



**Minnesota Senior Health Options (MSHO) Care Coordination (CC)
and Minnesota Senior Care Plus (MSC+) Community
Case Management (CM) Requirements
Updated 3.15.2021**

All Minnesota Senior Health Options (MSHO) members and Minnesota Senior Care Plus (MSC+) members are automatically enrolled in care coordination and receive care coordination until disenrollment. The assigned Care Coordinator (CC) must meet the definition of a “qualified professional”. Care coordination/case management 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 a person centered care plan with person centered measurable goals, and monitoring and follow-up, as described in the grid below.

*Please refer to the DHS eDocs Form Names Grid on last page for DHS form names and information.
All related UCare forms can be found, [HERE](#), all DHS forms can be found [HERE](#), all DHS Bulletins can be found [HERE](#).

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Initial Assignment	Upon receiving the monthly enrollment roster, the Care Coordinator (CC) is required to provide the member with the name and telephone number of the CC within 10 calendar days of initial assignment. Initial assignment is the first day the care system or county receives the care coordination enrollment roster. 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 Letters” found on UCare’s website.		
Initial Contact	The CC is required to: Make a minimum of 4 attempts to contact the member within the month of enrollment. Contacts may be by phone, face-to-face, on different days, and at different times, and/or by using the “Unable to Contact Letter” on UCare’s website. At a minimum, the documentation must include at least 3 phone call attempts to reach the member and documentation that a follow-up letter to reach the member was sent. (Sending the “Welcome Letter” is not considered an attempt to contact the member).		
Assessment Section			
New Member- This is a member that is newly enrolled on MSC+/MSHO with UCare AND has not had a previous MSC+/MSHO HRA entered into MMIS within the last 365 days. SNBC members who just turned 65 are considered New and need a full MSHO/MSC+ HRA.	<p>The CC is required to:</p> <ul style="list-style-type: none"> • Contact the member per the “Initial Assignment” and “Initial Contact with Member” section • Conduct an initial face-to-face HRA within the month of enrollment, but not to exceed 30 days, using the DHS-3428H for Rate Cell A members (not receiving PCA services) <p style="text-align: center;">OR</p> <p>Conduct an initial face-to-face for Rate Cell A members receiving PCA services within the month of enrollment, but not to exceed 30 days, using the Long Term Care Consultation (LTCC)/DHS-3428</p> <ul style="list-style-type: none"> ○ When completing the assessment, all questions and sections must be 	<p>The CC is required to:</p> <ul style="list-style-type: none"> • Contact the member per the “Initial Assignment” and “Initial Contact with Member” section • Conduct an initial face-to-face HRA within the month of enrollment, but not to exceed 30 days, using the Long-Term Care Consultation (LTCC)/DHS-3428 for members on EW. When completing the LTCC, all questions and sections must be completed or marked as “not applicable”, including the caregiver support section, if section “E” states “yes” to a caregiver. • Develop a collaborative care plan – see POC section • Complete an OBRA Level I assessment. • Enter the HRA in MMIS within 30 calendar days of the assessment date. • Enter the assessment on the MSHO Part C Assessment Log • Complete the <i>My Move Plan Summary document</i> DHS-3936 form if a 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 and has a destination to move to. 	

	<p>completed or marked as “not applicable”</p> <ul style="list-style-type: none"> • Develop a person-centered collaborative care plan – see POC section • Complete an OBRA Level I assessment. • Enter the HRA in MMIS within 30 calendar days of the assessment date. • Enter the assessment on the MSHO Part C Assessment Log <p>See section “Unable to Contact” or “Refusal” if applicable.</p>	<ul style="list-style-type: none"> • If a member or member’s rep. request a HRA to determine EW eligibility, the HRA must be completed within 20 calendar days of the request. • See section “Unable to Contact” or “Refusal” if applicable.
<p>Transferred Members from FFS or a Different MCO- These are members who are new or re-enrolled with UCare, coming from FFS or a different MCO.</p>	<p>The CC is required to:</p> <ul style="list-style-type: none"> • Contact the member per the “Initial Assignment” and “Initial Contact with Member” sections • Conduct an HRA within the month of enrollment, but not to exceed 30 days (see below to determine criteria for a face to face vs. telephonic assessment. If telephonic, the Transitional HRA may be used.) • To meet the HRA requirement with a telephonic assessment, the CC is required to: • Receive and review with the member, the following information from the previous care coordination entity: <ul style="list-style-type: none"> ○ The most recent copy of the DHS-3428, DHS-3428H or MnCHOICES summary or verification of a face-to-face HRA entered into MMIS within the past 365 days with an activity type 02 or 06 (indicating a face-to-face assessment). The full MMIS entry must be in the member’s file, not just the first page. <ul style="list-style-type: none"> ▪ The review must include pertinent areas of the DHS-3428 or DHS-3428H form (at a minimum, review the areas that are required for MMIS entry). The review should also include any questions that are pertinent to completion of an effective care plan. (The DHS-3427T form -Telephone Screening Document is NOT appropriate because it does not include review of ADLs). <p style="text-align: center;">- AND -</p> • The most recent POC, signed by the member. • Update the CC information in MMIS. • The CC is required to conduct a face-to-face HRA using DHS-3428 or the 3428H (depending on needs of the member) and POC when: 	

	<ul style="list-style-type: none"> • The CC does not receive a previous LTCC, DHS-3428H or MnCHOICES summary, and/or cannot verify that a face-to-face HRA has been conducted within the past 365 days -ex: by checking MMIS, -OR- • The CC does not receive a copy of the signed POC. <p>If the necessary documents were not received, CC is required to:</p> <ul style="list-style-type: none"> • Conduct the HRA face to face. • Enter the HRA into MMIS within 30 calendar days of the assessment date. • Complete a new POC using the Collaborative Care Plan Form, following all requirements stated in the Collaborative Plan of Care section of this document. • Enter the assessment on the Part C Assessment Log for MSHO members. <p>See section “Unable to Contact” or “Refusal” if applicable.</p> <ul style="list-style-type: none"> • If CC receives a valid POC that includes member signature, it can be updated in lieu of completing an “Unable to Contact” or “Refusal” POC.
<p>Transferred Members (from a UCare delegate) – This is when a UCare member that previously received case management from a UCare delegate (transfers from one delegate to another in the same health plan, e.g., Genevive to UCare; UCare to Fairview); and had an HRA entered into MMIS within the last 365 days.-</p>	<p>The CC is required to:</p> <ul style="list-style-type: none"> • Complete the DHS-6037 transfer form (the sender) and send via fax or secure email with the most recent assessment (e.g. MnCHOICES, LTCC, 3428H), OBRA Level I, POC, signed POC signature page, electronic version of the CL tool, DHS-3428Q (if applicable), electronic version of the PCA assessment with signature page, and other applicable case documents, to the new CC delegate (receiver) as soon as the enrollment with the new delegate occurs. For members on the monthly enrollment list that need to be transferred, the CC is required to send the DHS-6037 transfer form and supporting documentation to the new CC by the 15th of the month. <p>Upon receipt or verification of the transfer paperwork, the CC is required to:</p> <ul style="list-style-type: none"> • Contact the member per the “Initial Assignment” and “Initial Contact with Member” sections • Ensure that the member has a face-to-face reassessment within 365 days of the prior assessment. • Review the POC, HRA/LTCC assessment or MMIS screen with the member over the phone or face-to-face and document the discussion within 30 days. • Complete the Transitional Health Risk Assessment form and attach to the most current assessment (e.g. MnCHOICES, LTCC, and 3428H). • Update the CC information in MMIS. <p>The CC <u>is required to conduct a face-to-face HRA</u> using DHS-3428 or the 3428H (depending on needs of the member) and POC when:</p>

	<ul style="list-style-type: none"> • The CC does not receive a previous LTCC, DHS-3428H or MnCHOICES summary, and/or cannot verify that a face-to-face HRA has been conducted within the past 365 days -ex: by checking MMIS, ---OR- • The CC does not receive a copy of the signed POC. <p>If the necessary documents were not received, CC is required to:</p> <ul style="list-style-type: none"> • Conduct the HRA face to face. • Enter the HRA into MMIS within 30 calendar days of the assessment date. • Complete a new POC using the Collaborative Care Plan Form- see POC section • Enter the assessment on the Part C Assessment Log for MSHO members. • See section “Unable to Contact” or “Refusal” if applicable. <ul style="list-style-type: none"> ○ If CC receives a valid POC that includes member signature, it can be updated in lieu of completing an “Unable to Contact” or “Refusal” POC. 	
Care System or County PCC/Care Coordination Change	<p>The current CC completes the following:</p> <ul style="list-style-type: none"> • Confirm PCC with the member: <ul style="list-style-type: none"> ○ Reviewing EMR’s or Internal Systems to see if the member has established care is not sufficient. Confirmation needs to be a verbal discussion with the member and documented as such. ○ If the member states they plan to establish care with a new PCC, UCare expects the receiving CC to work with the member in scheduling the appointment to establish care. ○ <i>Ensure the PCC is in UCare’s provider network, if not, the current CC should work with the member to establish care at an in-network provider, prior to completing a PCC change form.</i> • Ensure the member does not have a future end date as members with future end dates cannot be transferred. • 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 sending CC if the transfer has been denied. • The sending entity is responsible for care coordination until the transfer effective date indicated on the PCC Change Request form. • The sending CC sends the DHS-6037 and accompanying transfer documentation to the receiving entity. • All required assessments and corresponding paperwork/documentation are expected to be fully completed prior to a transfer. • Delegates are required to reconcile their care coordination enrollment rosters on a monthly basis. 	
Annual Reassessment	<p>The CC is required to:</p> <ul style="list-style-type: none"> • Conduct a face-to-face HRA within 365 days of the prior assessment 	<p>The CC is required to:</p> <ul style="list-style-type: none"> • Conduct a face-to-face HRA within 365 days of the prior assessment using the Long-Term Care Consultation

	<p>using the DHS-3428H for Rate Cell A members (not receiving PCA services)</p> <p style="text-align: center;">OR</p> <p>Conduct an initial face-to-face for Rate Cell A members receiving PCA services within 365 days of the prior assessment using the Long Term Care Consultation (LTCC)/DHS-3428</p> <ul style="list-style-type: none"> ○ When completing the assessment, all questions and sections must be completed or marked as “not applicable” <ul style="list-style-type: none"> ● Close out the previous year’s POC by updating the column “Date Goal Achieved/Not Achieved” with a month and year documented and retained in member record. ● Develop a new POC with new and ongoing goals– See POC section ● Complete an OBRA Level I assessment. ● Enter the HRA into MMIS within 30 calendar days of reassessment. ● Enter all MSHO reassessments on the monthly Part C Assessment Log. <p>See “Unable to Contact” or “Refusal” section if applicable.</p>	<p>(LTCC)/DHS-3428 for members on EW. When completing the LTCC, all questions and sections must be completed or marked as “not applicable”, including the informal care giver assessment, if section “E” states “yes” to a caregiver.</p> <ul style="list-style-type: none"> ● Complete the DHS-3936 form if a 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 and has a destination to move to. ● Complete and enter into MMIS the DHS-3428Q for members attending an adult day center or residing in a customized living or foster care facility. ● Close out the previous year’s POC by updating the column “Date Goal Achieved/Not Achieved” with a month and year documented and retained in member record. ● Develop a new POC with new and ongoing goals– See POC section ● Complete an OBRA Level I assessment. ● Enter the HRA into MMIS within 30 calendar days of reassessment. For members on elderly waiver, assessments should be entered into MMIS prior to the capitation date. ● Enter all MSHO reassessments on the monthly Part C Assessment Log. <p>See section “Unable to Contact” or “Refusal” if applicable.</p>
<p>Caregiver* Support</p>	<p>*A caregiver is a non-paid person that, without their help, paid services would have to be put into place, and also someone who provides care beyond reimbursed hours/service.</p>	

	<p>If a caregiver is identified in the caregiver supports/social resources section “E” of the LTCC, the CC is required to:</p> <ul style="list-style-type: none"> • Complete the caregiver assessment section “O” of the LTCC; and incorporate caregiver needs into the POC, if needs are identified. • Document if the caregiver declines the assessment. • Indicate “NA” (not applicable) in the caregiver assessment section of the LTCC if a caregiver is not identified. • Ensure the caregiver assessment section is complete at the next annual reassessment if the LTCC is received during a transfer. <p>If the caregiver assessment is not completed during the face-to-face visit, the CC must document AT LEAST one attempt to call the caregiver to request it be returned, mail an additional copy if needed, or complete the caregiver assessment via phone.</p>
<p>OBRA Level I Assessment</p>	<p>The CC is required to complete an OBRA Level I assessment for all members at the time of any LTCC assessment. (This is not required for members on a CAC/CADI/DD/BI waiver).</p>
<p>Product Changes- This is when an existing UCare member has a product change- (includes going from MSC+ to MSHO, or vice versa only). If there is a change in CC delegate, refer to the “Transferred Members” section above. SNBC to MSC+/MSHO will show as a product change on care coordination enrollment rosters- refer to “New Member” process.</p>	<p>The CC is required to:</p> <ul style="list-style-type: none"> • Provide the member with the name and telephone number of the CC within 10 calendar days of initial assignment, if the CC has changed. 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 MSHO/MSC+ “Welcome Letters” found on UCare’s website. • Complete the Transitional Health Risk Assessment and attach it to the most current LTCC or DHS-3428H. This may be conducted via phone, or in person. • Review the POC and update as necessary. • Enter the assessment into MMIS. • Document all product change assessments on the Part C monthly log for MSHO members. • If there is no previous LTCC, DHS-3428H, or MnCHOICES assessment completed within 365 days a new LTCC/DHS-3428H is required within 30 days of enrollment in the new product. • See section “Unable to Contact” or “Refusal” if applicable. <ul style="list-style-type: none"> ○ If CC receives a valid POC that includes member signature, it can be updated in lieu of completing an “Unable to Contact” or “Refusal” POC.

<p>Unable to Contact</p>	<p>If the CC is unable to contact the member or the member was not located within 30 days of the enrollment date, or within 365 days from the last assessment, the CC is required to:</p> <ul style="list-style-type: none"> • Document all 4 attempts to reach the member within 30 days of the enrollment or before the 365th day of the last assessment. • At least 3 of these attempts must be made by phone. A good faith effort should be made to obtain a working phone number for the member. • Complete an “Unable-to-Contact Outreach Care Plan” and attach it in the member’s file. • Complete an MMIS entry, using the “H” screen with the activity date as the date the CC completed all 4 attempts to reach the member. • Attempt to reach the member again in 6 months. <p>Enter an unable to contact event on the Monthly Part C assessment log for MSHO members.</p>	<p>If the CC is unable to contact the member or the member was not located within 30 days of the enrollment date, the CC is required to:</p> <ul style="list-style-type: none"> • Document all 4 attempts to reach the member within 30 days of the enrollment. • At least 3 of these attempts must be made by phone. A good faith effort should be made to obtain a working phone number for the member. • Complete an “Unable-to-Contact Outreach Care Plan” and attach it in the member’s file. • Attempt to reach the member again in 6 months. • Enter an unable to contact event on the Monthly Part C assessment log for MSHO members. <p>If the CC is unable to contact the member or the member was not located within 365 days from the last assessment, the CC is required to:</p> <ul style="list-style-type: none"> • Document all 4 attempts to reach the member before the 365th day of the last assessment. • At least 3 of these attempts must be made by phone. A good faith effort should be made to obtain a working phone number for the member. • Complete an “Unable-to-Contact Outreach Care Plan” reflecting completed attempts within 365 days of the last assessment and attach it in the member’s file. • Complete MMIS entry to exit member from EW effective the last day of the month the member is eligible for EW, and follow DTR process. • Enter an unable to contact event on the Monthly Part C assessment log for MSHO members. <p>Attempt to reach the member again in 6 months to offer an assessment</p>
<p>Refusal</p>	<p>If a member verbally refuses an assessment, the CC is required to:</p> <ul style="list-style-type: none"> • Document the conversation with the member regarding the refusal. 	<p>If a member verbally refuses an assessment within 30 days of the enrollment date, the CC is required to:</p> <ul style="list-style-type: none"> • Document all attempts to reach the member within 30 days of the enrollment.

	<ul style="list-style-type: none"> • Complete a “Refusal Care Plan” with as much information as possible about what is important to the member and attach it in member file. • Complete an MMIS entry annually in the “H” screen with the activity date as the date the CC spoke to the member. • Attempt to reach the member again in 6 months. <p>Enter a” refusal” on the Monthly Part C Assessment Log for MSHO members.</p>	<ul style="list-style-type: none"> • Complete a “RefusalCare Plan” and attach it in the member’s file. • Attempt to reach the member again in 6 months. • Enter a refusal on the Monthly Part C Assessment Log for MSHO members. <p>If a member verbally refuses an assessment within 365 days from the last assessment, the CC is required to:</p> <ul style="list-style-type: none"> • Document all attempts to reach the member before the 365th day of the last assessment. • Complete a “Refusal Care Plan” reflecting completed attempts within 365 days of the last assessment and attach it in the member file. • Complete MMIS entry to exit member from EW effective the last day of the month the member is eligible for EW and follow DTR process. • Enter a refusal event on the Monthly Part C Assessment Log for MSHO members. <p>Attempt to reach the member again in 6 months to offer an assessment.</p>
<p>Entry of Assessments on Monthly Part C Logs</p>	<p>The CC is required to:</p> <ul style="list-style-type: none"> • Enter all MSHO assessments and reassessments on the monthly MSHO Part C Assessment Log. • Submit the MSHO Part C Assessment Log to assessmentreporting@ucare.org by the 10th calendar day of the following month. 	
<p>Collaborative Care Plan Section</p>		
<p>Collaborative Care Plan (POC)</p> <p>*A care plan is required for ALL MSHO and MSC+ members regardless of rate cell or waiver status.</p>	<p>The CC has the lead responsibility for creating, implementing, and updating the plan of care (POC). The CC is required to:</p> <ul style="list-style-type: none"> • Develop a person-centered collaborative POC with the member at the time of the initial or annual assessment using the Collaborative Care Plan form. The POC must be completed in its entirety following the directions outlined in the Collaborative Care Plan Instructions located on the UCare website. • Develop person-centered, prioritized goals on the POC for active problems noted in the HRA/LTCC. The CC is not required to develop a goal for problems that are not currently active - i.e. when a member is chronic and stable. 	

<p>Care Plan Signature Page</p> <p>Primary Care Clinic (PCC)/Primary Care Physician (PCP) Contact Clinic</p> <p>Interdisciplinary Care Team Collaboration (ICT)</p>	<ul style="list-style-type: none"> ○ Goals should be written based on needs/concerns that were identified with the member while completing their HRA. Goals should be written as SMART goals- (Specific, Measureable, Attainable, Realistic, and Time-bound). ○ Goals should be prioritized using high, medium or low with at least one goal being ranked as high priority. ● Send the POC to the member/rep within 30 calendar days of the assessment date using the POC cover letter. Day 1 is the date of the assessment. ● Update the POC every time services are modified. ● Obtain a signature from the member or authorized representative on the POC on an annual basis to document that they have discussed their POC with their CC. The POC is not considered valid unless signed by the member or authorized representative. ● Share the POC or POC summary with the PCP within 30 days of the face-to-face assessment. This may be done by mail, EMR, fax of POC/summary, or face-to-face. ● Communicate with the PCP as needed, and at least annually, and document this communication in the member’s record. ● Communicate updates and changes in the member’s condition to the PCC as appropriate. ● Ensure the POC includes the names and disciplines of members’ interdisciplinary care team (ICT). <ul style="list-style-type: none"> ○ The ICT, at a minimum includes the care coordinator, the member and/or member’s family/authorized representative, caregiver (as applicable), and the PCP. 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, as long as they are involved in the member’s care for current health problems. ● These may include but are not limited to: 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.
<p>Ongoing Contact With the Member and Care Plan Updates</p>	<p>The CC is required to:</p> <ul style="list-style-type: none"> ● Maintain ongoing contact or check-in with the member at a minimum of every 6 months (with a 30-day leeway before and after the 6 month contact) to update the POC, which includes documenting monitoring of progress or goal revisions (with date) directly on the POC. Contact may be by phone or face-to-face. ● If the member is unable to reach or refuses, update the existing POC and document the 4 attempts to reach the member in the member’s record.

EW Provider Signature Requirement	N/A	<p>The CC is required to:</p> <ul style="list-style-type: none"> • Give the member a choice of sending the entire POC, a summary of the POC, or sending no part of the POC to their providers. • Document this choice on the POC. <p>For members that choose to send all or the summary letter, the CC is required to make 2 attempts within 60 days of the care plan being created to get a signature from the provider, and document these attempts. This requirement is only for members open to EW. 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 if the member is opened to the waiver.</p>
Change in EW Services and/or Providers	N/A	<p>The CC is required to:</p> <ul style="list-style-type: none"> • Update the POC when there is a change in EW services and/or providers. • Send out a “Member Change Letter” requesting the member’s signature. • Offer the member a choice of sending the provider the entire the POC, a summary of the POC, or sending no part of the POC. • Document this choice on the POC. • Make 2 attempts to get 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.
Case Mix Service Caps	N/A	<p>All state plan home care and EW services must be based on assessed need and must not exceed the case mix monthly cap amount. This includes UCare’s monthly case management fee of \$180.</p>
Other Required Care Coordinator Activities		
Change in care coordinator	<p>The new CC must notify the member of their 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 by letter, the CC must use UCare’s approved Change in Care Coordinator Letter found on UCare’s website. It is best practice to make an additional phone call to member after letter is sent.</p>	

Financial Eligibility for Elderly Waiver (EW) Services	N/A	The CC is required to: <ul style="list-style-type: none"> • Verify financial eligibility for EW services prior to initiating EW services. • Complete the <u>Lead Agency Assessor/Case Manager/Worker LTC Communication Form</u> -DHS-5181 form and DHS-3543 form to determine eligibility. • Maintain a record of the DHS-5181 and DHS-3543 in the member record. *EW services should <u>NOT</u> be initiated until financial eligibility is verified.
Medicaid Eligibility Renewals	To the best of their ability, the CC is encouraged to remind members when they are at risk of losing Medicaid eligibility due to failure to complete and return Medical Assistance paperwork; and to assist members with the completion of renewal paperwork.	
90 Day Grace Period After MA Terms	If a member’s Medical Assistance (MA) terms, the CC is required to: <ul style="list-style-type: none"> • Complete any ongoing care management assessments that are needed in the next 90 days (i.e. HRA, POC, OBRA). • Retain the completed assessment documents in the member record. • Enter the DHS-3427 or the DHS-3427H and DHS-3428Q (if applicable) into MMIS when the member’s MA is reinstated. • Enter the assessment date on the Monthly Part C Assessment Log (MSHO only). • FOR EW MEMBERS ONLY: Refer to DHS-6037A Communication Form Scenarios. If the member’s MA is not reinstated, resulting in disenrollment from the health plan, the CC is required to provide the DHS-6037 transfer form and all supporting documentation to the county of residence by day 60.	
Actions For When a Member Moves	The CC is required to: <ul style="list-style-type: none"> • Send the DHS-5181 form to the county to inform them of the member’s new address and date of move. <ul style="list-style-type: none"> ○ Maintain a copy of this in the member record. • Inform the member to update their address with the county financial worker. 	
Actions For When a Member Dies	The CC is required to submit a Member Death Notification Form to UCare. Submit the DHS-5181 form to the county.	The CC is required to submit a Member Death Notification Form to UCare <u>and</u> close the waiver span in MMIS. Submit the DHS-5181 form to the county.
Action when a Member needs a HCBS modification to their 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: <ul style="list-style-type: none"> • Complete Part A and Part B of the DHS-7176H form 	

	<ul style="list-style-type: none"> • Once completed the CC sends the DHS7176H form to the provider to complete Part C via fax or secure email. The provider will complete Part C and send back to the CC. • The CC will review and confirms 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 into the POC. • Attach a signed copy to the support plan and maintain one in the member's file.
Admission to a Nursing Facility for Community-Based Members	<p>An OBRA Level I is required upon admission to the facility. UCare completes ALL Nursing Facility OBRA/PASRR activity in house, which includes:</p> <ul style="list-style-type: none"> • Completing OBRA Level 1, faxing it to the NF and making a referral for OBRA Level 2 if applicable. • Completing telephone screening (DHS-3427T form) and entering it into MMIS if applicable, (for non-waiver members). <p>The CC is required to:</p> <ul style="list-style-type: none"> • Monitor the daily authorization report for admissions. • Assist with care transitions and complete a TOC log. • Send the Communication Form, DHS-5181 to the county financial worker on the 31st day, if the member's stay is longer than 30 days, indicating the date the member was admitted into the nursing facility. • Exit Elderly Waiver members from the waiver 30 days after the first day of admission into the NF. • Complete a DTR for each waiver service the member is receiving, including one for waiver eligibility. • Members determined to be long term will 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. <ul style="list-style-type: none"> • The confirmation of long-term care status must come from the member/responsible party.
Transitions of Care	<p>MSHO: The CC is required to:</p> <ul style="list-style-type: none"> • Assist with the member's planned and unplanned movement from one care setting (e.g., member's home, hospital, and skilled nursing facility) to another care setting. Each movement, when due to a change in the member's health status, is considered a separate transition. • <u>Conduct Transition of Care activities and document these activities on the "Transitions of Care Log" on UCare's website, according to the TOC Log instructions (also on UCare's website).</u> • Conduct a reassessment in the event of a care transition that would involve significant health changes, repeated or multiple falls, recurring hospital readmissions or emergency room visits. <p>If the CC finds out about 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 required to:</p>

	<ul style="list-style-type: none"> • Follow-up with the member to discuss the care transition process, any changes to their health status, and POC. • Provide education about how to prevent a readmission and document this discussion in the case notes. The 15-day exception only applies if the CC finds out about all of the transitions after the member has returned to their usual care setting. <p>MSC+: The CC is required to:</p> <ul style="list-style-type: none"> • Follow-up with the member to discuss the care transition process, any changes to their health status and POC, and provide education about how to prevent a readmission. • Document this discussion in case notes. 	
Coordination With Local Agencies	<p>The CC is required to make referrals and/or coordinate care with county social services and other community resources when a member is in need of:</p> <ul style="list-style-type: none"> • 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; or Adult Protection. • Local Human Service Agencies for assessment and evaluation related to judicial 	
DTR Requirements	<p>If a waiver is requested and does not meet LOC, complete a DTR Notification Form and use reason code 1114.</p> <ul style="list-style-type: none"> • If a member is receiving home health care services (i.e. PCA, home health aide and skilled nursing services), and the care coordinator or member initiates a termination or reduction of those services, a DTR notice is required. To issue a DTR for home health care, complete the PCA Communication Form or the Home Health Communication form from UCare’s website and fax to UCare. 	<ul style="list-style-type: none"> • A DTR notice is required when a waived service has been denied, terminated, or reduced. • If a member initiates the termination or reduction of a waiver service, a DTR notice is required. • 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 for waiver eligibility must also be completed. • If a member is receiving home health care services (i.e. PCA, home health aide and skilled nursing services), and the care coordinator or member initiates a termination or reduction of those services, a DTR notice is required. To issue a DTR for home health care, complete the PCA Communication Form or the Home Health Communication form from UCare’s website and fax to UCare.

		<p>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 15 days prior to the ending of services.</p> <p>Additional tips for determining when a DTR letter is required are on the UCare website for reference.</p>
Documentation Notes	<p>The CC is required to document in the member’s care coordination record:</p> <ul style="list-style-type: none"> • All evidence that care coordination requirements as stated in this document are being met. • All attempts of any of the requirements that were attempted but not completed. 	
Policies and Procedures	<p>UCare and all care coordination delegates are required to have policies and/or procedures that support all the above stated requirements.</p>	
MSHO Model of Care Training	<p>UCare requires that all care coordinators complete the Model of Care training within three months of hire. Care Coordinators may access this training via WebEx contained on the provider page of UCare’s website (MSHO & UCare Connect + Medicare MOC Training). UCare will provide Model of Care training to care coordinators on an annual basis.</p>	

Members on other waivers: CAC/CADI/DD/BI

Members on a CAC, CADI, DD or BI Waiver

This could also include members residing in an Intermediate Care Facility for persons with developmental disabilities-only.

New member transferred from FFS - These are members who are new or re-enrolled with UCare, coming from FFS.

The care coordinator is required to:

- Contact the member per the “Initial Assignment” and “Initial Contact with Member” sections.
- Contact the CAC/CADI/DD/BI waiver case manager (CM) to introduce self as the member’s MSHO/MS+ care coordinator (CC). Find out when member’s last waiver assessment was conducted and request a copy of the assessment and signed POC. Document that all paperwork was received and reviewed.
- Complete the DHS-3428H assessment form face-to-face with the member or authorized rep within the enrollment month not to exceed 30 days.
- Complete a Collaborative Care Plan with signature page within 30 days of the assessment.
- Send a copy of the completed POC to the member, primary care provider and waiver CM.
- Complete a MMIS entry in the “H” screen.
- Enter the assessment on the MSHO Part C Assessment Log.

Member transferred from a UCare delegate– This is when a UCare member was previously case managed by a UCare delegate (transfers from one delegate to another in the same health plan, e.g., Genevive to UCare; UCare to Fairview); and had a DHS-3428H entered into MMIS within the last 365 days.

The care coordinator is required to:

- Contact the member per the “Initial Assignment” and “Initial Contact with Member” sections.
- Review transfer documents sent from previous care coordinator including current DHS-3428H assessment, signed Collaborative Care Plan, waiver assessment and waiver POC with signature page.
- Contact the CAC/CADI/DD/BI waiver case manager (CM) to introduce self as the member’s MSHO/MS+ care coordinator (CC). Find out when member’s last waiver assessment was conducted via MMIS.
- Contact the member via telephone to review the DHS-3428H assessment and review/update the care plan received from the previous care coordinator.
- If documentation is not received from the previous care coordinator, complete the DHS-3428H assessment face-to-face within the enrollment month not to exceed 30 days. Complete the Collaborative Care Plan with signature page within 30 days of the assessment.

Member transferred from another MCO– This is when a UCare member was previously case managed by another MCO (e.g. Medica, Health Partners); and had an entry into the “H” Screen of MMIS within the last 365 days.

The care coordinator is required to:

- Contact the member per the “Initial Assignment” and “Initial Contact with Member” sections.
- Review transfer documents received from previous care coordinator including current assessment that was entered into the “H” screen, signed care plan, waiver assessment and waiver POC with signature page.
- Contact the CAC/CADI/DD/BI waiver case manager (CM) to introduce self as the member’s MSHO/MSO+ care coordinator (CC). Find out when member’s last waiver assessment was conducted via MMIS.
- Contact the member via telephone to complete DHS-3428H assessment and review/update the care plan received from the previous care coordinator.
- Complete a MMIS entry in the “H” screen.
- If documentation is not received from the previous care coordinator, complete the DHS-3428H assessment face-to-face within the enrollment month not to exceed 30 days. Complete the Collaborative Care Plan with signature page within 30 days of the assessment.
- Enter the assessment on the MSHO Part C Assessment Log.

Annual Reassessment

The CC is required to:

- Complete a face-to-face DHS-3428H assessment within 365 days of the previous assessment. Complete a collaborative care plan with signature page within 30 days of the assessment.
- Coordinate assessment with the member and waiver CM whenever possible.
- Following the assessment, request and obtain a copy of the waiver CM’s assessment and signed POC.
- Send a copy of the completed collaborative care plan to the member, primary care provider and waiver CM.
- Complete a MMIS entry in the “H” screen.
- Enter the assessment on the MSHO Part C Assessment Log.

Product Changes, the CC is required to:

- Contact the member per the “Initial Assignment” and “Initial Contact with Member” sections above.
- Update or complete via phone the DHS-3428H assessment AND collaborative care plan.
- Enter the assessment into MMIS “H” screen.
- Document all product change assessments on the MSHO Part C monthly log.

Ongoing Contact with the member, the CC is required to:

- Contact the member/authorized rep. every 6 months at a minimum and update the DHS-3428H and Collaborative Care Plan.

Unable to Contact or Refusal – review appropriate section above.

DHS eDocs Form Names

<u>eDocs Number</u>	<u>Title of Document</u>
DHS-3427	<u>LTC Screening Document – EW, MSC+, MSHO</u> <ul style="list-style-type: none">• This screening document form is used by lead agencies to record LTC screenings.
DHS-3427H	<u>Health Risk Assessment Screening Document-MS C+, MSHO and SNBC Form:</u> <ul style="list-style-type: none">• This form is used by managed care organizations to record the health risk assessments for data entering into the MMIS.
DHS-3428	<u>Minnesota Long Term Care Consultation Services Assessment Form:</u> <ul style="list-style-type: none">• This form is used by lead agencies to record LTC assessments.
DHS-3428D	<u>Supplemental Waiver PCA Assessment and Service Plan:</u> <ul style="list-style-type: none">• Lead agencies use this form when assessing for PCA services for people on HCBS waivers and the Alternative Care Program.
DHS-3428H	<u>Minnesota Health Risk Assessment Form:</u> <ul style="list-style-type: none">• 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	<u>Person’s Evaluation of Foster Care, Customized Living or Adult Day Service Form:</u> <ul style="list-style-type: none">• 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	<u>MHCP Request for Payment of Long-Term Care Services</u> <ul style="list-style-type: none">• Application sent when an enrollee begins receiving waived services must complete this form. Should be completed and returned within 10 days.
DHS-3936	<u>My Move Plan Summary Form:</u> <ul style="list-style-type: none">• 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 (DHS-3936) form with case manager/support planner
DHS-5181	<u>Lead Agency Assessor/Case Manager/Worker LTC Communication Form:</u>

	<ul style="list-style-type: none"> 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.
DHS-6037	<u>HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form:</u> <ul style="list-style-type: none"> This form assists health plan, county, and tribal care coordinators and case managers to share information.
DHS-6037A	<u>HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form: Scenarios for People on EW and AC:</u> <ul style="list-style-type: none"> Instructional form for using DHS-6037 for the Alternative Care, Elderly Waiver, and Essential Community Supports programs.
DHS-7176H	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 well-being. If the person agrees to the changes, the license holder/provider implements the modification as identified and agreed to in this form.