The benefits included in SNBC include most, but not all, basic Medical Assistance benefits. For more information on the services covered and not covered by SNBC, please visit www.dhs.state.mn.us/SNBC. UCare’s SNBC product names are UCare Connect and UCare Connect + Medicare. For more general information on UCare’s SNBC products, see our Product Tip Sheets.

Personal Care Assistance (PCA) and Home Care Nursing (HCN) are NOT included in SNBC. Individuals enrolled in SNBC and who are eligible for or are receiving PCA or HCN services obtain them through Medical Assistance fee-for-service. UCare does not authorize and does not receive payment for these services.

Home and Community-Based Services (HCBS) or waiver services are NOT included in SNBC. Individuals enrolled in SNBC and eligible for or receiving HCBS may obtain these services through their county. UCare does not receive payment for HCBS and does not provide waiver case management. This function remains the county’s responsibility.

HCBS, PCA and HCN services have been “carved out” of SNBC since 2008 per the direction of the Managed Care for People with Disabilities Stakeholder Workgroup that continues to work with DHS to design the SNBC program.

SNBC care management
UCare is required to assess and provide care management for SNBC members.

For more details on what SNBC plans are required to do, please see the DHS SNBC contract template at www.dhs.state.mn.us/SNBC.

What is a care navigator?
All UCare SNBC members are offered a care navigator, a staff member from UCare’s Clinical Services team who is available to help members access services, obtain preventive care and navigate the health plan.

What is a care coordinator?
Members who indicate a high level of need based on past medical history and/or self-reported health risk assessment information may be assigned a care coordinator. The care coordinator works with the member to design a plan of care to manage the member’s health needs.

Members receiving HCBS/waiver services or mental health targeted case management may not be assigned a care coordinator; however, these members have access to a care navigator who is a resource at UCare for them and their case manager. Members may be referred for care coordination on an as-needed basis.

More information
Contact UCare at 612-676-6503 or 1-877-903-0063 toll free if you have questions about UCare Connect, UCare Connect + Medicare and waiver services and/or coordination of services for members on waivers.
<table>
<thead>
<tr>
<th>Title</th>
<th>UCare Connect Care Navigator</th>
<th>UCare Connect Care Coordinator</th>
<th>UCare Connect Complex Care Manager</th>
<th>County Waiver Case Manager</th>
<th>Mental Health Targeted Case Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>Short-term</td>
<td>Ongoing</td>
<td>Short-term</td>
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<tr>
<td>Who Provides</td>
<td>UCare Clinical Services staff (with a health care background). All members have access to a care navigator.</td>
<td>UCare partners with counties and local agencies to provide this service. Care coordinators are qualified professionals (e.g., primarily a social worker or registered nurse) employed by a county or agency with expertise in providing care management to individuals with specific disabilities.</td>
<td>Registered nurse in UCare’s Clinical Services department.</td>
<td>Counties have primary responsibility for waiver case management.</td>
<td>UCare contracted county or agency staff.</td>
</tr>
<tr>
<td>Key Roles</td>
<td>Conducts outreach and answers inbound calls from members. Assists in finding or changing a primary care provider. Educates members about preventive care. Refers members to UCare programs and services, when appropriate. Assists members in completing the Health Risk Assessment (HRA). Assists members in accessing services such as durable medical equipment.</td>
<td>Provides ongoing case management for members with high needs. Develops a Plan of Care, arranges services and monitors according to care plan. Conducts annual F-F assessment and quarterly telephonic check-in with the member. Assists members in transitioning care from one care setting to another. Collaborates with discharge planners, case coordinators, primary care providers and other members of the interdisciplinary team. Makes referrals to all appropriate services. <em>Note:</em> For members assigned to care coordination, their care coordinator becomes their primary or lead case manager.</td>
<td>Provides case management assistance for members with short-term, acute medical or behavioral health needs. Assists members (not assigned to a care coordinator) in transitioning care from one care setting to another. Collaborates with discharge planners, case coordinators, primary care providers and other members of the interdisciplinary team. Makes referrals to care coordination if needed.</td>
<td>Manages Home and Community-Based Services (HCBS) or waiver services. Coordinates waiver services and collaborates with case coordinator, when necessary. Manages PCA and Home Care Nursing (HCN) services. Communicates with UCare, case coordinator and care navigator as needed. Members may be referred to care coordination if needed.</td>
<td>Provides MH-TCM case management services to members with serious and persistent mental illness. Conducts a functional assessment and individual treatment plan that is updated every six months. Provides face-to-face services with the member at a frequency consistent with the member need, minimally once a month. Makes referrals to all appropriate services. Where needed, helps member to comply with medical and behavioral health treatment plans.</td>
</tr>
</tbody>
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