

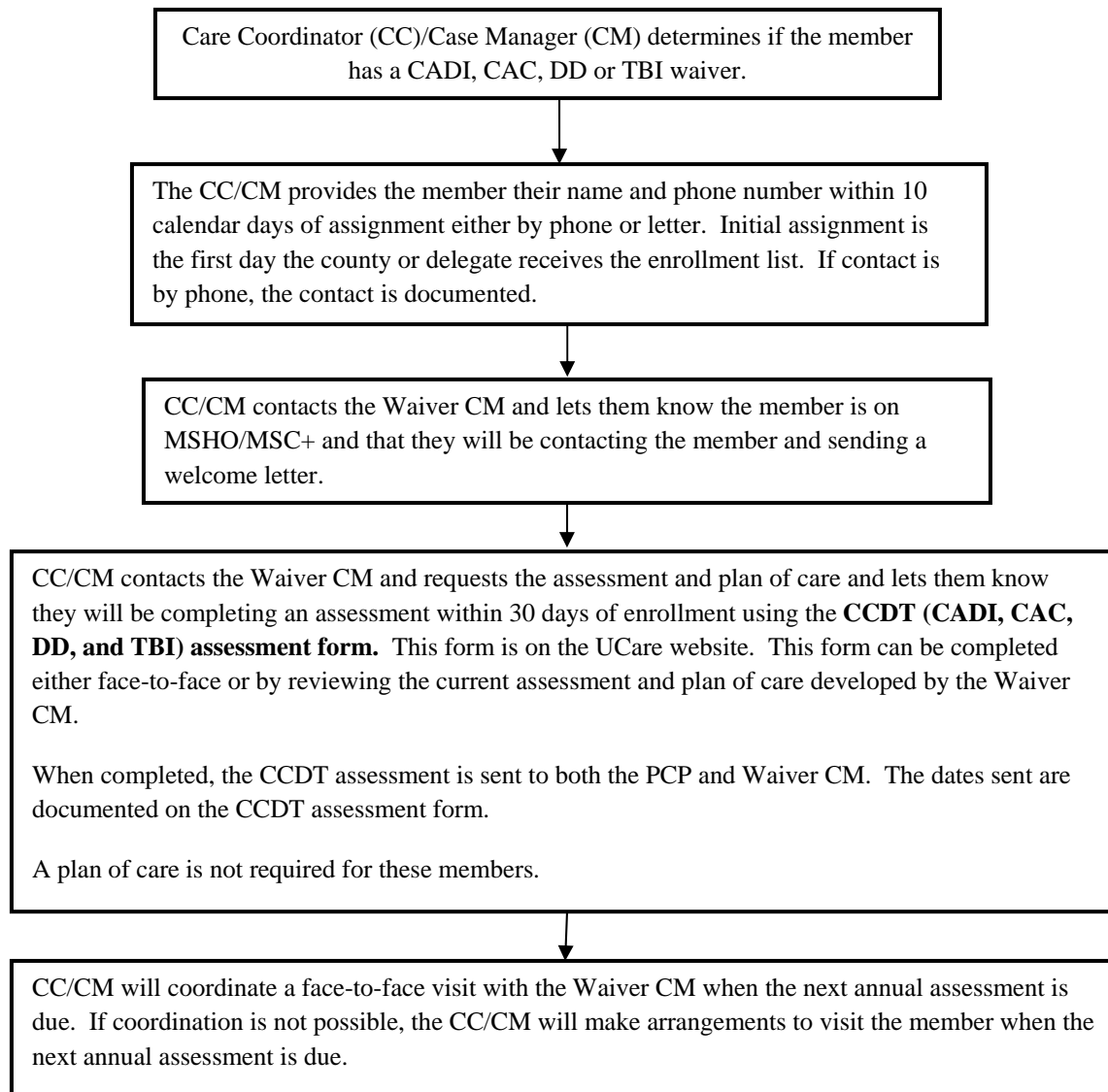


## Care Coordination/Case Management for MSHO/MS<sup>+</sup> members who are on a CADI, CAC, DD, or TBI Waiver

All MSHO/MS<sup>+</sup> activities such as contact, health risk assessments, care planning, etc. continue to be required per UCare guidelines. However, to avoid duplication with the waiver case manager, the Care Coordinator (CC)/Case Manager (CM) may complete some of these requirements in conjunction with the Waiver Case Manager's current assessment and plan of care.

The CC/CM will work together with the Waiver Case Manager (Waiver CM) to coordinate services for these members. The CC/CM will use the DHS Managed Care Organization/Lead Agency Communication Form #5841 to communicate any state plan home care services that are authorized by UCare.

### New Member or Transferred Member





### **Ongoing contact with the member**

The CC/CM must have ongoing contact with the Waiver CM and/or member at a minimum of every 6 months and update the CCDT assessment as necessary. This contact may be either face-to-face or telephonically.

The CC/CM will work with the Waiver CM to coordinate services for the member.

The CC/CM will use the DHS Managed Care Organization/Lead Agency Communication Form #5841 to communicate any state plan home care services that are authorized by UCare.

### **Annual Reassessment**

On an annual basis, the CC/CM will request the Waiver CM's assessment and plan of care. The CC/CM will complete a new CCDT assessment and coordinate a face-to-face visit with the Waiver CM. If coordination is not possible, the CC/CM will make arrangements to visit the member within the month the annual assessment is due.