member initiates a termination or reduction of those services. ○ For PCA DTRs, use the *PCA 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 member is taking any medications, the CC is required to** complete the below tasks at time of member's Initial Assessment or Annual Reassessment (not required for UTR*/Refusals): • Discuss information from the *Dispose of Medications Safely* form with the member. Document the discussion by checking the box in the medications section of the Care Plan. • 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.	
Change in CC within the Same Entity	The new CC must notify the member of the CC's name and phone number within 10 calendar 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.	

	Community Non-Elderly Waiver Members Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI*	Community Elderly Waiver Members

Primary Care Clinic (PCC*) 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*s).**
	• 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.	

Financial Eligibility for Elderly Waiver Services	Not Applicable.	**The CC is required to:** • Verify member's financial eligibility for Elderly Waiver services prior to initiating the services.

	Community Non-Elderly Waiver Members Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI*	Community Elderly Waiver Members
		• 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 record.
Medical Assistance Eligibility Renewals	**The CC is strongly encouraged to:** • Remind members when they are at risk of losing MA* eligibility due to failure to complete and return 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 Grace Period After MA* Terms	**If a member's MA* terms, the CC is required to:** • Complete any assessments that are needed in the following 90 days. • Continue all care coordination tasks for the 90 days following MA termination. • Retain the completed assessment documents in the member record. • Enter the assessment data (and DHS-3428Q if applicable) into MMIS* when the member's MA is reinstated. • 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, 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.	
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 file.	

	Community Non-Elderly Waiver Members Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI*	Community Elderly Waiver Members
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 Care Plan. • Attach a signed copy to the Care Plan. Also maintain a copy in the member's file.	
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. ○ OBRA Level II referral for Mental Health and Developmental Disability. ○ 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.	

	Community Non-Elderly Waiver Members Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI*	Community Elderly Waiver Members
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, Care 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.	

*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.
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.
Change in Condition	UCare requires CCs to conduct an additional assessment in the event of a significant change in a member's condition, including care transitions that involved significant health changes, repeated or multiple falls, recurring hospital readmissions, or recurring emergency room visits. All CCs are Qualified Professionals*, and UCare depends on the use of their clinical, professional judgment to determine whether a change in condition or care transition warrants a reassessment. In addition, members, providers, family members, or others may request a comprehensive assessment, and UCare must provide this within 20 days of the request.
CSP/CSSP	Community Support Plan/Coordinated Services & Supports Plan:

	These forms are used following a MnCHOICES Assessment and document the services a person will use to meet their needs in order to remain in or return to the community.
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.
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.
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 every 6 months thereafter.
PCC	Primary Care Clinic
PCP	Primary Care Physician
Qualified Professional	Must hold a Minnesota licensure (Licensed Social Worker, Registered Nurse, Physician Assistant, Nurse Practitioner, Public Health Nurse, or physician) with the exception of County Social Worker, who are employed by the county.
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 verbally 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-sensitive. Find more information on the UCare website.
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.
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-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-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-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.