



**2011 Special Needs Basic Care (SNBC)-UCare Connect  
Care Management Requirements  
Updated 2/24/2011**

Case coordination is part of care management for Special Needs Basic Care (SNBC) - *UCare Connect* members.

All *UCare Connect* members are automatically enrolled in case coordination, assigned a Case Coordinator who is a Qualified Professional, and receives case coordination until they disenroll.

Each member has access to a Case Coordinator (CC) that serves as their advocate, helping the member navigate complex social service and health care delivery systems. The Case Coordinator provides the following services:

- Assess member needs and develops a comprehensive plan of care.
- Coordinate and establish a healthcare home (Primary Care Provider (PCP), Primary Care Clinic (PCC)).
- Promote access to and completion of preventive care.
- Refer to disease management as clinically appropriate.
- Coordinate transitional care.
- Provide access to UCare's health promotion programs.
- Assist and support assigned case managers as requested.

**CASE MANAGEMENT:**

In the event that a member requires active case management for acute complex medical needs, complex medical case management is done by a registered nurse (RN) at UCare. In the event that a member requires active case management for social service needs, social service case management is performed at the county level by a County Waiver Case Manager or a county contracted designee. UCare does not oversee the activities performed by the County Waiver Case Manager or contracted designee. The Case Coordinator is expected to coordinate with the County Waiver Case Manager or contracted designee to ensure that services are appropriate for the member. Please refer to last page of requirements grid for a description of the different roles and responsibilities of the Case Coordinator, County Waiver Case Manager, Complex Medical Case Manager, and Health Plan Navigator.

UCare or its delegates conduct case coordination as described in the requirements grid, which refers primarily to activities conducted by UCare or the delegated entity Case Coordinator.

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Initial contact with member	The CC must provide the member with the name and phone number of the CC assigned to the member within 10 calendar days of initial assignment. Initial assignment is the first day the care system or county receives the enrollment roster. This may be done by phone or letter. The contact must be documented. If by letter, the CC must use UCare’s approved welcome letter found on UCare’s website.
Comprehensive assessment – Member not on a waiver.	<p>The CC:</p> <ul style="list-style-type: none"> <li>◆ Conducts a comprehensive face-to-face assessment within 30 calendar days of enrollment with the member using the SNBC <i>UCare Connect</i> Assessment Tool or other assessment tool approved by UCare.</li> <li>◆ Uses other supplemental assessment tools recommended by UCare as clinically appropriate: <ul style="list-style-type: none"> <li>○ CAGE (substance abuse).</li> <li>○ Brief MAST (substance abuse).</li> <li>○ Brief MSE (mental status exam).</li> <li>○ PHQ-9 (Quick Depression Assessment).</li> <li>○ Other tools as appropriate.</li> </ul> </li> <li>◆ Completes the DHS LTC Form #3427 and enters required data into MMIS within 30 calendar days of enrollment.</li> <li>◆ Shares assessment information with UCare, as requested.</li> </ul>
Comprehensive assessment – Member is on a waiver	<p>If the member is on a DD, CADI, CAC, or TBI waiver, the CC:</p> <ul style="list-style-type: none"> <li>◆ Notifies the Waiver Case Manager that the member is on <i>UCare Connect</i>.</li> <li>◆ Completes the SNBC <i>UCare Connect</i> Interim Assessment Form telephonically or face-to-face within 30 calendar days of enrollment but does not enter any information into MMIS.</li> <li>◆ Coordinates a face-to-face visit with the Waiver CM when the next face-to-face visit is scheduled. If coordination is not possible, the CC will make arrangements to visit the member within 6 months of transfer or enrollment.</li> </ul>
Medicare Part C Reporting of Assessments	For all members who have an assessment that is not entered into MMIS, the CC must enter the assessment on the Part C Reporting Log. This pertains to members who are on a DD, CADI, CAC or TBI waiver and members in a nursing home. The actual date of the assessment must be entered. The Part C reporting log can be found on UCare’s website.
Unable to contact member	Within 30 days of enrollment, the CC must make 3 attempts to contact the member for an assessment. Attempts may be by phone, letter, or face-to-face and must be documented. If the CC is unable to contact the member, the CC should send the “Unable to Reach” letter found on UCare’s website. (Each “Unable to Reach”

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	letter counts as one attempt.)
Refusal of assessment due to unable to contact	If the CC was unable to contact the member, the CC must document the refusal of an assessment on the SNBC UCare Connect Assessment Tool, complete DHS LTC Form #3427 and enter it into MMIS as a refusal.
Refusal of assessment or services and personal risk management plan (PRMP)	If the CC was able to contact the member, and the member refuses to have an assessment or to receive services, the CC 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 CC must document the refusal of an assessment on the SNBC UCare Connect Assessment Tool, complete DHS LTC Form #3427 and enter it into MMIS as a refusal. The CC should also complete a Plan of Care (POC). (See “Comprehensive Plan of Care (POC) when member refuses an assessment or services” section.)
Comprehensive plan of care (POC) when member refuses an assessment or services	The CC should document refusal of an assessment or services on the plan of care (POC) and complete the Health and Safety Section of the POC, along with other applicable sections of the POC.
Comprehensive plan of care (POC) – Member is not on a waiver	<p>The CC must develop and implement a comprehensive plan of care (POC) within 30 days of the LTC and comprehensive assessment, in conjunction with the member and/or family members, the member’s authorized health care decision maker, Primary Care Physician (PCP), and specialist (as applicable).</p> <p>The POC must be on the SNBC UCare Connect POC form or other form approved by UCare. If the member is not opened to complex medical case management, the CC must complete sections I-IV of the POC and check in with the member every three months. The CC should document check-ins on the POC document. The POC must be based on the information collected through the assessment and include:</p> <ul style="list-style-type: none"> <li>◆ Member problem list/needs.</li> <li>◆ Goals.</li> <li>◆ Interventions to address medical, social, behavioral, educational, and other service needs of the member.</li> <li>◆ Outcomes. (Outcomes must be monitored and POC revised as necessary.)</li> </ul> <p>If the member is opened to complex medical case management, the Complex Medical Case Manager will complete all sections of the POC, and monitor the member as frequently as needed. The CC and Complex Medical Case Manager will work together to coordinate care as needed.</p>
Comprehensive plan of care (POC) – Member is on a	If the member is on a DD, CADI, CAC, or TBI waiver, the CC does not have to do a POC but they must request a copy of the POC from the Waiver Case Manager.

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waiver	
Care plan signature page	The CC must send a copy of the POC to the member or member's representative for their signature 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.
Ongoing case management	<p>All UCare Connect members are opened to case management services. The level of case management services is based on the comprehensive assessment results and POC.</p> <ul style="list-style-type: none"> <li>◆ At a minimum, the CC provides ongoing monitoring for each SNBC member on a quarterly basis. (See "Ongoing contact with member and care plan update" section.)</li> <li>◆ The CC must ensure coordination with services and supports needed by the member, to include MH-TCM, ARMHS, ACT, IRTS, and other referrals as necessary.</li> <li>◆ Social service case management is done at the county level by the County Case Manager. UCare does not oversee case management activities performed by the County Case Manager or designee.</li> </ul>
Ongoing case management for members that require intensive case management due to serious health conditions	<ul style="list-style-type: none"> <li>◆ Complex medical case management is done by an RN at UCare.</li> <li>◆ Member is monitored as frequently as needed.</li> <li>◆ CC remains involved and at a minimum, provides monitoring for each SNBC member on a quarterly basis.</li> </ul>
Service back-up plan	For members receiving care or services, the CC must document a discussion of what the member should do in the event that services or caregivers become unavailable.
Ongoing contact with member and care plan update	The CC must have ongoing contact or check-in with the member at a minimum of every 3 months to update the plan of care. The CC must make 3 attempts to contact the member. Attempts may be made by phone, letter or face-to-face. If the CC is unable to contact the member, the CC must document this in the case notes.
Annual reassessment – Member is not on a waiver	<p>The CC must conduct an annual face-to-face reassessment using the SNBC <i>UCare Connect</i> assessment tool or other assessment tool approved by UCare; and, must complete the DHS-LTC form #3427 at least once every 12 months.</p> <p>The LTC assessment must be completed and entered into MMIS, including a review of ADL information, with the annual reassessment.</p> <p>The CC must share annual reassessment information with UCare, as requested.</p>
Annual reassessment – Member is on a waiver	If the member is on a DD, CADI, CAC, or TBI waiver, the CC must complete the SNBC <i>UCare Connect</i> Interim Assessment Form for the annual reassessment.

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	<p>The CC will coordinate a face-to-face visit with the Waiver CM. If coordination is not possible, the CC will make arrangements to visit the member within the month the annual assessment is due.</p> <p>Do not enter any information into MMIS but document the assessment on the Part C reporting log.</p>
Transition management	<p>As needed, the CC must 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"> <li>◆ A consistent CC to support the member throughout the transition(s).</li> <li>◆ Sharing of essential information with the receiving facility within one business day of date the CC learns about admission; essential information includes:             <ul style="list-style-type: none"> <li>○ Services member currently was receiving;</li> <li>○ Names of service providers; and,</li> <li>○ PCP and specialist (as applicable), contact information (resource for current medications, chronic conditions and current treatment).</li> </ul> </li> <li>◆ PCP and specialist (as applicable) notification of admission within one business day of date the CC learns of admission, if PCP/specialist/clinic is not involved with the admission.</li> <li>◆ Communication with facility, providers, member, and/or responsible party about the transition process and changes in member's health status and care needs.</li> <li>◆ Communication with discharge planner, re: what services member used; what new services/equipment may be needed; and who will arrange services.</li> <li>◆ Follow up with member (by phone or in person) within one business day of notification, regarding:             <ul style="list-style-type: none"> <li>○ Medication changes and filling new prescriptions;</li> <li>○ DME and supplies;</li> <li>○ Follow up appointment and transportation needs;</li> <li>○ Changes in functional status (e.g., bathing, eating, etc.); and,</li> <li>○ What to do if condition changes or worsens.</li> </ul> </li> <li>◆ Enter each transition* onto the "Individual Care Transitions Log" form (and file form in member's record).</li> </ul> <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</p>

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	a total of three transitions and each one would have its own entry on the “Individual Care Transitions Log”.
Coordination with local agencies	<p>The CC must make referrals and/or coordinate care with county social services and other community resources when a member is in need of:</p> <ul style="list-style-type: none"> <li>◆ Pre-petition screening.</li> <li>◆ Preadmission screening for HCBS.</li> <li>◆ County case management for HCBS.</li> <li>◆ Child protection.</li> <li>◆ Court ordered treatment.</li> <li>◆ Case management and service providers for people with DD.</li> <li>◆ Mental Health Targeted Case Management (MH-TCM).</li> <li>◆ Adult protection services.</li> <li>◆ Assessment of medical barriers to employment.</li> <li>◆ State medical review team or social security disability determination.</li> <li>◆ Work with local agency staff or county attorney staff for members who are victims or perpetrators in criminal cases.</li> <li>◆ Assessment and evaluation related to judicial proceedings.</li> <li>◆ Assertive Community Treatment (ACTS), Intensive Residential Therapy Settings (IRTS), or Adult Rehabilitative Mental Health Services (ARMHS).</li> </ul>
Management of waiver services	The CC refers new members to the appropriate county Waiver Case Manager or county designee for management of waiver services (DD, CADI, CAC, TBI) as needed.
Referral to additional benefits available	<p>The CC should refer members to the following additional benefits as applicable:</p> <ul style="list-style-type: none"> <li>◆ ActiveU-Fitness kit and free monthly YMCA membership.</li> <li>◆ Preventive services and annual exam reminders.</li> <li>◆ See-A-Dentist Guarantee.</li> <li>◆ Discounts on community education programs.</li> <li>◆ Car seat education and distribution.</li> <li>◆ M.O.M.S program.</li> <li>◆ Smoking Cessation program.</li> <li>◆ Health Connection-24 hour telephonic access to Mayo nurses.</li> </ul>
PCC/PCP/Specialist contact	The CC must fax a copy of the POC or a POC summary to the member’s PCP and specialist (as applicable) on an annual basis. The CC must communicate updates and changes to the member’s condition as appropriate. If

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	the member has a waiver case manager, the POC is reviewed but not faxed to the PCC/PCP/Specialist.
Advance directives	The CC 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.
Change of Case Coordinator or Complex Medical Case Manager assignments	The new CC or Complex Medical Case Manager must notify the member of their name and phone number within 10 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 CC letter found on Ucare's website.
Medicaid eligibility renewals	To the best of their ability, the CC is encouraged to remind members when 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.
Transfer of member between delegates	<p>The current case coordination agency (sender) completes the Universal Transfer Form (UTF) from UCare's website and sends or faxes the UTF with the most recent assessments and plan of care to the new case 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 15<sup>th</sup> of the month.</p> <p>The receiver does the following:</p> <ul style="list-style-type: none"> <li>◆ Reviews UTF, assessments, and current plan of care, and document this on the UCare Interim Assessment form.</li> <li>◆ Identifies when next assessment is due. Reassessments should be kept on schedule, based on information on the UTF.</li> <li>◆ Contacts the transferred member within 10 calendar days of transfer, by letter or phone, to introduce the new case coordinator.</li> <li>◆ If the receiver is unable to obtain a copy of the most recent assessment and POC, then they must treat the member as a new member, and complete a new assessment and POC.</li> <li>◆ If the member does not have a county waiver case manager, or is not on a DD, CADI, CAC, or TBI waiver, updates the care coordinator information in MMIS.</li> </ul>
Internal change of CC	<p>The new CC does the following:</p> <ul style="list-style-type: none"> <li>◆ Contacts the transferred member within 10 calendar days of transfer, by letter or phone, to introduce the new case coordinator.</li> <li>◆ Reviews previously completed assessment and current POC and <u>documents review in member's record.</u></li> <li>◆ If there have been no changes in member's condition and member's needs are being met, stay on same</li> </ul>

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	<p>check-in and assessment cycle.</p> <ul style="list-style-type: none"> <li>◆ If member has a change of condition or needs that are not being met, complete a new assessment and POC.</li> <li>◆ If the member does not have a county waiver case manager, or is not on a DD, CADI, CAC, or TBI waiver, updates the care coordinator information in MMIS.</li> </ul>
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 and must be referred to UCare, or, if applicable, one of its utilization review delegates.
Actions for when a member dies	The CC must notify UCare when a member has died. (The death notification form is on UCare’s website). The CC must complete the DHS 5181 form and send it to the county financial worker.
Documentation notes	If any of the case coordination requirements were attempted but not completed, the CC must document all attempts in the plan of care and/or progress notes.
Policies and procedures	All UCare delegates are required to have policies and /or procedures that support all the above stated requirements.

## Case Management Roles for SNBC

<b>Case Coordinator – Primary Contact for the member and UCare</b>	<b>Health Plan Navigator</b>	<b>County Waiver Case Manager</b>	<b>Complex Medical Case Manager</b>
<ul style="list-style-type: none"> <li>• Provide care coordination &amp; case management.</li> <li>• Complete all required assessment activities.</li> <li>• Develop &amp; implement the plan of care.</li> <li>• Work collaboratively with the interdisciplinary team.</li> <li>• Establish connections and/or referrals for services.</li> <li>• Assist with maintaining member eligibility.</li> <li>• Coordinate &amp; establish a healthcare home.</li> <li>• Promote access to &amp; completion of preventive care.</li> <li>• Refer to Disease Management as clinically appropriate.</li> <li>• Coordinate transitional care.</li> <li>• Provide access to UCare’s health promotion programs</li> </ul>	<ul style="list-style-type: none"> <li>• Assist &amp; support Case Coordinator as requested.</li> </ul>	<ul style="list-style-type: none"> <li>• Management of home and community based waivers.</li> <li>• Coordinate waiver services and collaborate with Case Coordinator.</li> </ul>	<ul style="list-style-type: none"> <li>• Done by an RN at UCare.</li> <li>• Provide case management for acute complex medical needs.</li> <li>• Refer to Disease Management as clinically appropriate.</li> <li>• Refer to specialty providers as needed.</li> </ul>