

New enrollee = an enrollee new to UCare, even if transitioning from another health plan, with the same product, or an enrollee who is new to the product –ie – MSC enrollee transitioning to MSC+.

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Minnesota Senior Care Plus (MSC +) Case Management (CM) Requirements Updated 1/6/09

All MSC+ Enrollees are automatically enrolled in Case Management and assigned a Case Manager (CM).

	Community (Non-Elderly Waiver) Members	Community Elderly Waiver Members	Nursing Facility (NF) Residents
Initial contact with enrollee	Initial contact within 30 calendar days of enrollment. Contact may be by letter, face to face, or by phone. If contact is by letter, must use UCare’s approved MSC+ Welcome Letter.	Initial contact within 30 calendar days of enrollment. Contact may be by letter, face to face, or by phone. If contact is by letter, must use UCare’s approved MSC+ Welcome Letter.	Initial contact within 30 calendar days of enrollment. Contact may be by letter, face to face, or by phone. If contact is by letter, must use UCare’s approved MSC+ Welcome Letter.
Initial assessment	The CM (CM) must provide the enrollee with the name and telephone number of the CM within 10 days of the initial assessment, new assignment, or change in CM. The CM must conduct an initial assessment within 90 calendar days of enrollment, for enrollees with enrollment dates of January, February, and March 2009, and within 30 days for enrollees with enrollment dates of 4/1/09 or later using the LTCC form, and must be conducted face to face. If the CM is able to obtain a hard copy of an LTCC that was conducted within the past 12 months, or is able to verify	The CM (CM) must provide the enrollee with the name and telephone number of the CM within 10 days of the initial assessment, new assignment, or change in CM. For UCare EW enrollees transitioning from MSC, the CM must contact the enrollee via phone or face to face within 90 calendar days of enrollment for enrollees with enrollment dates of January, February, and March 2009, and within 30 days for enrollees with enrollment dates of 4/1/09 or later, to assess and evaluate their status and determine if there has been a change of condition since the last assessment. This assessment does not need to be a full LTCC (unless a change of condition occurs), but	Within 90 calendar days of enrollment for enrollees with enrollment dates of January, February, and March 2009, and within 30 days for enrollees with enrollment dates of 4/1/09 or later CM should make a face to face contact with the Enrollee, and review the NF Minimum Data Set (MDS) completed by the facility staff and review the feasibility of the enrollee’s return to the community. The CM must document this review on the Institutional Care Coordination Documentation (ICCD) form. The CM should assist with transition during placement of Enrollees in nursing homes and with

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	<p>that an LTCC has been entered into MMIS within the past 12 months, then an LTCC does not need to be conducted, but the CM must conduct an interim assessment via phone using UCare’s Interim Assessment Form, including review of ADL’s, and document this in the Enrollee’s record, within 30 calendar days of enrollment. The CM should update MMIS if needed. If the enrollee’s condition warrants a new assessment, a new LTCC should be conducted, face to face.</p> <p>The CM must make 3 attempts to contact the Enrollee for assessment. If the Enrollee refuses to have an assessment, the CM must document the refusal and discuss (and document discussion of) a personal risk management plan. The CM must make another attempt to assess no later than at the time of the six month check-in.</p>	<p>should include a review of activities of daily living, and should include a review of the current plan of care (POC) to see if the POC is meeting the Enrollee’s needs, or if the need for services or interventions has changed. The care coordinator should document this assessment in the enrollee record using UCare’s Interim Assessment Form. The POC must be updated if the needs have changed based on this review. If a change of condition occurs, or if the CM is unable to obtain a copy of the previous LTCC assessment the CM must complete a new LTCC assessment.</p> <p>The CM must make 3 attempts to contact the Enrollee for assessment. If the Enrollee refuses to have an assessment, the CM must document the refusal and discuss (and document discussion of) a personal risk management plan. The CM must make another attempt to assess no later than at the time of the six month check-in.</p>	discharges back to the community.
Initial assessment form	Must use the DHS LTCC form #3428 or #3428A or UCare’s Interim Assessment form, based on the above. If using the LTCC, all questions and	Must use the DHS LTCC form #3428 or #3428A or UCare’s Interim Assessment form, based on the above. If using the LTCC, all questions and	Must use the UCare ICCD form.

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	sections must be completed or marked as “not applicable, including the Caregiver Support section.	sections must be completed or marked as “not applicable, including the Caregiver Support section.	
OBRA Level 1	An OBRA Level 1 assessment must be completed by the CM for all enrollees at the time of the LTCC assessment. A new OBRA Level 1 assessment must be completed at the time of the annual reassessment.	An OBRA Level 1 assessment must be completed by the CM for all enrollees at the time of the LTCC assessment. A new OBRA Level 1 assessment must be completed at the time of the annual reassessment.	An OBRA Level 1 is required only on admission to the facility. The OBRA Level 1 is only valid up to 60 days prior to a nursing home admission. If the previous OBRA Level 1 was completed > 60 days prior to admission, it must be re-done by the CM.
Transferred enrollees	<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 1, and plan of care to the new care coordination agency (receiver) as soon as enrollment with the new agency occurs.</p> <p>The receiver does the following:</p> <ul style="list-style-type: none"> • Review UTF, OBRA, LTCC, and current plan of care, and document this on the UCare Interim Assessment form. • Identify when next assessment is due. Initial assessments and 	<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 1, and plan of care to the new care coordination agency (receiver) as soon as enrollment with the new agency occurs.</p> <p>The receiver does the following:</p> <ul style="list-style-type: none"> • Review UTF, OBRA, LTCC, and current plan of care, and document this on the UCare Interim Assessment form. • Identify when next assessment is due. Initial assessments and reassessments should be kept on 	<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 enrollment with the new agency occurs.</p> <p>The receiver does the following:</p> <ul style="list-style-type: none"> • Review UTF and current ICCD. • Identify when next check in is due and whether the sender has attended a care conference. Initial assessments and reassessments should be kept on

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	<p>reassessments should be kept on schedule, based on information on the UTF.</p> <ul style="list-style-type: none"> Contact the transferred enrollee within 10 calendar days of transfer, by letter or face to face, to introduce the new care coordinator. <p>If the receiver is unable to obtain a copy of the most recent LTCC, then they must treat the enrollee as a new enrollee, and complete a new LTCC and OBRA Level I, face to face. The CM (CM) must provide the enrollee with the name and telephone number of the CM within 10 days of new assignment, or change in CM.</p>	<p>schedule, based on information on the UTF.</p> <ul style="list-style-type: none"> Contact the transferred enrollee within 10 calendar days of transfer, by letter or face to face, to introduce the new care coordinator. <p>If the receiver is unable to obtain a copy of the most recent LTCC, then they must treat the enrollee as a new enrollee, and complete a new LTCC and OBRA Level I, face to face, within 30 calendar days of the transfer, and develop a new plan of care within 30 calendar days of the LTCC. The CM (CM) must provide the enrollee with the name and telephone number of the CM within 10 days of the new assignment, or change in CM.</p>	<p>schedule, based on information on the UTF and ICCD.</p> <ul style="list-style-type: none"> Contact the transferred enrollee within 10 calendar days of transfer, by letter or face to face, to introduce the new care coordinator, ensure that services are appropriate. <p>If the receiver is unable to obtain a UTF, or is unable to access information in MMIS, then they must review the MDS and care plan within 30 days of the transfer and document this on the ICCD form.</p>
Comprehensive Plan of Care (POC)	Not required for those members assessed as not needing waiver services.	<p>A comprehensive care plan must be developed for every enrollee within 30 calendar days of the LTCC or UCare Interim Assessment, based on above, using UCare’s Comprehensive Care Plan form. If a plan of care is received from another care coordination agency, it must be transferred to UCare’s care plan form within 30 days of the assessment.</p> <p>The CM has the lead responsibility for</p>	The CM must review the institutional plan of care and document this review on the ICCD form.

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		creating, implementing, and updating the care plan. The care plan must be updated every time the services are modified.	
Care plan signature page		<p>The enrollee or enrollee’s representative must sign the UCare Plan of Care on an annual basis to document that they have discussed their care plan with their CM, are in agreement with it, have been offered a choice of providers, and that they have no waiver service needs at the present time.</p> <p>The CM must document that they have sent a copy of the care plan to the enrollee or the enrollee’s representative; and, if care plan is not signed, the CM must document they attempted to obtain a signature.</p>	
Personal risk management plan	If an enrollee refuses an assessment or refuses recommended services, the CM must discuss a personal risk management plan (discussion about how to deal with situations when support has been refused) and document this on the Member Plan section of the care plan form or case notes if no care plan.	If an enrollee refuses an assessment or refuses recommended services, the CM must discuss a personal risk management plan (discussion about how to deal with situations when support has been refused) and document this on the Member Plan section of the care plan form.	

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Service back-up plan		For enrollees receiving care or services, the CM must document a discussion of what the enrollee should do in the event that services or caregivers become unavailable.	
Ongoing contact with enrollee and care plan updates	Check in with the Enrollee, via phone or face to face every six months (30 day leeway before and after the 6 month contact). Annual reassessment using the LTCC.	Check in with the Enrollee, via phone or face to face every six months (30 day leeway before and after the 6 month contact). Annual reassessment using the LTCC.	Check in with the Enrollee, via phone or face to face every six months (30 day leeway before and after the 6 month contact). Annual review of the facility plan of care and MDS assessment. Document this on the ICCD form.
PCC/PCP contact	During the annual assessment the CM will encourage that members establish a relationship between a Primary Care Provider (PCP) or clinic, and that annual PCP visits occur.	The Primary Care Provider (PCP) must be given a copy of the Plan of Care either by fax or mail on an annual basis. The CM will establish a system of communication between themselves and the PCP or clinic for relaying information about significant health events including but not limited to ER use, hospital, or NF admissions and that annual visits occur.	Not Applicable.
Annual re-assessment	An annual reassessment using the LTCC must be completed at least once per 12 months.	An annual reassessment using the LTCC must be completed at least once per 12 months.	An annual review of the MDS and relocation feasibility must be completed at least once per 12 months.
Advance directives	The CM must document on an annual basis that they addressed or discussed advance directives with the enrollee, or that an advance directive is culturally inappropriate for the	The CM must document on an annual basis that they addressed or discussed advance directives with the enrollee, or that an advance directive is culturally inappropriate for the enrollee.	The CM must document on an annual basis that they addressed or discussed advance directives with the enrollee, or that an advance directive is culturally inappropriate for the enrollee.

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	enrollee.		
Medicaid eligibility renewals	Upon receipt of the Medicaid renewals report, the CC must call the enrollee and advise them that they are at risk of losing Medicaid eligibility due to failure to complete and return MA paperwork. The CC must document this contact in the enrollee’s record.	Upon receipt of the Medicaid renewals report, the CC must call the enrollee and advise them that they are at risk of losing Medicaid eligibility due to failure to complete and return MA paperwork. The CC must document this contact in the enrollee’s record.	Upon receipt of the Medicaid renewals report, the CC must call the enrollee and advise them that they are at risk of losing Medicaid eligibility due to failure to complete and return MA paperwork. The CC must document this contact in the enrollee’s record.
DTR requirements- EW services	<p>A DTR letter must be sent to the enrollee any time waiver services are denied, terminated, or reduced. DTR of these services requires does NOT require review by a Medical Director. Denial decisions may be made by CMs.</p> <p>No DTR is needed if the enrollee initiates the termination or reduction of a waiver service.</p> <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 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</p>	<p>A DTR letter must be sent to the enrollee any time waiver services are denied, terminated, or reduced. DTR of these services requires does NOT require review by a Medical Director. Denial decisions may be made by CMs.</p> <p>No DTR is needed if the enrollee initiates the termination or reduction of a waiver service.</p> <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 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.</p> <p>The county action letter is not appropriate</p>	N/A.

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	the DTR Notification form. The county action letter is not appropriate for DTR notification.	for DTR notification. If an enrollee refuses an annual assessment visit, the CM must deny, terminate, or reduce waiver services using the DTR process.	
Logging of DTRs	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.	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 NF for community based members	Assist with admission or discharge planning.	Assist with admission or discharge planning.	Assist with discharge planning if applicable.
Change of CM assignment	The CM must provide the Enrollee with the name and phone number of the CM assigned to the Enrollee within 10 days of a new assignment or change in CM.	The CM must provide the Enrollee with the name and phone number of the CM assigned to the Enrollee within 10 days of a new assignment or change in CM.	The CM must provide the Enrollee with the name and phone number of the CM assigned to the Enrollee within 10 days of a new assignment or change in CM.
Financial eligibility for waived services		The enrollee’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 Enrollee’s eligibility for EW services and implement those services only upon verification of eligibility (receipt of approval via the DHS form #5181). The CM	

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		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 enrollee is not financially eligible for EW services, the CM should notify the member via DTR form, and update the POC to exclude waiver services.	
Documentation notes	If any of the CM requirements were attempted but not completed, the CM must document all attempts in the care plan or progress notes.	If any of the CM requirements were attempted but not completed, the CM must document all attempts in the care plan or progress notes.	If any of the CM requirements were attempted but not completed, the CM must document all attempts in the care plan or progress notes.
Admission to nursing home	Assist with discharge planning if the enrollee is discharged to home.	Assist with discharge planning if the enrollee is discharged to home.	The CM may keep the same assessment schedule if enrollee was followed in the community prior to admission to a nursing home. The OBRA Level 1 is only valid up to 60 days prior to a nursing home admission. If the previous OBRA Level 1 was completed > 60 days prior to admission, it must be re-done by the facility.
Actions for when a enrollee dies	The CM must submit a death notification to UCare.	The CM must submit a death notification to UCare	The CM must submit a death notification to UCare.
Policies and	All UCare delegates are required to		

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Procedures	have policies and /or procedures that support all the above stated requirements.		