2020 UCare Special Needs BasicCare (SNBC)
Home and Community-Based Services

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 Provider Tip Sheets under Additional Resources for UCare Connect Plans.

Personal Care Assistance (PCA) and Home Care Nursing (HCN) (formerly known as Private Duty Nursing) are NOT included in UCare Connect/UCare Connect + Medicare. Individuals enrolled in UCare Connect/UCare Connect + Medicare 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 UCare Connect/UCare Connect + Medicare. Individuals enrolled in UCare Connect/UCare Connect + Medicare 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 UCare Connect/UCare Connect + Medicare 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.

UCare Connect/UCare Connect + Medicare Care Management
UCare offers a health risk assessment to all members upon enrollment and annually thereafter.

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 receive care navigator services. A staff member from UCare’s Clinical Services team is available to help members access services, obtain preventive care and navigate the health plan.

What is a case manager?
Members who indicate a high level of need based on past medical history and/or health risk assessment information are offered case management services. The case manager 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 case manager; however, these members do receive care navigation services providing UCare resources for them and their case manager. Members may be referred for case management at any time on an as-needed basis.

More information
Contact UCare at 612-676-6502 or 1-877-903-0062 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/Connect + Medicare Case Manager</th>
<th>UCare Connect Care Transition Management</th>
<th>County Waiver Case Manager</th>
<th>Mental Health Targeted Case Manager</th>
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<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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<td>Who Provides</td>
<td>UCare Clinical Services staff (with a health care background). All members receive Care Navigator services.</td>
<td>UCare partners with counties and local agencies to provide this service in addition to internal case management staff. Case managers are qualified professionals (e.g., social worker or registered nurse) employed by a county, UCare or agency with expertise in providing case management to individuals with disabilities.</td>
<td>Registered nurse in UCare’s Clinical Services department.</td>
<td>Counties and their contracted agencies have primary responsibility for waiver case management.</td>
<td>UCare contracted county or agency staff.</td>
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<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 accessing services such as durable medical equipment.</td>
<td>Provides ongoing case management for members with high needs. Develops a person-centered plan of care, arranges services and monitors according to care plan. Conducts annual F-F assessment and regular telephonic check-in with the member. Assists members in transitioning care from one care setting to another. Collaborates with discharge planners, MH-TCMs, primary care providers and other members of the interdisciplinary team. Makes referrals to all appropriate services. Note: 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 case manager) in transitioning care from one care setting to another. Collaborates with discharge planners, care coordinators, primary care providers and other members of the interdisciplinary team.</td>
<td>Manages Home and Community-Based Services (HCBS) or waiver services. Coordinates waiver services and collaborates with care coordinator, when necessary. Manages PCA and Home Care Nursing (HCN) services. Communicates with UCare case manager and care navigator as 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>
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