Minnesota Senior Health Options (MSHO) and Minnesota Senior Care (MSC+)
Care Coordination (CC) Requirements for Institutionalized Members
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 an individualized care 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.

Table of Contents

Nursing Home Requirements Grid	
Initial Assignment	Upon receiving the monthly care coordination 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.
Assessment Section	
Initial Health Risk Assessment	Within the month of enrollment, but not to exceed 30 days, the CC is required to: • Review the MDS assessment completed by the facility staff. • Document the review of the MDS assessment and other pertinent information about the member on the Institutional Care Coordination Document (ICCD) form. • Document face-to-face contact with the member. • Obtain a copy of the nursing home's plan of care (POC) and keep it in the member record. • List the members of the ICT on the ICCD or obtain the signature page of the MDS to show proof of the member's ICT and keep it in the member's record. • Document any discussion with the facility if modifications are needed to the POC. • Enter the assessment on the MSHO Part C Assessment Log (for MSHO members).
Annual Re-Assessment	The CC is required to: • Conduct a face-to-face assessment and complete a new ICCD form within 365 days of the last face-to-face annual assessment. • Review the comprehensive assessment (MDS) and POC at the time of the ICCD and document the review. • Maintain a copy of the nursing home POC and keep in the member record. • List the members of the ICT on the ICCD or obtain the signature page of the MDS to show proof of the member's ICT and keep in the member record. • Reassess the member's desire/ability to return to the community or indicate "not applicable" (due to member's condition). Enter the assessment on the MSHO Part C Assessment Log (for MSHO members).
Product Change-This is a UCare member that has had a product change	The CC is required to: • Provide the member with the name and telephone number of the new 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 care coordination enrollment roster. This may be done by phone or letter, and must be documented in the member

(i.e. MSHO to MSC+ or vice versa)	record. If contact is by letter, the CC must use the approved MSHO/MSC+ "Welcome Letter- Member in Nursing Home" found on UCare's website. • Review the MDS, POC, and ICCD within the month of enrollment via phone or face-to-face. • Document the review on the ICCD form under the comments section and attach to the member record. Enter the assessment on the MSHO Part C Assessment Log (for MSHO members).
ICF-DD members	**For members residing in a group home** that are identified as institutional on the care coordination enrollment roster, refer to the Community Care Coordination Requirements Grid.
OBRA Level I	Not applicable for institutionalized members.
Entry of HRA into MMIS	Not applicable for institutionalized members.
Other Required Care Coordinator Activities	
Ongoing Contact with Member	The CC is required to: • Contact or check in with the member/or facility staff at a minimum of every 6 months via phone or face-to-face (with a 30 day lee-way before and after the previous 6-month contact date). • Document the 6-month check in and updates on the ICCD form.
Advance Directives	The CC must document on an annual basis that they addressed or discussed advance directives with the member, or Document the reason why advance directives were not discussed.
Annual Preventive Care	The CC is required to: • Document on the ICCD form that a conversation was initiated with the member and/or facility staff regarding preventive health care (e.g., pneumovax, flu shot, dental visit, vision evaluation) or, the POC was reviewed for preventive health measures).
Interdisciplinary Team Collaboration	The CC is required to: • Ensure the facility POC employs an interdisciplinary approach by incorporating the unique primary, acute, long term care, mental health and social service needs of each member with appropriate coordination and communication across all providers. 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 (including MLTSS) 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. • Document a list of members of the ICT (from the ICT section of the MDS) in the member record.

DTR requirements-medically necessary services	UCare, or one of its utilization review delegates, must review all services that require a medical necessity review. UCare issues a 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. DTR of these services requires review and determination by a Medical Director.
Transitions of Care	**MSHO**: 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, when due to a change in the member's health status, is considered a separate transition. • **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).** • 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. 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: • 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 discussion in case notes.** The 15-day exception only applies if the CC finds out about all of the transitions after the member has returned to the usual care setting. **MSC+:** The CC is required to: • 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.
Transfer and Communication Form (DHS #6037)	The sending CC is required to: • Complete the DHS-6037 Form and send or fax it with the most recent ICCD or corresponding EMR/NP assessment to the new CC agency (receiver) as soon as the enrollment with the new agency occurs, but no later than the 15th day of the month. • Refer to the Primary Care Clinic change process on the UCare website. The receiving CC is required to: • Review transferred documents for completeness and attach in the member record.

	• Document this review in the member's file. • Complete a new ICCD face-to-face within 30 days of the transfer if unable to get the previous ICCD from the sending CC. • Refer to the Primary Care Clinic change process on the UCare website.
Actions for when a member moves	CC is required to: • Send the DHS-5181 communication form to the county to inform them of the member's new address and date of move. • Document this in member record. • Inform the member or representative to update their address with the county financial worker.
Actions for when a member discharges to the community	The CC is required to: • Complete an HRA with the member face-to-face using the DHS-3428 Long Term Care Consultation (LTCC) form. 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. • 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 *My Move Plan Summary document* 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.
Actions for when a member dies	The CC is required to: • Submit a Member Death Notification Form to UCare. • Send the DHS-5181form to the county financial worker.
Documentation Notes	The CC is required to document in the member's care coordination record: • 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 & Procedures	UCare and all care coordination delegates are required to have policies and/or procedures that support all the above stated requirements.
MSHO Model of Care Training	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.

DHS eDocs Form Names	
eDocs Number	Title of Document
DHS-3428	Minnesota Long Term Care Consultation Services Assessment Form: • This form is used by lead agencies to record LTC assessments.
DHS-3936	My Move Plan Summary Form: • When a person who receives long-term services and supports is moving to a new residence, he or she completes the My Move Plan Summary (DHS-3936) form with case manager/support planner.
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.