



2011 Minnesota Senior Care Plus (MSC+) Case Management (CM) Requirements Updated 2/24/2011

All Minnesota Senior Care Plus (MSC+) members are automatically enrolled in case management and assigned a Case Manager (CM) who is a Qualified Professional and receive case management until disenrollment.

	Community Non-Elderly Waiver Members	Community Elderly Waiver Members	Institutionalized Members
Initial assignment	The member must be provided with the name and telephone number of the Case Manager (CM) within 10 calendar days of initial assignment and document this. Initial assignment is the first day the care system or county receives the enrollment list.		
Initial contact with member	The CM must make 3 attempts to contact the member within 30 calendar days of enrollment. Contact may be by letter, face-to-face or by phone. If contact is by letter, the CM must use UCare's approved MSC+ welcome letter found on UCare's website.		
Unable to contact/refusal	If the CM is unable to contact the member within the first 30 days of enrollment, an entry in MMIS needs to be completed with activity type 39 (refusal of HRA) and the activity date as the first date the CM attempted to reach the member. The CM will again attempt to reach the member in 6 months. The CM will continue to document attempts to reach the member and annually update MMIS as appropriate.		
Initial Health Risk Assessment	<p>A health risk assessment is NOT required when:</p> <ul style="list-style-type: none"> ◆ The member has a change in CM, but there is not change in health plan or product. This includes transfers from one delegate to another in the same health plan, e.g., Aspen to UCare, UCare to county; or, a transfer between CMs in the same entity; and ◆ The CM receives all of the following from the previous case management entity: <ul style="list-style-type: none"> ○ The previous LTCC (or verification of an LTCC entered into MMIS within the past 12 months, using activity type 02 or 06); and, ○ The most recent plan of care (POC). <p>If the previous LTCC is not received or verified in MMIS or if a plan of care is not</p>		<p>Review of the Minimum Data Set (MDS), completion of an Institutional Care Coordination Document ICCD form, and face-to-face or phone contact with member or facility is NOT required when:</p> <ul style="list-style-type: none"> ◆ The member has a change in CM, but there is not change in health plan or product. This includes transfers from one delegate to another in the same health plan, e.g., Aspen to UCare, UCare to

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	<p>received, a new, full LTCC assessment must be done face-to-face.</p> <p>Upon receipt or verification of the LTCC and receipt of the POC, the CM would be required to:</p> <ul style="list-style-type: none"> ◆ Ensure that the member has a face-to-face reassessment every 12 months. The CM may keep the current annual assessment schedule as long as a yearly LTCC is done. ◆ Inform the member of a change in CM within 10 days of change in CM assignment. ◆ Document in case notes the review of the POC, LTCC assessment or MMIS screen. ◆ Update the care coordinator information in MMIS. ◆ No health risk assessment is due at this time. ◆ No new POC is required at this time, but the existing POC may be updated to include documentation of the review of transfer information. The CM must still ensure that services are appropriate and adequate for the member. <hr/> <p>A health risk assessment via phone or in person IS REQUIRED when:</p> <ul style="list-style-type: none"> ◆ The member changes CM due to a change in health plan (member becomes a new enrollee). ◆ The member changes products, even if member stays within the same health plan, and/or keeps the same CM (member becomes a new enrollee). <p>The health risk assessment:</p> <ul style="list-style-type: none"> ◆ Must be conducted within 30 days of enrollment or within 10 days of request by member, member’s rep or other party. • May be conducted via phone, or in person. • Must include a review of pertinent areas of the LTCC #3428 or LTC #3427 assessment form (at a minimum, those elements of the LTCC # 3428 marked with a “SD”, that refer to the questions on the DHS form #3427 – LTC 		<p>county; or, a transfer between CMs in the same entity; and</p> <ul style="list-style-type: none"> ◆ The CM receives the most recent ICCD form. <p>Upon receipt of the ICCD form, the CM would be required to:</p> <ul style="list-style-type: none"> ◆ Review current ICCD and document review on ICCD form. ◆ Identify when next check in is due and whether the sender has attended a care conference. Initial assessments and reassessments should be kept on schedule, based on information on the ICCD. ◆ Inform the member of a change in CM within 10 days of change in CM assignment. ◆ Update the care coordinator information in MMIS. <hr/> <p>Review of the MDS, completion of an Institutional Care Coordination Document ICCD form, and face-to-face or phone contact with member or facility IS REQUIRED when:</p> <ul style="list-style-type: none"> ◆ The member changes CM due to a change in health plan (member becomes a new enrollee). ◆ The member changes products, even if member stays within the

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	<p>screening document, or all elements of the LTC #3427, plus a review of ADLs, and current medications). This should also include any questions that are pertinent to completion of an effective care plan. (The #3427T – Telephone Screening Document is NOT appropriate because it does not include review of ADLs).</p> <p>In order to do a telephonic assessment, the CM must receive the following from the previous case management entity:</p> <ul style="list-style-type: none"> ◆ The previous LTCC (or verification of an LTCC entered into MMIS within the past 12 months, using activity type 02 or 06.) ◆ The most recent plan of care (POC). <ul style="list-style-type: none"> ○ If the previous LTCC or POC is not received (or verified in MMIS), a new full LTCC assessment must be done face-to-face. ○ The POC must meet UCare’s care plan requirements. If appropriate information is not received on the transferred POC, the CM must revise the received POC, or complete a new POC using the “Collaborative Care Plan” form. If the received POC is not sufficient to determine services needs, the CM should conduct a full LTCC, face-to-face, and complete a new POC. <p>Upon completion of the telephonic health risk assessment, the CM would be required to:</p> <ul style="list-style-type: none"> ◆ Ensure that the member has a face-to-face reassessment every 12 months. The CM may keep the current annual reassessment schedule as long as a yearly LTCC is done. ◆ Inform the member of a change in case manager within 10 days of change in CM assignment. ◆ Document the review of the POC and existing LTCC assessment or MMIS screen. ◆ Update the care coordinator information in MMIS. 		<p>same health plan, and/or keeps the same CM (member becomes a new enrollee).</p> <ul style="list-style-type: none"> ◆ The previous ICCD form is not received. ◆ Within 30 days of enrollment, the CM would be required to review MDS assessment completed by the facility staff; document review of assessment and other pertinent information about the member on the ICCD form; and make a face-to-face or phone contact with member or facility at the time of the initial assessment. <hr style="border: 1px wavy orange;"/> <p>Review of the MDS, completion of an Institutional Care Coordination Document ICCD form, and face-to-face contact with member IS REQUIRED when:</p> <ul style="list-style-type: none"> ◆ The member is brand new and has never been seen before. ◆ Within 30 days of enrollment, the CM would be required to review MDS assessment completed by the facility staff; document review of assessment and other pertinent information about the member on

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	<p>A face-to-face, full LTCC, using DHS form #3428 IS REQUIRED when:</p> <ul style="list-style-type: none"> • The CM does not receive a previous LTCC and/or cannot verify that a LTCC has been conducted within the past 12 months. (The CM does not have verification of a LTCC entered into MMIS within the past 12 months; activity type 02 or 06 not in MMIS within the past 12 months); and/or, • The CM does not receive a copy of the POC. • Must be conducted within 30 days of enrollment or within 10 days of request by member, member’s rep or other party. • Enter or update care coordinator information in MMIS. 		<p>the ICCD form; and make a face-to-face contact with member at the time of the initial assessment.</p>
<p>Members on CAC/CADI/DD/TBI waiver</p>	<p><u>New Member or Transferred Member:</u> The CM contacts the CAC/CADI/DD/TBI waiver case manager (CM) to let them know the member is on MSC+ and that they will be contacting the member and sending a welcome letter. CM requests the assessment and plan of care and lets the Waiver CM know they will be completing an assessment with in 30 days of enrollment using the CADI/CAC/DD/TBI assessment form. (CCDT assessment form found on UCare’s website). This form can be completed either face-to-face or by reviewing the current assessment and plan of care developed by the Waiver CM. When completed, the CM sends the CCDT assessment to both the Primary Care Provider and Waiver CM. The dates sent are documented on the CCDT assessment form. A plan of care is not required for these members. CM will coordinate a face-to-face visit with the Waiver CM when the next face-to-face visit is scheduled. If coordination is not possible, the CM will make arrangements to visit the member within 6 months of the transfer or enrollment.</p> <p><u>Annual Assessment:</u> On an annual basis the CM will request the Waiver CM’s assessment and plan of care. The CM will complete a new CCDT assessment and coordinate a face-to-face visit with the Waiver CM. If coordination is not possible, the CM will make arrangements to visit the member within the month the annual reassessment is due.</p>		<p>Not applicable.</p>

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	<p><u>Ongoing Contact with the member:</u> CM must have ongoing contact with the Waiver CM and/or member at a minimum of every 6 months and update the CCDT assessment form as necessary.</p> <p><u>Entering assessments into the MMIS system is the responsibility of the CAC/CADI/TBI/DD waiver CM. Care systems and counties do not enter any assessments into MMIS.</u></p>		
Entry of health risk assessment into MMIS	For members NOT on a waiver, the CM is required to enter this assessment into MMIS using the LTC Screening document (DHS form #3427), using an activity type code 01 (telephone screen). The CM would keep the current reassessment schedule and conduct a full LTCC, face-to-face, within 12 months of the previous full LTCC.	For members who are on a waiver, the health risk assessment is NOT entered into MMIS (because there is not an appropriate way to do this), but is kept in the member's chart. The assessment should be logged for Part C reporting.	Not applicable.
	Any time a comprehensive LTCC (face-to-face initial or reassessment) is completed, the screening MUST be entered into MMIS, using an activity type code 02 or 06.		If a comprehensive face-to-face LTCC assessment is completed before member is discharged from an institution, use activity type code 04 (relocation/transition assessment).
Initial assessment form	Must use the DHS LTCC form #3428 or #3428A. If completing a health risk assessment when a previous LTCC has been done within the past year, and other criteria are met for a health risk assessment, then the DHS #3427 may be used. When completing the LTCC, all questions and sections must be completed or marked as 'not applicable', including the Caregiver	Must use the DHS LTCC form #3428 or #3428A. If completing a health risk assessment when a previous LTCC has been done within the past year, and other criteria are met for a health risk assessment, then the DHS #3427 may be used. When completing the LTCC, all questions and sections must be completed or marked as 'not applicable', including the Caregiver	The CM must review the MDS assessment completed by the facility staff.

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	Support section. The LTCC must be entered into MMIS within 30 days of assessment	Support section. The LTCC must be entered into MMIS prior to capitation end date.	
OBRA Level I assessment	An OBRA Level I assessment must be completed by the CM for all members at the time of the LTCC assessment. A new OBRA Level I assessment must be completed at the time of annual reassessment.		OBRA Level I is required only on admission to the facility. It is the responsibility of the CM to provide a completed OBRA Level I to the facility. The OBRA Level I is only valid up to 60 days prior to a nursing home admission. If the previous OBRA Level I was completed greater than 60 days prior to admission, it must be redone by the CM.
Collaborative Plan of Care (POC)	Not applicable because a POC is not required for community non-elderly waiver members.	<p>A collaborative care plan must be developed and/or updated for every member within 30 calendar days of the health risk assessment (LTCC), using the Collaborative Care Plan form.</p> <p>The CM has the lead responsibility for creating, implementing, and updating the care plan. The care plan must be updated every time services are modified.</p> <p>The care plan must meet all care plan requirements as outlined in the DHS care plan audit protocol including the following:</p>	<p>The CM must review the nursing facility's plan of care within 30 days of enrollment, document their review on the UCare ICCD Form, and document any discussion with the facility if modifications are needed to the care plan.</p> <p>The CM must annually assess the member's desire or ability for relocation back to community and document this on the ICCD form.</p>

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		<ul style="list-style-type: none"> • Identification of member needs and concerns. • Goal created for each identified need found in the LTCC/HRA • Goals and target dates, with a month and year. It is not acceptable to state “ongoing”. • Interventions. • Documentation of monitoring progress toward goals, interventions, and services. • Outcomes and achievement dates with a month & year. It is not acceptable to state “ongoing”. • Follow-up plan for contact for preventative care, long term care and community support, medical care, or mental health care, or any other identified concern. • Caregiver support is planned, if applicable. 	
Care plan signature page	Not applicable because a POC is not required for community non-elderly waiver members.	<p>The member or member’s representative must sign the Plan of Care form on an annual basis to document that they have been given a summary of the care plan and are in agreement with the services and plan of care.</p> <p>It also must state that they were given a choice between Home and Community Based Services (HCBS) and nursing</p>	Not applicable.

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		<p>home services; that they have been involved in their care planning; and that they were given timely information about available services and their right to exercise a choice in selecting HCBS providers, if applicable. The CM must allow the member to see a copy of the UCare HCBS provider directory, either in hard copy, or in an electronic format.</p> <p>The CM must document that they have sent a copy of the care plan to the member or the member’s representative; and, if the care plan is not signed, the CM must document they attempted to obtain a signature.</p>	
Personal risk management plan (PRMP)	If the member refuses to have an assessment or refuses recommended services, the CM must document the refusal and discuss (and document discussion of) a personal risk management plan (PRMP) or document the member’s refusal to discuss a PRMP. The CM must make another attempt to assess no later than at the time of the six month check-in.		Not applicable.
Service back-up plan	Not applicable.	For members receiving care or EW services, the CM must document a discussion of what the member should do in the event that EW services or caregivers become unavailable.	Not applicable.

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Financial eligibility for elderly waiver (EW) services	Not applicable.	The member's financial eligibility for EW services must be verified prior to initiating EW services. The CM must communicate with the county financial worker, using the Lead Agency Case Manager/Worker Communication form (DHS form #5181, which includes verification of completeness of the DHS form #3543) to determine the member's eligibility for EW services and implement those services only upon verification of eligibility (receipt of approval via the DHS form #5181). The CM should place a copy of the #5181 form in the care coordination chart. EW services should NOT be initiated if financial eligibility is not documented via the #5181 form or verbal notification of eligibility from the financial worker. The CM must make a best effort to obtain the form. If the member is not financially eligible for EW services, the CM should notify the member via DTR form, and update the POC to exclude waiver services.	Not applicable.
Primary Care Clinic (PCP)/Primary Care Physician (PCP) contact	The CM must attempt to contact the member's PCC/PCP within 90 days of enrollment, and at least annually thereafter, to address the member's needs and plan of care. This contact may be by phone, written communication, fax of care plan or care plan summary, or face-to-face. Communication must occur as needed, at least annually, and the CM should document this communication.		As needed.
Ongoing contact with	The CM must have ongoing contact or check-in with the member at a minimum of every 6 months (30 day leeway before and after the 6 month contact) to update the		The CM must have ongoing contact or check-in with the member and/or

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member and care plan update	plan of care. Contact may be by phone or face-to-face.		<p>facility staff at a minimum of every 6 months (30 day leeway before and after the 6 month contact). Contact may be by phone or face-to-face. The CM must document six month check-in and updates on the UCare Institutional Care Coordination Documentation Form.</p> <p>The CM must attend a minimum of one care conference annually (attendance may be by telephone). It is the CM's responsibility to follow up with the facility regarding care conference dates and attendance.</p>
Annual reassessment	<p>CM must complete the LTCC by the last day of the same month as the previous year's LTCC. Example, if last LTCC was done 11/2/10, then the reassessment must be done by 11/30/11.</p> <p>The reassessment must be a face-to-face contact.</p> <p>The LTCC must be entered into MMIS within 30 days of reassessment.</p>	<p>CM must complete the LTCC by the last day of the same month as the previous year's LTCC. Example, if last LTCC was done 11/2/10, then the reassessment must be done by 11/30/11.</p> <p>The reassessment must be a face-to-face contact.</p> <p>The LTCC must be entered into MMIS prior to capitation end date.</p> <p>*During the first year of enrollment, the waiver span must be renewed 11 months after opening; therefore the LTCC would be done in the month</p>	<p>The CM must complete a new ICCD form annually.</p> <p>The CM must review the comprehensive assessment (MDS) and POC at least once per 12 months and document their review.</p> <p>CM also must reassess member's desire to return to the community or indicate "not applicable" (due to member's condition.)</p>

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		prior to the month of the last year's LTCC.	
Advance directives	The CM must document on an annual basis that they addressed or discussed advance directives with the member, or that an advance directive is culturally inappropriate for the member.		The CM must document on an annual basis that they addressed or discussed advance directives with the member, or that an advance directive is culturally inappropriate for the member.
Annual preventive care	Documentation in member's record that substantiates a conversation was initiated with member about the need for an annual, age-appropriate comprehensive preventive health exam.	Documentation on member's POC that substantiates a conversation was initiated with member about the need for an annual, age-appropriate comprehensive preventive health exam	Documentation on the ICCD that substantiates 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 care plan was reviewed for preventive health measures.
Caregiver* support *A caregiver is a non-paid person or someone who provides care beyond reimbursed hours/services.	If a caregiver is identified in the "Caregiver Supports/Social Resources" section of the LTCC, then the CM must complete the "Caregiver Assessment" section of the LTCC; and, have documentation in member's record regarding caregiver needs, if applicable. If the caregiver declines the assessment, document this. If a caregiver is not identified, the CM must indicate "NA" (not applicable) in the caregiver assessment section of the LTCC.	If a caregiver is identified in the "Caregiver Supports/Social Resources" section of the LTCC, then the CM must complete the "Caregiver Assessment" section of the LTCC; and, incorporate caregiver needs into the POC, if needs are identified. If the caregiver declines the assessment, document this. If a caregiver is not identified, the CM must indicate "NA" (not applicable) in the caregiver assessment section of the LTCC.	Not applicable.
Change in Case Manager	The new Case Manager (CM) 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 CM must use		The new Case Manager (CM) must notify the member of their name and phone number within 10 calendar days

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	UCare's approved change in CM letter found on UCare's website.		of change in assignment. This can be done by phone or letter. The contact must be documented. If by letter, the CM must use UCare's approved change in CM letter found on UCare's website.
Medicaid eligibility renewals	To the best of their ability, the CM is encouraged to remind members that they are at risk of losing Medicaid eligibility due to failure to complete and return Medical Assistance paperwork; and, to assist members with the completion of renewal paperwork.		
DTR requirements- medically necessary services	UCare, or one of its utilization review delegates, must review all services that require a medical necessity review. A DTR letter must be sent 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.	UCare, or one of its utilization review delegates, must review all services that require a medical necessity review. A DTR letter must be sent 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 and must be referred to UCare, or, if applicable, one of its utilization review delegates.	UCare, or one of its utilization review delegates, must review all services that require a medical necessity review. A DTR letter must be sent 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.
DTR requirements – waived services	Not applicable.	The Minnesota Department of Human Services (DHS) requires that MSHO members receive a Denial, Termination, or Reduction (DTR) letter when previously authorized waiver services are denied, terminated, or reduced. Tips for determining when a DTR letter is required include the following: <ul style="list-style-type: none"> ♦ A DTR notice is required when a 	Not applicable.

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		<p>CM denies, terminates, or reduces a waiver service that has been requested by the member, ordered by a participating provider, ordered by an approved, non-participating provider, ordered by a care manager, or ordered by a court.</p> <ul style="list-style-type: none"> ◆ If the member initiates the termination or reduction of a waiver service, then a DTR notice is not necessary, but the CM must document that the member initiated the termination; and document that the CM notified the service provider. ◆ If a member is receiving extended PCA services, and the case manager/care coordinator initiates a termination or reduction of those services, a DTR notice should be issued, unless the duration of the current authorization has ended <u>and</u> the member is asking to terminate the service. To issue a DTR for extended PCA services, complete the Care Coordinator UR Communication form (found on UCare’s website) and fax to UCare. <p>Delegated counties and care systems must submit a completed DTR Notification Form to UCare within 1 business day of the decision date to initiate UCare’s DTR letter generation</p>

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		process. At a maximum, UCare needs the DTR Notification Form within 10 calendar days from the service request date so we can issue the DTR in a timely manner. UCare will generate the actual DTR letter upon receipt of the DTR Notification form. The DTR notice provides the member with information about the service being denied, terminated, or reduced, and provides appeal rights. The county Notice of Action should not be used for UCare members.	
Logging of DTRs-waivered services	Not applicable.	The CM is required to log all DTRs for waiver services and submit to UCare on a monthly basis, even if there are no entries.	Not applicable.
Admission to a nursing home for community-based members	Not applicable.	When a member is in a nursing home greater than 30 days, the CM must close the waiver span in MMIS. CM will send DHS-5181 to the county of financial responsibility informing them of the nursing home admission and to close the waiver span. CM should notify providers that the member is in the nursing home and they should no longer bill for services.	It is the responsibility of the CM to provide a completed OBRA Level I to the facility. The OBRA Level I is only valid up to 60 days prior to a nursing home admission. If the previous OBRA Level I was completed greater than 60 days prior to admission, it must be redone by the CM.
Transition management	<p>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* and requires:</p> <ul style="list-style-type: none"> • A consistent CM to support the member throughout the transition. • Sharing of essential information with the receiving facility within one business day of date the CM learns about 		

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	<p>admission; essential information includes:</p> <ul style="list-style-type: none"> ○ services member currently was receiving; ○ names of service providers; and, ○ PCP contact information (resource for current medications, chronic conditions and current treatment). <ul style="list-style-type: none"> ● PCP notification of admission within one business day of date the CM learns of admission, if PCP/clinic is not involved with the admission. ● Communication with facility, providers, member, and/or responsible party about the transition process and changes in member’s health status and care needs. ● Communication with discharge planner, re: what services member used; what new services/equipment may be needed; and who will arrange services. ● Follow up with member or representative (by phone or in person) within one business day of notification regarding: <ul style="list-style-type: none"> ○ medication changes and filling new prescriptions; ○ DME and supplies; ○ follow up appointment and transportation needs; ○ changes in functional status (e.g., bathing, eating, etc.); and, ○ what to do if condition changes or worsens. ● Enter each transition* onto the “Individual Care Transitions Log” form (and file form in member’s record). <p>* Example: Member leaves home and is admitted to a hospital=one transition; member is discharged from hospital to a skilled nursing facility (SNF) =one transition; member returns home=one transition. Member has a total of three transitions and each one would have its own entry on the “Individual Care Transitions Log”.</p>		
<p>Universal transfer form (UTF)</p>	<p>The current care coordination agency (sender) completes the Universal Transfer Form (UTF) from UCare’s website and sends or faxes the UTF with the most recent LTCC, OBRA Level I, and plan of care (if member is on a waiver) on to the new care coordination agency (receiver) as soon as the enrollment with the new agency occurs. For members on the monthly enrollment list that need to be transferred, send the UTF and supporting documentation to the new care coordinator by the 15th of the month.</p> <p>Please refer to the Primary Care Clinic change process located on the UCare website.</p>		<p>The current care coordination agency (sender) completes the Universal Transfer Form (UTF) from UCare’s website and sends or faxes the UTF with the most recent Institutional Care Coordination Document ICCD to the new care coordination agency (receiver) as soon as the enrollment with the new agency occurs. For members on the monthly enrollment</p>

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			list that need to be transferred, send the UTF and supporting documentation to the new care coordinator by the 15 th of the month. Please refer to the Primary Care Clinic change process located on the UCare website.
Actions for when a member moves	CM will send the DHS-5181 communication form to the county of financial responsibility to inform them of the member's new address and date of move. CM will keep record of this in member's file. CM will inform the member to update their address with the county and UCare Customer Service.		
Case mix service caps	Not applicable.	All state plan home care and EW services must be based on assessed need and must not exceed the case mix monthly cap amount. If costs are over budget, the CM and member (or member's rep) must evaluate and make a determination regarding service needs and priorities in order to ensure that service costs do not exceed the monthly case mix cap. If the member and/or CM feel strongly that the member must receive services that exceed the monthly case mix cap, the CM must request a benefit exception from UCare. When requesting a benefit exception, the CM must provide a detailed cost benefit analysis for review by UCare. If the benefit exception request is denied, service costs must not exceed the monthly waiver cap.	Not applicable.
Actions for when a member	The CM must submit a death notification to UCare.	The CM must submit a death notification to UCare <u>and</u> close the	The CM must submit a death notification to UCare.

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dies		waiver span in MMIS. (Using DHS-5181).	
Documentation notes	The CM must document in the member's care coordination record all evidence that care coordination requirements as stated in this document are being met. If any of the requirements were attempted but not completed, the CM must document all attempts in the member care coordination record.		
Policies and procedures	All UCare delegates are required to have policies and/or procedures that support all the above stated requirements.		