UCare Connect, Connect Expansion and Connect + Medicare
Care Coordination Requirement Grid
Updated 1/1/2022

The assigned Care Coordinator/Case Managers herein after referred to as Care Coordinator (CC) must meet the required 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, 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	UCare provides the member with a care navigator welcome letter within 10 calendar days of initial assignment. • Initial assignment is the first day the delegate receives the enrollment roster. Upon receiving the enrollment roster, the CC is required to: • Look each member up in MN-ITS to determine waiver status. • Complete a HRA and Support Plan, then return members to UCare via the Monthly Activity Log if the member is open to a waiver, Mental Health TCM, or the member is institutionalized. **Do not initiate care coordination for these members.** ○ **MEMBERS ENROLLED IN CONNECT AND CONNECT + MEDICARE ARE REQUIRED TO BE OFFERED A FACE-TO-FACE HRA REGARDLESS OF WAIVER STATUS.**
Members open to waiver	Members open to a waiver (BI, CAC, CADI, DD) should be returned to UCare via the Monthly Activity Log. • If the CC believes care coordination services should be provided despite the member being open to a waiver and Mental Health TCM, a UCare Care Coordination Referral form must be submitted to UCare for review and approval

Initial Contact with Member	For newly enrolled members, the CC is required to:
	    ○ Send the Case Management Welcome Letter should within 10 days of enrollment
	    ○ Complete the HRA with the member within 60 days of enrollment
	        ▪ Document a minimum of 4 actionable* attempts to reach the member within 60 days of enrollment
	    ○ Complete the Support Plan within 30 days of the HRA being completed
	
	*"Actionable" means communication that the member can act upon such as a voicemail left at a known number for the member or mailing a letter to a known address for the member
	
	• A good faith effort should be made to obtain a working phone number for the member. **(Sending the "Case Management Welcome Letter" is not considered an attempt to contact the member**).

Outreach Attempts	The CC is required to:
	• HRAs (Initial and Reassessment)
	    ○ 4 actionable contact attempts must be made, if unable to reach member
	    ○ For example: 3 phone calls and 1 letter
	• 6-month check in
	    ○ 4 actionable contact attempts must be made, if unable to reach member.

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	◦ For example: 3 phone calls and 1 letter • Support Plan ◦ 4 actionable contact attempts must be made, if unable to reach member ◦ For example: 3 phone calls and 1 letter • Transition of Care (TOC) ◦ 4 actionable contact attempts must be made, if unable to reach member ◦ For example: 3 phone calls and 1 letter
Unable to Reach	If the CC is unable to contact the member within 60 days of the enrollment date, or **WITHIN** 365 days from the previous year's completed HRA or initial enrollment date, the CC is required to: • Enter an unable to reach in MMIS with the activity date as the date the CC made the final contact attempt (4th outreach attempt). • Complete Unable to Reach Support Plan • Send a copy of the Provider Engagement Letter to the PCP. • Add the member to the Monthly Activity Log as unable to reach and return to UCare by the 15th day of the following month.
Refusal	If the member refuses an assessment within 60 days of the enrollment date, or **WITHIN** 365 days from the last assessment or initial enrollment date, the CC is required to: • Enter a refusal in MMIS with the activity date as the date the CC spoke to the member. • Complete Refusal Support Plan • Send a copy of the Provider Engagement Letter to the PCP. • Send the Member Refusal Letter to the member. • Add the member to the Monthly Activity Log as a refusal and return to UCare by the 15th day of the following month.
Interdisciplinary Care Team (ICT)	At a minimum, the ICT 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 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.
Care System or County Primary	The CC completes the following: • Confirm member has an established PCC

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<tr><td>Care Clinic Change (PCC)</td><td>• Ensure PCC is reflected correctly on the care coordination enrollment roster.
   o If the care coordination enrollment roster does not reflect the correct PCC the CC must submit a Primary Care Clinic (PCC) Change Request form and submit it to UCare.
      ▪ Submit to UCare no later than the 24th day of the month to ensure the change will be made the following month.
   o If the member states they plan to establish care with a new PCC, the CC works with the member in scheduling the appointment to establish care.
      ▪ 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.</td></tr>
<tr><td>Product Change- when a member moves from Connect to Connect + Medicare or vice versa.</td><td>If there is a change in CC due to a product change, the existing (sending) CC is required to:
• Send a copy of the current HRA, Support Plan, and relevant case notes to the new (receiving) CC.

The CC is required to:
• Provide the member with the name and telephone number of the new CC within 10 days of the assignment if the CC has changed. This may be done by phone or letter (using the approved letter on UCare's website),and must be documented in the member record.
• Obtain, and review the current HRA and update the Support Plan received from the previous (sending) CC. Update Support Plan as appropriate.
• Complete the Transitional Health Risk Assessment form and attach to the most current HRA. This may be conducted via phone or in person.
• If unable to obtain a completed HRA and Support Plan that was completed within the last 365 days, or if there has been a change in condition, the CC is required to complete a new HRA and Support Plan face-to-face.
• Enter the assessment into MMIS within 30 calendar days of the assessment completion date.
• Enter all assessments on the Monthly Activity Log.</td></tr>
<tr><td>Entry of Assessments on Monthly Activity Log</td><td>The CC is required to:
• Enter all assessments, unable to reach and refusals on the Monthly Activity Log.
• Submit the Monthly Activity Log to connectintake@ucare.org by the 15th calendar day of the following month.</td></tr>
<tr><td>Admission to a Nursing Facility</td><td>If a member is admitted to a Nursing Facility and their stay is expected to be less than 90 days, keep the member open to care coordination. Once the member is admitted for greater than 90 days, the CC is required to return the member to</td></tr>
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<tr><td>from the Community</td><td>UCare via the Monthly Activity Log.
<u>UCare Responsibilities:</u>
• Complete all Preadmission Screening and Resident Review (PASRR) activities.
• Notify the delegate when a PASRR is received.
<u>CC Responsibilities:</u>
• Monitor the daily authorization report for admissions.
• Assist with transitions and complete a TOC log.</td></tr>
<tr><td>Comprehensive Support Plan</td><td>The CC is required to:
• Develop a person-centered Support Plan within 30 days of the HRA completion date.
• Maintain a record of the assessment and Support Plan in the member's case file.
• Share the assessment and Support Plan information with UCare upon request
• Share the Support plan with ALL member's Interdisciplinary Care Team (ICT), including the member and PCP at a minimum
    o Document ALL members of the ICT (refer to ICT section above for definition of ICT)

The CC develops the person-centered Support Plan. The Support Plan is based on the information collected through the HRA with the member or authorized representative/legal guardian, and includes:
• Input from the member and/or family members, the member's authorized health care decision maker, Primary Care Physician (PCP), and other interdisciplinary care team members.
• Person-centered member problem list/needs.
• Discussion of service back-up plan.
• Prioritized person-centered member goals.
    o At least one goal must be considered "high" priority level.
        ▪ ALL SUPPORT PLANS, INCLUDING UNABLE TO REACH AND REFUSAL SUPPORT PLANS, REQUIRE AT LEAST ONE "HIGH" PRIORITY LEVEL GOAL.
• Member driven interventions to address medical, psychosocial, cognitive, mental health, functional, and other service needs of the member.
• Measurable outcomes (must be monitored and revised every 6 months at a minimum) with a target achievement date identified by month/year.</td></tr>
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<tr><td></td><td>• Outcomes should be written as SMART goals- (Specific, Measurable, Attainable, Realistic, and Time-bound).
• Complete the Support Plan in its entirety including the sections on safety plan, emergency plan and evacuation plan whether or not the member accepts services.
• Document all members of the ICT, including PCP, CC, member and other specialists involved in the member's care

Refer to ICT section above for definition of ICT.

The CC is required to:
• Send the Support Plan to the member/authorized representative within 30 calendar days of the HRA completion.
    o Day 1 is the date the HRA is completed.
• Send a copy of the Support Plan to the member's PCP and all members of the Interdisciplinary Care Team (as applicable) on an annual basis.
• Communicate updates and changes in the member's condition to the PCP and Interdisciplinary Care Team.</td></tr>
<tr><td>Support Plan Signature Page</td><td>The CC is required to:
• Obtain a signature from the member or authorized representative on the Support Plan to document that they have discussed their support plan with their CC.
    o The Support Plan is not considered valid unless signed by the member or authorized representative.
• If the signature page is mailed to the member to obtain the signature, document the date of when the signature page was sent
    o 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 date the follow up attempt was made.</td></tr>
<tr><td>Safe Disposal of Controlled Substances</td><td>• The CC is required to:
    o Complete the "UCare Safe Medication Disposal" form found on the UCare website, including manually adding two community drop off sites closest to the member's location.
    o Document the discussion of controlled substances and safe disposal including the member was provided the "UCare Safe Medication Disposal" leave behind document. This documentation should be added as free text in the medication section of the HRA and/or Support Plan.</td></tr>
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<tr><td>Ongoing Contact with Member and Support Plan Updates</td><td>The CC is required to:
• Maintain ongoing contact or check-in with the member at a minimum of every 6 months to update the Support Plan which includes:
    o Documenting the monitoring of progress or goal revisions (with date).
        ▪ Contact may be completed by phone or face-to-face (refer to contact attempt requirements in the “unable to reach or refusal” section).
• Return the member to UCare via the Monthly Activity Log if any of the following occur:
• The CC is unable to reach the member at the 6-month review.
• The member becomes a long-term resident of a skilled nursing facility.
• The member opens to a waiver or Targeted Case Management.
    o If a member demonstrates a Clinical need e.g Medical/Mental Health/SUD for care coordination please complete a UCare Care Coordination Referral form located on the UCare website
• Send the Support Plan to the PCP, Interdisciplinary Care Team, and member/rep within 30 calendar days of the HRA completion date.</td></tr>
<tr><td>Institutionalized Members</td><td>The CC is required to:
• Complete a face-to-face or telephonic assessment using the Institutional HRA
• When completing the HRA, all questions and sections must be completed or marked as “not applicable”.
• Determine the HS code based on member need/risk and agreement to continued care coordination services.
    o Refer to Monthly Activity Log for HS code definitions.
• Enter the reassessment on the Monthly Activity Log and return to UCare by the 15th of the following month.
• Develop a Support Plan (included in the Institutional HRA form), separate from the MDS, with any ongoing and new goals within 30 days of the HRA being completed.
• Update the “Date Goal Achieved/Not Achieved” column from the most current Support Plan with a month and year documented and retain in member’s file
• Send the Support Plan to the PCP, Interdisciplinary Care Team, and member/rep within 30 calendar days of the HRA completion date.</td></tr>
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<tr><td>Reassessment</td><td>The CC is required to:
• Complete an assessment using the HRA WITHIN 365 days of the previous year’s assessment AND upon a change in condition.
  o When completing the HRA, all questions and sections must be completed or marked as “not applicable”.

• Determine the HS code based on member need/risk and agreement to continued care coordination services.
  o Refer to Monthly Activity Log for HS code definitions.
• Enter the reassessment on the Monthly Activity Log and return to UCare by the 15th of the following month.
• Update the “Date Goal Achieved/Not Achieved” column from the most current Support Plan with a month and year documented and retain in member’s file.
• Develop a new Support Plan with ongoing and new goals within 30 days of the HRA being completed.
• Send the Support Plan to the PCP, Interdisciplinary Care Team, and member/rep within 30 calendar days of the HRA completion date.</td></tr>
<tr><td>Medicaid Eligibility Renewals</td><td>The CC is required to:
• Review the UCare Connect eligibility renewal report, provided by UCare on a monthly basis and remind members when they are at risk of losing Medicaid eligibility due to incomplete or unprocessed Medical Assistance paperwork.

The UCare Keep Your Coverage Team reaches out to members to see if they need additional assistance with maintaining eligibility.
• CC may collaborate with the Keep Your Coverage Team for support in assisting the member with maintaining eligibility.</td></tr>
<tr><td>Change in care coordinator (within the same agency)</td><td>The new Care Coordinator (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.</td></tr>
<tr><td>Reassessments When Member is in the 90 Day Grace Period</td><td>If a member’s Medical Assistance (MA) terms, the CC is required to:
• Complete any ongoing care coordination requirements that are needed for 90 days (e.g. HRA and Support Plan) after the member’s MA termed.
• Retain the completed assessment documents in the member record.</td></tr>
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<tr><td>After MA Terminates</td><td>When the member’s MA is reinstated
• Enter the assessment date on the Monthly Activity Log</td></tr>
<tr><td>Advance Directives</td><td>The CC is required to document on an annual basis that they discussed advance directives with the member and document the result of conversation.</td></tr>
<tr><td>Transition of Care (TOC)</td><td>The CC is required to:
• 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 from one setting to another is considered a separate transition.
• Notify the member’s PCP of the admission, transfer, and/or discharge.
• Notify the member’s ICT of the admission, transfer, and/or discharge
  o CC is expected to organize ICT meetings, as needed, to ensure the ICT members, the member, and authorized representative (if applicable) are updated to any new developments related to the member’s needs/care.
• If applicable, update the member’s Support Plan to reflect and additional needs or changes in the member’s condition
  o Send a copy of the updated Support Plan to the member, authorized representative (if applicable), and the ICT
    ▪ Refer to ICT section above for definition of ICT
• 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.
• Conduct a reassessment in the event of a care transition that may involve significant health changes, repeated or multiple falls, recurring hospital readmissions or emergency room visits.
• Follow-up with the member to discuss the care transition process, and any changes to their health status and Support Plan.
• Provide education about how to prevent readmission and document this discussion in case notes.

If the CC is notified 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:
• Follow-up with the member to discuss the care transition process, and any changes to their health status and Support Plan.
• Provide education about how to prevent readmission and document this discussion in case notes.
• Refer to the TOC log instructions on the UCare website for additional instruction.</td></tr>
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<tr><td>Coordination with Local Agencies</td><td>The CC is required to make referrals and/or coordinate care with local/county social services and other community resources when a member is in need of:
• Housing stabilization services
• Pre-petition screening
• Preadmission screening for HCBS
• County case management for HCBS
• Child protection
• Court ordered treatment.
• Case management and service providers for people with developmental disabilities.
• Relocation service coordination
• Adult protection
• Assessment of medical barriers to employment
• State Medical Review Team or Social Security disability determination
• Working with Local Agency social service staff or county attorney staff for Enrollees who are victims or perpetrators in criminal cases
• Any other community resources, as appropriate.</td></tr>
<tr><td>DTR Requirements-Medically Necessary Services</td><td>UCare or one of its utilization review (UR) delegates must review all services that require a medical necessity review. UCare sends a denial, termination, or reduction (DTR) letter to the member any time services that require prior authorization and review of medical necessity according to UCare's prior authorization grid are denied, terminated, or reduced. A DTR of these services requires review and determination by a UCare Medical Director.</td></tr>
<tr><td>Transfer of Member Between Delegates</td><td>The current (sending) CC is required to:
• Complete the DHS-6037 form and send or fax the form to the new CC delegate (receiving) as soon as the enrollment roster with the new delegate is indicated, but no later than the 15th calendar day of the month.
• Include the following supporting case documentation with the DHS-6037 form:
    o Current HRA and any other relevant assessments
    o Support Plan
    o Relevant case notes.
The receiving CC is required to:</td></tr>
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	• Contact the transferred member within 10 calendar days of assignment, by letter or phone, to introduce the new CC. • Review the DHS-6037 form, assessments, and current Support Plan with the member and document this review in the member record. • Identify when the next assessment is due. Reassessments should be kept on schedule, refer to the reassessment section for detail. • Complete the Transitional Health Risk Assessment form and attach to the most current assessment (HRA). This may be conducted via phone or in person. • Complete a HRA and Support Plan if unable to obtain a copy of the most recent HRA and Support Plan from the previous CC. • Enter any assessments on the Monthly Activity Log.

Transfer of Member to MSHO/MSC+ Delegates	The current (sending) CC is required to:
	• Complete the DHS-6037 form and send or fax the form to the new CC delegate (receiving) as soon as the enrollment roster with the new delegate is indicated, but no later than the 15th calendar day of the month.
	• Include the following supporting case documentation with the DHS-6037 form:
	  ○ Current HRA and any other relevant assessments
	  ○ Support Plan
	  ○ Relevant case notes.

Actions For When a Member Moves	The CC is required to: • Send the DHS-5181 form to the county to inform them of the member's new address and date of move. ○ Maintain a copy of this in the member record. • Assist the member in updating their address with the county financial worker as needed.
Member Death	The CC is required to: • Complete the UCare Death Notification form and submit to UCare. • Complete the DHS-5181 form and send it to the county financial worker.
Documentation Requirements	The CC is required to document in the member record: • All evidence of 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	UCare and all care coordination delegates are required to have policies and /or procedures that support all the above stated requirements.

DHS eDocs Form Names	
eDocs Number	Title of Document
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.
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.