UCare Connect and Connect + Medicare
Care Coordination Requirements Grid
Effective 1.1.2024

The assigned 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 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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*All items marked with an asterisk have a definition included on the Definitions and Abbreviations page.

<table>
<tr><th colspan="2">CONNECT AND CONNECT + MEDICARE REQUIREMENTS GRID</th></tr>
<tr><td>Initial Assignment</td><td>Initial assignment* is the first day the care system or county receives the care coordination enrollment roster. ALL members enrolled in Connect and Connect + Medicare are required to be offered a Health Risk Assessment. 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 member's record. If contact is by letter, the CC must use UCare's approved Connect/Connect + Medicare Welcome Letter (for new members) or Change of Care Coordinator Letter (for transferred members) found on the UCare website.
Document verification of eligibility and waiver status via MN-ITS*.</td></tr>
<tr><td>Initial Contact</td><td>The CC is required to:
Contact the member to complete an assessment within 60 days of enrollment*.
Document a minimum of 4 actionable attempts* or fewer if member is reached.
Contacts may be by phone, televideo, in-person or secure email on different days, at different times, and by using the Unable to Reach Member Letter on the UCare website.
NOTE: Sending the Welcome Letter is not considered an actionable attempt to contact the member.
Proceed with appropriate assessment type below.</td></tr>
<tr><th colspan="2">ASSESSMENTS</th></tr>
<tr><td>New Member/Initial Health Risk Assessment (HRA)</td><td>A member is considered NEW when newly enrolled into UCare Connect or Connect + Medicare and has not had a previous assessment entered in MMIS* within the last 365 days. ALL members enrolled in Connect and Connect + Medicare are required to be offered an assessment* within 60 days of new enrollment. If a member declines an in-person, a televideo assessment can be completed. If member declines a televideo, a telephonic HRA may be completed per member choice. Document the in-person and televideo HRA was offered and member preferences in the member's record. Members with previous coverage that experience a gap due to loss of MA eligibility (IE: exceeding 90-day grace period) are reflected on the enrollment roster as a NEW member if re-enrolled. The assessment used for Connect and Connect + Medicare is Health Risk Assessment (DHS-3428H).
NOTE: See Connect + Medicare Additional Encounter Requirements and Assessment Guide for additional assessment requirements.</td></tr>
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	CC is required to:
	• Contact the member per *Initial Assignment* and *Initial Contact* sections.
	• Members on waiver: Document outreach to waiver case manager. Include CC contact information and request copy of waiver support plan.
	• Complete an assessment* with the member within 60 calendar days of enrollment.
	• When completing the HRA, all questions and sections must be completed or marked as "not applicable".
	• Have *Safe Disposal of Medication** conversation and complete follow-up tasks.
	  ○ Not required for members living in skilled nursing facility.
	• Develop a person-centered Support Plan.
	  ○ See *Support Plan* and *Support Plan Signature* sections for additional details and timelines.
	• Enter assessment data into MMIS* within 30 calendar days of the assessment date.
	  ○ This includes members residing in skilled nursing facilities.
	• Add member to Monthly Activity Log and update Health Status code, based on assessment outcome.
	  ○ Return the Monthly Activity Log to UCare by the 15th day of the following month.
	NOTE: If new member is Unable to Reach or Refusal refer to their respective sections.

Transferred Member	There are two types of transferred members: **Transferred Member from a UCare Delegate:** Members who are transferred between UCare delegates. The enrollment roster will indicate "care coordinator change" in the status column to notify of a UCare delegate change (e.g., MHR to UCare, Olmsted County to MHR, etc.). **Transferred Member from different SNBC Managed Care Organization (MCO) to UCare Connect/Connect + Medicare:** When a member enrolls in UCare Connect/Connect + Medicare and was previously with a different. The enrollment roster does not indicate a change of MCO (e.g., UCare to Medica, Medica to UCare, etc.). Member will have a status of "New Member/Termed Member." Care coordinators (CC) may use Transfer Member Health Risk Assessment (THRA) when an HRA and Support Plan completed within the last 365 days are obtained, and the member is able to be reached within 60 calendar days of enrollment. By completing the THRA the CC is adopting this assessment and Support Plan as their own. If the member was a previous UTR/Refusal, the THRA process may not be used.
	The previous (sending) CC is required to: • Thoroughly complete all areas of the DHS-6037 Transfer Form and send via secure email or fax to the new (receiving) CC when confirmed via enrollment roster.

	◦ *Care Coordination Contact List* is located on the UCare website. • The transfer must also include: ◦ The most recent HRA, Support Plan, Support Plan Signature Page with member signature, relevant case notes, and other applicable case documents. ▪ This includes UTR/Refusal Support Plans as applicable. **The new (receiving) CC is required to:** • Provide the member with the name and phone number of the CC within 10 calendar days of transfer. ◦ This may be done by phone or letter and must be documented in the member's record. If contact is by letter, the CC must use UCare's approved Change of Care Coordinator Letter for delegate-to-delegate transfer or Welcome Letter for MCO-to-MCO transfer found on the UCare website. • If a member transferred from another MCO as a new member, verify in MNITS and request transfer documents from previous MCO. Contact information for MCO's is located on the DHS 6037 document. • If unable to obtain a copy of the most recent HRA and Support Plan from the previous CC or there has been a change in condition treat as new member. Refer to *New Member/Initial Health Risk Assessment* section for requirements. ◦ Contact ConnectIntake@ucare.org if transfer documents have not been received. • Review of the *HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form (DHS-6037),* current HRA with supporting documents, and update the Support Plan received from the previous (sending) CC. ◦ Ensure a signature page is received or check with sending CC to get a copy. If unable to obtain, follow the *Support Plan Signature Page* section to obtain a new member signature. • Identify when the next assessment is due. ◦ THRA will not reset assessment timeline. Reassessments are kept on the same schedule and due within 365 days of the last HRA. • Make 4 actionable attempts* to reach the member. The contacts may be by phone, televideo, in-person, or secure email on different days, different times, and by using the *Unable to Reach Member Letter* on UCare website. • Complete the THRA with the member by phone, televideo, or in-person within 60 days of enrollment and attach to the member record with the current HRA. ◦ When completing the THRA, all questions and sections must be completed or marked as "not applicable." ◦ Document review in member record. ◦ Update HRA/Support Plan as needed.

	• If a member with a current HRA/Support plan is unable to be reached or declines the THRA, update the current Support Plan in lieu of completing a full UTR/Refusal Support Plan. Do not complete the THRA document.
	• Enter the CC Change activity in MMIS* within 30 calendar days of the activity date.
	• Add member to Monthly Activity Log when a THRA is completed. Because the member has a current HRA/Support Plan, the HS code remains HP.
	    o Do not add transfers within your organization to the Monthly Activity Log.
	    o Return Monthly Activity Log to UCare by the 15th day of the following month.

Product Change	A Product Change is when a member moves from Connect to Connect + Medicare or vice versa. Members who have product changes are considered "new" members and must have an assessment completed within 60 days of the enrollment into the new product. Care coordinators may use a Transfer Member Health Risk Assessment (THRA) when an HRA and Support Plan completed within the last 365 days are obtained, and the member is able to be reached within 60 calendar days of enrollment. By completing the THRA the CC is adopting this assessment and Support Plan as their own. If there is not a previous HRA/Support Plan within the previous 365 days, a new assessment* is required within 60 days of enrollment. • If the member was a previous UTR/Refusal, the THRA process may not be used.

	The CC is required to:
	• Provide the member with the name and phone number of the CC within 10 calendar days of Product Change.
	    o This may be done by phone or letter and must be documented in the member's record. If contact is by letter, the CC must use UCare's approved *Welcome Letter* found on the UCare website.
	• Identify when the next assessment is due.
	    • THRA will not reset assessment timeline. Reassessments are kept on the same schedule and due within 365 days of the last HRA.
	• Make 4 actionable attempts* to reach the member. The contacts may be by phone, televideo, in-person, or secure email on different days, different times, and by using the *Unable to Reach Member Letter* on UCare website.
	• Complete the THRA with the member by phone, televideo, or in-person within 60 days of enrollment and attach to the current HRA.
	    o When completing the THRA, all questions and sections must be completed or marked as "not applicable".
	    o Review/update HRA/Support Plan as needed.
	    o Document review in member record.

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If a member with a current HRA/Support plan is unable to be reached or declines the THRA, update the current Support Plan in lieu of completing a full UTR/Refusal Support Plan. Do not complete the THRA document. MMIS activity still required.
Add member to Monthly Activity Log. Because the member has a current HRA/Support Plan, the HS code remains HP.
Return Monthly Activity Log to UCare by the 15th day of the following month.
Enter the Product Change activity in MMIS* within 30 calendar days of the activity date.
MMIS activity type 07, assessment result 51 and effective date of the last assessment.

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<tr><td>Institutionalized Members</td><td>
Connect/Connect + Members living in Skilled Nursing Facilities/Institutionalized settings utilize the Health Risk Assessment (DHS-3428H), Support Plan documents and assessment timelines. This includes members identified as “institutional” on the enrollment roster living in ICF/Group Home/AFC.
For new admission to skilled nursing facility from community, reference Admission to Nursing Facility section.
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The CC is required to:
New Members: Contact the member per the “Initial Assignment” and “Initial Contact with Members” sections above.
NOTE: All institutional assessments are to be completed in-person effective 1/1/2024.

If the member is UTR/Refusal complete steps per UTR/Refusal Support Plan sections as applicable.
See New Member/Initial Health Risk Assessment (HRA).
See Support Plan and Support Plan Signature sections.

Reminder: A signature page is required for Institutional members.
Documentation of the review of MDS and facility care plan is required for members living in SNF. A copy of the MDS and facility care plan is NOT required to be retained in the member record.
Determine if there are any additional needs or changes to the MDS or facility care plan and make suggestions to SNF staff.

Product Change: The THRA is not applicable to members living in a Skilled Nursing Facility.

A member living in a SNF that has a product change requires a new assessment and Support Plan.

See New Member/Initial Health Risk Assessment (HRA).
See Support Plan and Support Plan Signature sections.

Members living in ICF/Group Home/AFC identified as “institutional” on the enrollment rosters may use the THRA process.

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	Reassessment:
	• Contact the member to complete an in-person assessment* WITHIN 365 days of previous HRA AND upon a change in condition*.
	  ○ 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.
	• Document a minimum of 4 actionable attempts* or fewer if member reached.
	  ○ If member is UTR/Refusal, proceed to *Unable to Reach* or *Refusal* sections.
	  ○ Contacts may be by phone, televideo, in-person, or secure email on different days, at different times, and by using the "Unable to Reach Member Letter" on the UCare website.
	• See *Annual Reassessment* section.
	• See *Support Plan* and *Support Plan Signature* sections.
	  ○ Reminder: A signature page is required for Institutional members.
	  ○ Documentation of the review of MDS and facility care plan is required for members living in SNF. A copy of the MDS and facility care plan is NOT required to be retained in the member record.
	  ○ Determine if there are any additional needs or changes to the MDS or facility care plan and make suggestions to SNF staff.

Annual Reassessment	**The CC is required to:**
	• Contact the member to complete an in-person assessment* WITHIN 365 days of previous HRA, AND upon a change in condition*.
	  ○ 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.
	• If a member declines an in-person assessment, a televideo assessment may be completed. If member declines a televideo, a phone assessment may be completed per member choice. Document the member's informed choice of assessment methods and member preferences in the member's record.
	  ○ **NOTE**: *Additional Connect + Medicare Encounter Requirements*.
	• Document a minimum of 4 actionable attempts* or fewer if member reached.
	  ○ If member is UTR/Refusal, proceed to *Unable to Reach* or *Refusal* sections.
	  ○ Contacts may be by phone, televideo, in-person, or secure email on different days, at different times, and by using the "Unable to Reach Member Letter" on the UCare website.
	• Members on waiver: Document outreach to waiver case manager. Include CC contact information and request copy of waiver Coordinated Services and Support Plan (CSSP) or MnCHOICES support plan.
	• When completing the HRA, all questions and sections must be completed or marked as "not applicable".

	• Have Safe Disposal of Medication* conversation and complete follow-up tasks.
	  ○ Not required for members living in skilled nursing facility.
	• Update and close the "Date Goal Achieved/Not Achieved" column from the current Support Plan with a brief description of the outcome, month and year documented. Save in member's record.
	  ○ This includes THRA goals, UTR/Refusal Support Plans, etc.
	• Develop a new person-centered Support Plan with new and ongoing goals.
	  ○ See *Support Plan* and *Support Plan Signature* sections for additional details and timelines.
	• Enter MMIS* entry within 30 calendar days of the assessment date.
	  ○ This includes members residing in skilled nursing facilities.
	• Add member to Monthly Activity Log and determine the Health Status code based on assessment outcome.
	  ○ Return the Monthly Activity Log to UCare by the 15th day of the following month.

Unable to Reach (UTR)	**The CC is required to complete tasks for the following scenarios:**
	Initial Enrollment: Initial outreach to complete an HRA is due within 60 days of enrollment.
	-OR-
	Annual Reassessment: If the member is due for their first annual reassessment, the required tasks listed below are to be completed within 365 days from the original enrollment date and within 365 days thereafter.
	• Example: Member enrolls new to UCare 01/01/22 and is Unable to Reach after 4 attempts on 01/27/22, members annual assessment is due PRIOR to 12/31/22 (all 4 contact attempts must be completed by 12/31/22).
	  ○ See *Reassessment Due Date*.
	
	Both Scenarios require these tasks:
	• Document a minimum of 4 actionable attempts* to reach the member to schedule an assessment*.
	  ○ Contacts may be by phone, televideo, in-person, or secure email on different days, at different times, and by using the "Unable to Reach Member Letter" on the UCare website.
	  ○ For members with no known working number, a good faith effort should be documented to locate member's contact information. Investigative research is not considered an actionable attempt. The UTR Support Plan provides outreach investigation options. Alternatives may be used to locate a member's contact information as able. Examples may include:
	    ▪ Contact Waiver Case Manager (as applicable) to collaborate and obtain working number.
	    ▪ 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, PROMPT, EPIC).

	▪ *Public records* search.
	• Connect + Medicare: Complete Unable to Reach Support Plan with at least one high priority goal within 30 calendar days of activity date.
	  ○ It is not required to mail the Unable to Reach Support Plan to the member.
	  ○ Reminder: at the time of annual reassessment, close previous Support Plan goals.
	  ○ When completing the UTR Support Plan, all questions and sections must be completed or marked as “not applicable”.
	  ○ Safe Disposal of Medications* is not required for UTR members.
	• Connect: Document outreach attempts and outcomes in member record.
	  ○ Reminder: at the time of annual reassessment, close any previous Support Plan goals.
	• Send the Provider Engagement Letter to the PCP **IF** known within 30 calendar days of the 4th actionable attempt.
	• Enter UTR activity in MMIS* within 30 calendar days of the activity date.
	  ○ Activity and effective dates are the date of the final actionable attempt* to reach the member.
	  ○ This includes members residing in skilled nursing facilities.
	• Add the member to the Monthly Activity Log as an Unable to Reach member.
	  ○ Update Monthly Activity Log with the Health Status Code of “NR”.
	  ○ Return the Monthly Activity Log to UCare by the 15th day of the following month.
	
	Product Changes
	• For UTR members that experience a Product Change, refer to the *New Member* section.
	• Additional MMIS entry is needed when a UTR/Refusal member has a Product Change and remains a UTR/Refusal.
	
	Mid-Year Review
	Complete ongoing contact Mid-Year at a minimum.
	• Connect + Medicare: Update the UTR Support Plan with the outcome of contact, new goals/interventions as applicable.
	• Connect: Document Mid-Year outreach attempts and outcomes in member record.
	• Complete Transition of Care outreach/tasks when known.
	• Assist with member requests for transportation, services/supports as needed.
	  ○ For members that are actively reaching out with needs, care coordinator is encouraged to attempt to complete an assessment.
	  ○ At any point if member is able to be assessed, refer to *Annual Assessment* section above.

Refusal	**The CC is required to complete tasks for the following scenarios:**
	Initial Enrollment: Initial outreach to complete an HRA is due within 60 days of enrollment.
	-OR-
	Annual Reassessment: If the member is due for their first annual reassessment and declines or refuses, the required tasks listed below are to be completed within 365 days from the original enrollment date and within 365 days thereafter.
	• Example: Member enrolls new to UCare 01/01/22 and refuses after 2 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).
	  ○ See *Reassessment Due Date**.
	
	Both Scenarios require these tasks:
	• Document a minimum of 4 actionable attempts* to schedule an assessment*or fewer if member reached.
	  ○ Contacts may be by phone, televideo, in-person, or secure email on different days, at different times, and by using the "Unable to Reach Member Letter" on the UCare website.
	• Document the conversation with the member noting the member refusal.
	• Connect + Medicare: Complete Refusal Support Plan with at least one high priority goal within 30 calendar days of activity date.
	  ○ It is not required to mail the Refusal Support Plan to the member.
	  ○ Reminder: at the time of annual reassessment, close previous Support Plan goals.
	  ○ When completing the Refusal Support Plan, all questions and sections must be completed or marked as "not applicable".
	  ○ Safe Disposal of Medications* is not required for refusal members.
	• Connect: Document outreach attempts and outcome in member record.
	  ○ Reminder at the time of annual reassessment, close any previous Support Plan goals.
	• Send the Provider Engagement Letter to the PCP **IF** known within 30 calendar days of member refusal.
	• Send Member Refusal Letter to member within 30 calendar days of member refusal.
	• Enter Refusal activity in MMIS* within 30 calendar days of the activity date.
	  ○ Activity and effective dates are the date the member refuses assessment.
	  ○ This includes members residing in skilled nursing facilities.
	• Add the member to the Monthly Activity Log as a Refusal member.
	  ○ Update Monthly Activity Log with the Health Status Code of "NI".
	  ○ Return the Monthly Activity Log to UCare by the 15th day of the following month.

	Product Changes • For Refusal members that experience a Product Change, refer to the *New Member* section. • Additional MMIS entry is needed when a UTR/Refusal member has a Product Change and remains a UTR/Refusal. **Mid-Year Review** • Complete ongoing contact Mid-Year at a minimum. • Connect+ Medicare: Update the Refusal Support Plan with the outcome of contact and new goals/interventions as applicable. • Connect: Document Mid-Year Review outreach attempts and outcome in member record. • Complete Transition of Care outreach/tasks when known. • Assist with member requests for transportation, services/supports as needed. ○ For members that are actively reaching out with needs, care coordinator is encouraged to attempt to complete an assessment. • At any point if member is able to be assessed, refer to *Annual Assessment* section above.
SUPPORT PLANS	
Support Plan	The Support Plan reflects a summary of the members assessed strengths, supports, and identified risks and choices. It is a living document that should be updated routinely throughout the year. All members receive outreach at the Mid-Year at a minimum to monitor progress toward goal completion, to provide health education, support, and resources or to attempt to complete the HRA. Updates include additional follow up as stated on the Support Plan as well as Transition of Care updates.
	The CC is required to: • Update and close the "Date Goal Achieved/Not Achieved" column from the current Support Plan with a brief description of the outcome, month and year documented. Retain in member's file. • Develop a person-centered Support Plan with the member at the time of the initial or annual reassessment using the UCare Connect/Connect + Support Plan. • Support Plan must include the names and disciplines of members' Interdisciplinary Care Team (ICT)* as applicable. • **All elements are to be completed in its entirety. Any sections that do not apply should be marked "N/A."** • The Support Plan must include identification of any risks to health and safety and plans for mitigating these risks, including informed choices made by enrollees to manage their own risk. • Information collected through the HRA with the member or representative*/legal guardian includes:

	○ Input from the member and/or family members, the member's authorized health care decision maker, Primary Care Physician (PCP), and other ICT* members. • Develop person-centered goals for identified areas noted in the HRA including any goals to be continued from previous Support Plan. It is not required to develop goals for problems that are not currently active - I.e., when a member's chronic condition is well managed and/or stable. Clearly document in the member safety plan any areas of identified risks for which the member 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. ○ Interventions should include the necessary steps to achieve the goal, who will provide assistance and resources/referrals needed to meet the goal. • The Support Plan is shared within 30 calendar days of the assessment. Day 1 is the date of the assessment. Document in the member record the Support Plan was shared with applicable ICT* members.
Support Plan Signature Page	**The CC is required to:** • Obtain a Support Plan signature from the member or member's representative*. This signature demonstrates that the CC has discussed the Support Plan with the members. ○ The Support Plan is not valid unless signed by the member or representative*. ○ This includes members living in skilled nursing facility. • Sign Support Plan Signature Page and include CC credentials. • If the signature page is mailed to the member to obtain the signature, document the date of when the signature page was sent. ○ Conduct at least one follow-up attempt by phone or mail within two 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.
Mid-Year Review and Ongoing Support Plan Updates	**CC is required to:** • Maintain ongoing contact with all members mid-year at a minimum to update the Support Plan which includes: ○ 4 actionable attempts* to complete Mid-Year Review. ○ Document the "monitoring of progress/goal revisions" and any sections titled "update" directly on the Support Plan. Include date of contact. ▪ **NOTE:** This includes UTR and Refusal Support Plans. • If there is no UTR/Refusal Support Plan for a Connect member, CC should document outreach and outcome in member record.

	• Contact may be completed by phone, televideo, or in-person and is allowed any time 5-7 months from the last assessment date.
	    ○ If the member has a completed HRA and Support Plan and is unable to be reached or refuses the Mid-Year Review, the CC can update the existing Support Plan. This scenario does not require an Unable to Reach Support Plan or Refusal Support Plan to be completed.
	• Connect + Medicare Members: If the assessment was by phone, continue to offer an in-person or televideo visit for the Mid-Year Review update and ongoing contact.
	• Send the updated Support Plan to the Interdisciplinary Care Team* with significant changes.
	• Communicate with the Interdisciplinary Care Team* at least annually.
	    ○ **Monthly Activity Log:** Add Mid-Year Review to the Monthly Activity Log. Do not change HS code when reporting these updates.
	    ○ If member is unable to be reached or refuses the Mid-Year Review, no log is needed.
	    ○ Return the Monthly Activity Log to UCare by the 15th of the following month.

OTHER REQUIRED ACTIVITIES	
Monthly Activity Log	**The CC is required to:** • Enter all assessments, unable to reach and refusals on the Monthly Activity Log. • Enter Mid-Year Reviews and Transition of Care Support Plan updates on the Monthly Activity Log. Do not change HS code when reporting Mid-Year Reviews. ○ If member is unable to be reached or refuses the Mid-Year Review, no log is needed. • Enter all Connect + Medicare additional encounters completed. • Enter transfers from another MCO/FFS and delegate-to-delegate transfers. • Submit the Monthly Activity Log to connectintake@ucare.org by the 15th calendar day of the following month.
Connect + Medicare Additional Encounter Requirements	Care coordinators are to ensure a completed in-person or televideo encounter is completed at least once in a 12-month period with a member of the ICT. If the member declines to meet in-person or via televideo for the assessment, care coordinators may opt to conduct an in-person or televideo encounter at the time of the Mid-Year review update or provide another in-person encounter during the year. Alternatively, if the care coordinator can confirm the PCP or Waiver case manager has seen the member in-person or via televideo, the care coordinator may document this in the member record.

	If none of the above is successful, the care coordinator should support the member in setting up an in-person or televideo encounter with the PCP or other ICT Specialty Care Provider engaged in the member's treatment plan. Document the refusal to meet in-person or televideo with the care coordinator. Also document the time and date of the in-person or televideo encounter with the PCP or other ICT Specialty Care Provider to meet the CMS encounter requirement. • **Monthly Activity Log (MAL):** Add all care coordination additional encounters to MAL under Support Plan update using the "Other" drop down. Do not change HS code when reporting Mid-Year Reviews or other Support Plan updates. ○ Return the Monthly Activity Log to UCare by the 15th of the following month.
Transitions of Care (TOC)	Transition of Care (TOC) assistance is provided when a member experiences a planned or 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. **Transition of Care activities are completed within one business day of the notification.**

	The CC is required to:
	• Monitor EAS for admissions and discharges on business days.
	• Monitor the Daily Authorizations Reports for out-of-state and out-of-network admissions and discharges.
	• Assist with care transitions.
	• Follow steps below.
	
	CONNECT + MEDICARE MEMBERS:
	• Assist with the member's planned and unplanned transitions from one care setting to another care setting.
	    ○ Complete the **TOC* Log**, found on the UCare website along with TOC Log instructions. When completing the TOC Log, all questions and sections must be completed or marked as "not applicable".
	    ○ Contact member/representative* to assist with transition.
	        ▪ When reaching out to the member/representative* for TOC Log tasks, make and document at least 2 actionable attempts*.
	    ○ Share CC contact information and Support Plan/services with receiving setting within one business day of notification of transition.
	    ○ Notify PCP* of transition via fax/phone/EMR/secure email (if PCP was not admitting physician) within one business day of notification of each transition.
	    ○ Document reason for admission and all other relevant information on TOC Log.
	    ○ Continue to log subsequent transitions until member returns to usual setting.

	- In addition, the below tasks should be completed when the member discharges TO their usual care setting. This includes situations where it may be a 'new' usual care setting for the member (i.e., a community member who decides upon permanent nursing home placement). - Communicate with member/representative about care transition process, changes to the member's health status, and support plan updates within 1 business day of notification of transition. - Provide education about transitions and how to prevent unplanned transitions/readmissions. - Complete 4 Pillars for Optimal Transition - Indicate if the member has a follow-up appointment scheduled with primary care or specialist. If not, provide explanation in comments. - For mental health hospitalizations, indicate if the member has a follow-up appointment scheduled with a mental health practitioner within 7 days of discharge. - Indicate if the member can manage their medications or has a system in place to manage medications. If not, provide explanation in comments. - Indicate if member can verbalize warning signs and symptoms and how to respond. If not, provide explanation in comments. - Indicate if the member uses a Personal Health Care Record. If not, provide explanation in comments. - Indicate whether the member's Support Plan has been updated following this transition. If not, provide explanation in comments. - Indicate whether you have reviewed the discharge summary with the member. If not, provide explanation in comments. - Conduct a Change in Condition* assessment in the event of a care transition when a member experiences significant health changes, repeated or multiple falls, recurring hospital admissions, or recurring emergency room visits. **NOTE:** Because members are categorically at-risk during times of transition of care, the care coordinator's judgment may dictate additional follow up based on the care coordinators knowledge of the members situation. - If the TOC resulted in a change to member's services, goals, and/or needs, enter the Support Plan modifications on the *Monthly Activity Log.* **NOTE:** If the CC is notified of the transition(s) 15 days or more after the member has returned to their usual care setting, the CC is not required to complete a TOC Log. However, the **CC is still required to:**

	• Follow-up with the member to discuss the care transition process, any changes to their health status, and their Support Plan. • Provide education about how to prevent a readmission and document this discussion in the member record. • When reaching out to the member/representative*, make and document at least 2 actionable attempts*. • The 15-day exception only applies if the CC finds out about *all* the transitions after the member has returned to their usual care setting. **CONNECT MEMBERS:** • Upon return to usual setting, follow-up with the member to discuss the transition, any changes to their health status, and/or changes to their Support Plan. Use Transition of Care Talking Points on the UCare website. ○ When reaching out to the member/representative*, make and document at least 2 actionable attempts*. • Provide education about how to prevent a readmission and document this discussion in the case notes. • If the TOC resulted in a change to member's services, goals, and/or needs, enter the Support Plan modifications on the *Monthly Activity Log*. • Conduct a 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. • Use professional judgement to determine additional care coordination intervention.
Admission to Nursing Facility	UCare completes **ALL Nursing Facility (NF)** OBRA/Pre-admission Screening and Resident Review (PASRR) activity internally. Those tasks include: • Completing and faxing the OBRA Level 1 to the NF. Make a referral for OBRA Level II if applicable. • For non-waiver members and members on a DD waiver, complete telephone screening (DHS-3427T form) and entering it into MMIS* if applicable. **CC Responsibilities:** • Monitor EAS and the Daily Authorization Report for admissions. • Assist with care transitions. • Connect + Medicare: complete a TOC log. • Determine if a Change in Condition reassessment is warranted. ○ An HRA is not required solely based upon admission to Skilled Nursing Facility.

	• If the member is due for an annual reassessment while receiving care in a SNF, complete based on existing reassessment timelines.
Advance Directives	**The CC is required to:** • Document on an annual basis that advance directives were discussed with the member. • If advance directives were not discussed, document the reason.
Member Death	**The CC is required to:** • Submit a Member Death Notification form to UCare. • Submit the DHS-5181 form to the county of financial responsibility (CFR).
Denial/Termination/ Reduction (DTR)	Denial, Termination, Reduction-UCare or one of its utilization review (UR) teams 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. • Connect and Connect + Medicare care coordinators do not complete DTRs. CC will support the member and UR as needed.
Safe Disposal of Medications	**If member is taking any medications, including controlled substances, the CC is required to complete the below tasks at time of member's Initial Assessment or Annual Reassessment (Not required for UTR/refusal members or Institutional members as the facility has primary responsibility for the disposal of unused medications):** • Discuss information from the Disposal of Medications Safely form with the member. Document the discussion by checking the box in the medications section of the Support Plan. • Provide member with the Dispose of Medications Safely handout. CC must manually add two community drop-off sites closest to the member's location.
Change in Care Coordinator Within the Same Entity	• The new care coordinator (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 by letter, the CC must use UCare's approved Change in Care Coordinator Letter found on the UCare website. • Enter new CC's information in MMIS H-Screen.
Care System or Primary Care Clinic Change (PCC Change)	**The CC completes the following:** • Confirm member has an established PCC. • Ensure PCC is reflected correctly on the care coordination enrollment roster. ○ 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.

	○ 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 with an in-network provider, prior to completing a PCC change form. **NOTE:** The change of PCC does not affect care coordination assignment.
Transferring Member to MSC+/MSHO	**The current (sending) CC is required to:** • Ensure member has a Primary Care Clinic and it is reflected correctly on the care coordination enrollment roster. • Educate member on enrollment options with MSC+/MSHO. • Thoroughly complete all areas of the DHS-6037 Transfer Form and send via secure email or fax to the new (receiving) CC entity. ○ Send to the new CC entity by the 15th of the month. • The transfer must also include: ○ The most recent HRA, Support Plan, Support Plan Signature Page with member signature, relevant case notes, and other applicable case documents.
Medical Assistance Eligibility Renewals	**The CC is required to:** • Review the UCare Connect eligibility renewal report provided by UCare monthly and remind members when they are at risk of losing Medical Assistance eligibility due to incomplete or unprocessed Medical Assistance paperwork. • Assist members with the completion of renewal paperwork as appropriate. **NOTE:** The UCare Keep Your Coverage Team reaches out to select members to provide additional assistance with maintaining eligibility. CC may collaborate with the Keep Your Coverage Team for support in assisting the member with maintaining eligibility.
90 Day Grace Period After MA Terms	**If a member's Medical Assistance (MA) terms, the CC is required to:** • Continue all Care Coordination activities for 90 days after the member's MA termed. • If assessment is due during the 90-day grace period*, complete HRA prior to 365 days of previous HRA and save documents in the member record. See *Annual Assessment section* above. ○ When the member's MA is reinstated, enter the assessment activity in MMIS*. ○ Add the assessment date to the Monthly Activity Log. ○ Return the Monthly Activity Log to UCare by the 15th day of the following month. **NOTE:** If a member enrolls in a new health plan during their 90-day grace period, the grace period ends and new MCO takes over care coordination responsibilities. Document transfer in member record.
Member Change of Address	**The CC is required to:** • Educate member if the new residence will impact care coordination assignment and/or UCare eligibility.

	○ Review DHS-5218, Health Plan Choices by County. • Send the DHS-5181 form to the county of financial responsibility to inform them of the member's new address and date of move. ○ Save a copy of the DHS-5181 in the member record.
Behavioral Health Home (BHH) Services	**The CC is required to:** • Contact BHH provider within 30 business days of notification that the member is receiving BHH. During this call, the CC will: ○ Provide the BHH provider with the CC's contact information. ○ Share information related to the member's Support Plan. ○ Establish contact frequency between BHH provider and CC and preferred method of communication. • Include BHH service on the member's Support Plan. • Include BHH provider as ICT. • Notify BHH staff of any known ER/hospitalization admission and/or discharge. • Notify BHH staff of any transitions of care, post discharge plans and follow-up plans. • Document all contact with BHH provider in the member's record.
Care Coordination with Local Agencies	**The CC is required to make referrals and/or coordinate care with local/county social services and other community resources when needed by member, including but not limited to:** • Housing stabilization services • Pre-petition screening • Preadmission screening for HCBS • County case management for HCBS • 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

Policies and Procedures	UCare and all care coordination delegates are required to have policies and/or procedures that support all the above stated requirements.
Model of Care Training	UCare requires that all CCs complete the Model of Care training within 90-days of hire and annually thereafter. CCs may access this training via WebEx located on the Care Coordination and Care Management page of the UCare website (titled MSHO, ISNP, Connect + Medicare Model Of Care Recorded Training). UCare will also provide Model of Care training to CCs on an annual basis via Quarterly All Care Coordination Meeting. • Each CC will need to submit the electronic attestation form following the completion of training located on the Care Coordination and Care Management page if MOC is not attended via live Quarterly Meeting.
Documentation and Notes	**The CC is required to document in the member record, all evidence of:** • Care coordination requirements being met. • Care coordination requirements that were attempted but not completed. • Member documents including, but not limited to, HRA, Support Plans and TOCs in member record. • Communication with members, representatives, providers, and any other ICT members.

Definitions/Acronyms

Term/Acronym	Definition
Actionable Attempts	An attempt to reach the member where the member can actively respond. This includes a message left on a known working number, letter mailed to a known address at least two days apart or a secure email sent to a known email address. Phone attempts, letters and secure email attempts are made on different dates and varying times. Best practice is to use working phone numbers when available before using letters/secure email. Unable to Reach Member Letter should be one of your 4 attempts.

Assessment Guide	There are 3 methods for completing assessments/reassessments: in-person, televideo, and by phone. Televideo requires robust documentation that member has been given an informed choice of in-person first. Phone assessments must have robust documentation that member has been given an informed choice of in-person first, then televideo second, before completing a phone assessment. See job aid and decision tree on CC website for more guidance. Televideo must be a visual, real time, interactive, HIPAA-compliant telehealth encounter. **NOTE:** An in-person assessment is required: • For all institutional assessments (effective 1/1/2024). • Any time a member/representative* requests an in-person assessment. • If during a televideo or phone assessment, the CC determines an in-person assessment is necessary to complete the assessment. • **Connect + Medicare:** CC is required to continue attempts to meet with member in-person or televideo at least once within the assessment year. If the member completes a phone assessment, the care coordinator will work with the member to set up an in-person or televideo encounter with a member of the ICT. Reference *Connect + Medicare Additional Encounter Requirements*.
Assignment Date	Date the member is assigned to the delegate via the monthly enrollment roster.
CAC/CADI/DD/BI/EW	Home and Community Based Waiver Types: Community Alternative Care (CAC)/Community Access for Disability Inclusion (CADI)/Developmental Disability (DD))/Brain Injury (BI)/Elderly Waiver (EW).
Caregiver Support	A caregiver is a non-paid person that, without their help, paid services would have to be put into place. If there already are services in place, a caregiver is someone who provides care beyond reimbursed hours/service. Caregiver assessment located on eDocs DHS-6914.
Change of Condition	UCare requires care coordinators to conduct an additional HRA in the event of a significant change in a member's condition. Care coordinators may also conduct a reassessment in the event of a care transition that would involve significant health changes, repeated or multiple falls, recurring hospital admissions or emergency room visits. All care coordinators 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.
CSP/CSSP	Community Support Plan/Coordinated Services & Supports Plan. These forms are used following a MnCHOICES Assessment.

EAS	Encounter Alert Services – allows providers throughout the state to receive member encounter alerts, for individuals who have been admitted to, discharged, or transferred from, an EAS participating hospital, emergency department, long-term care facility, or other provider organization in real time.
EMR	Electronic Medical Record.
Enrollment Date	First day of the month the member is enrolled in the current health plan.
FFS	Fee for Service. A person that remains on traditional Medical Assistance without a Managed Care Organization.
HCBS	Home and Community-Based Services. 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.
HRA	Health Risk Assessment (DHS-3428H).
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, as long as 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.
Institutionalized	A member permanently residing in a Skilled Nursing Facility. This may include ICF/DD, Group Homes, Adult Foster Care, and Board and Lodge facilities.
MA	Medical Assistance.
MAL	Monthly Activity Log
MCO	Managed Healthcare 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 requires checking MN-ITS to verify member's eligibility status upon initial assignment.

PCC	Primary Care Clinic.
PCP	Primary Care Physician.
Qualified Professional	Care coordinators are required to be Qualified Professionals (defined in Minnesota as a licensed social worker, mental health professional, registered nurse, physician assistant, nurse practitioner, public health nurse or physician) with the exception of a county social worker who is employed by the county.
Reassessment Due Date	Reassessment timelines differ based on the outcome of the initial assessment: If the initial assessment results in a UTR/Refusal the reassessment due date is within 365 days of the original enrollment date*. Subsequent reassessments need to be within 365 days of the last activity date. • UTR Activity Date = date of last actionable attempt to reach member for assessment. • Refusal Activity Date = date member refused/declined HRA. If the initial assessment results in a completed assessment the reassessment is due within 365 days of the previous assessment activity date.
Representative	A members verified legal alternative decision maker. For example: court appointed guardian/conservator or health care agent. Obtain a copy of guardian/conservator or Health Care Directive documents to verify level of representation. **Some 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, Time-bound.
THRA	Transfer Member Health Risk Assessment. CC may use Transfer Member Health Risk Assessment (THRA) when an HRA and Support Plan completed within the last 365 days are obtained, and the member is able to be reached within 60 calendar days of enrollment. By completing the THRA the CC is adopting this assessment and Support Plan as their own. THRAs may be used for Product Changes, Members Transferred Between Delegates, and Members Transferred from different SNBC Managed Care Organizations (MCO) to UCare Connect/Connect + Medicare.
UTR	Unable to Reach.

eDocs Form Names	
eDocs Number	**Title of Document**
DHS-3426	OBRA Level 1 Criteria-Screening for Developmental Disabilities or Mental Illness
DHS-3427H	Health Risk Assessment Screening Document-MSC+, MSHO and SNBC Form: • This is a companion form to the DHS-3428H. This form is used by managed care organizations to record the health risk assessments for data entering in MMIS.
DHS-3428H	Minnesota Health Risk Assessment Form: • Health plan care coordinators use it to record the health risk assessments that are entered into the MMIS.

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 address changes, death notification, care coordinator changes and name changes to the county financial worker.
DHS-5841	Managed Care Organization, County Agency, and Tribal Nation Communication Form - Recommendation for State Plan Home Care Services: • Health plans, counties and tribes use this form to make initial or modified requests for authorization of home care services or provide information about changes in services authorized by a health plan. This form is used for clients in MSHO, MSC-Plus, SNBC and MA-Families and Children.
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-8354	MCO Member Address Change Report Form. • This form is for Care Coordinators to report member change of address. Online use only: DHS-8354-ENG (MCO Member Address Change Report Form) (mn.gov)