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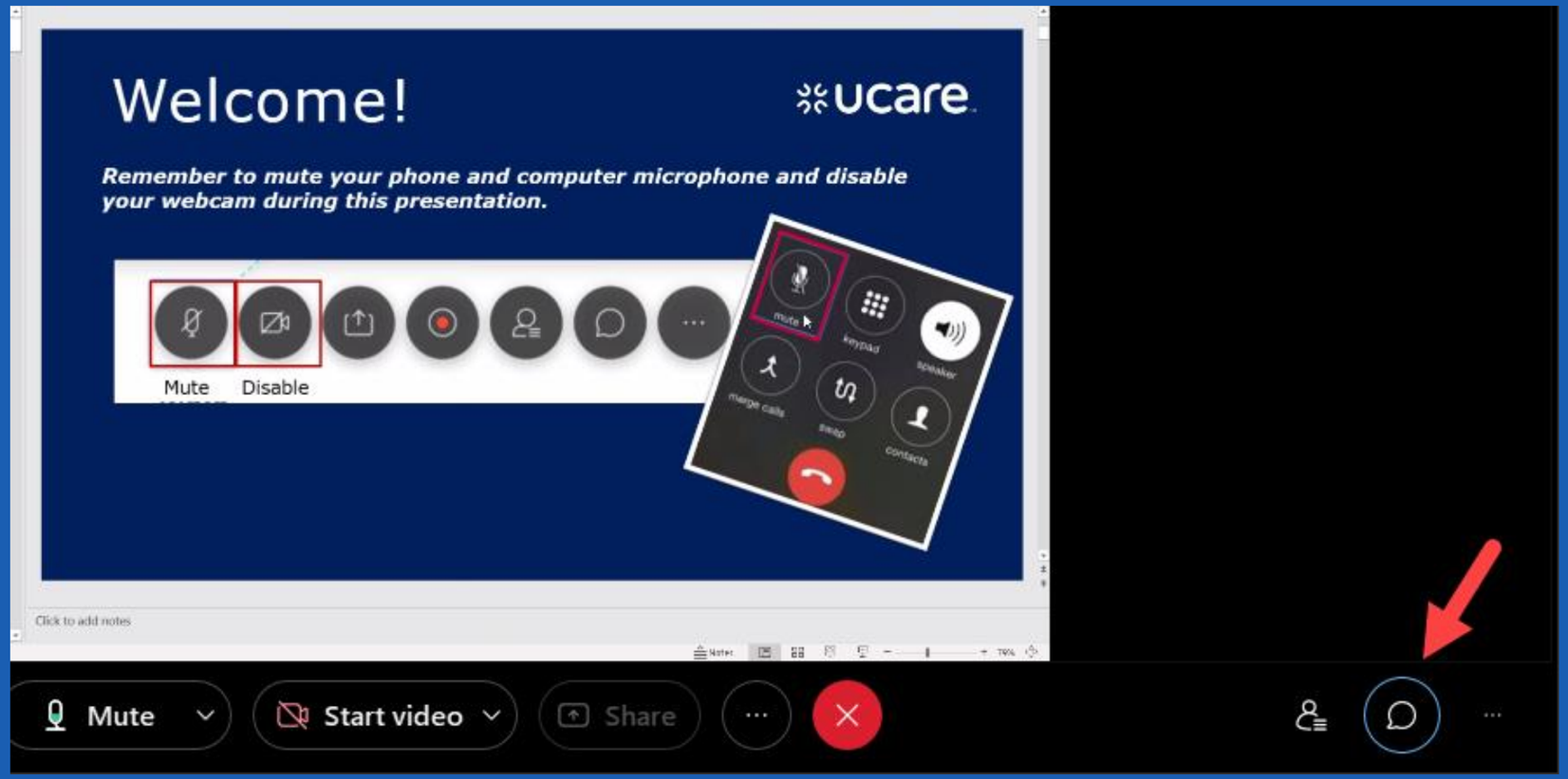
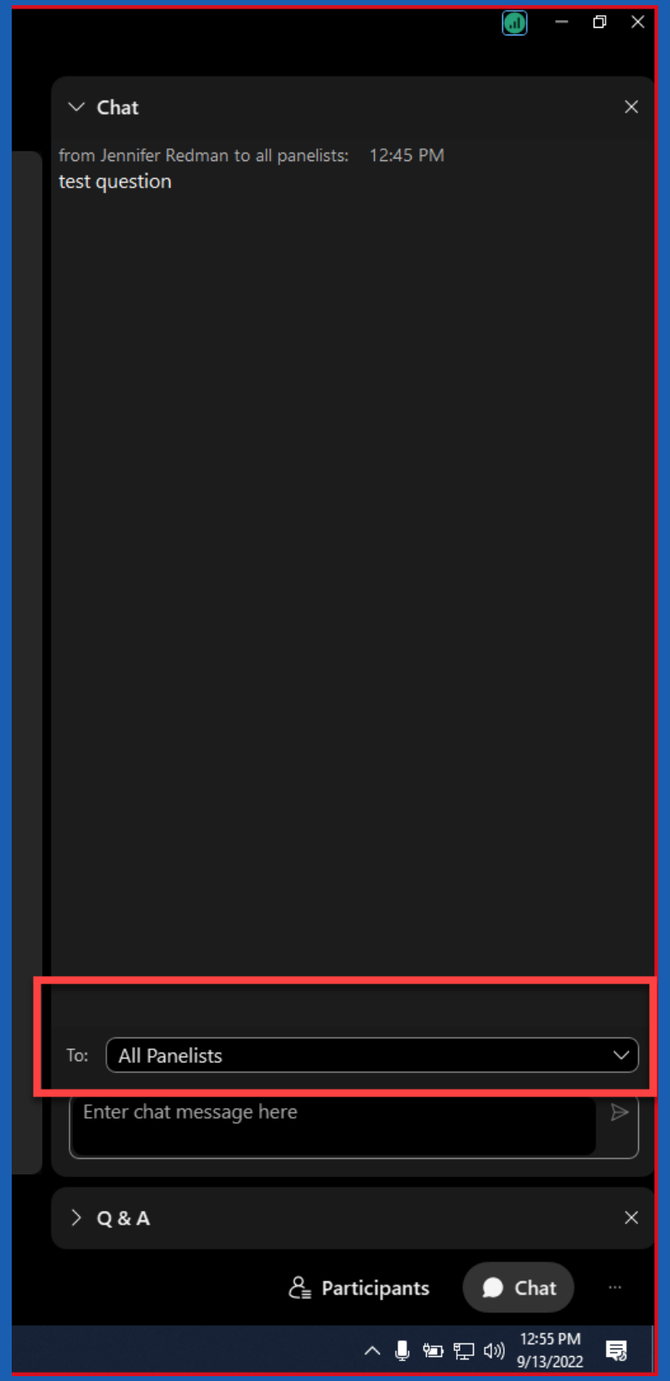
UCare
Connect/Connect + Medicare & MSC+/MSHO

2nd Quarterly All Care Coordination Meeting

June 11, 2024

Questions welcome!





Today’s Agenda

Time	Topic	Audience	Presenter
9:00–9:05	Welcome	All	Clinical Liaisons
9:05-10:05	Care Coordination Updates	All	Clinical Liaisons
10:05-10:10	SNBC Accessibility Survey	CT/CT+	Jennie Paradeis
10 Minute BREAK			
10:20-10:50	MSS Roadshow	All	Malorie Potter, Crysil Dougherty & Kathryn Schaefer
10:50-11:10	Medication Review Programs	All	Diane Koetz & Emily Taber
11:10-11:20	Disease Management Programs	All	Liz Sperr
11:20-11:35	Transportation Updates and Qryde	All	Amber Jackson, Brent Forbord, Kathy Engeldinger & Trent Brier
MSC+/MSHO Presentations (SNBC Optional)			
11:35-11:45	CFSS	MSC+/MSHO	Esther Versalles-Hester
11:45-11:55	LSS Healthy Transitions	MSC+/MSHO	Lisa Beardsley

Care Coordination Updates

Presenters: Clinical Liaisons

Care Coordination Meeting Schedule

- UCare Quarterly All Care Coordination Meeting
  - Attendance **required** for all care coordinators.
- CEU Events
  - Attendance is optional for all.
- Office Hours
  - Attendance is optional for all
  - MSC+/MSHO and Connect/Connect + Medicare will be separate, offered same day at different times.
- Housing Support Office Hours

Registration for all events can be found in the monthly care coordination newsletter.

➡ Save the date ⬅

UCare Product	Meeting Type	Date	Time
MSC+/and MSHO Connect/Connect + Medicare	UCare Quarterly All Care Coordination Meeting	September 10 December 10	9 am – 12 pm
MSC+/MSHO and Connect/Connect + Medicare	CEU Event (optional)	August November	Topics and date/times TBD
MSC+/MSHO	Office Hours (optional)	July 23 October 22	10 am – 11 am
Connect/Connect + Medicare	Office Hours (optional)	July 2 October 22	11:30 am – 12:30 pm

Inquiring with U!

Care Coordination Satisfaction Survey

Some of the changes made because of the 2023 CC satisfaction survey:

- Gaps in care reports provided
- Improved turnaround times for EW and PCA auth processing
- Additional verification of PCCs prior to enrollment
- Improved accuracy of enrollment rosters
- Website clean up-consistency of organization and naming of documents
- Member-facing letters in multiple languages
- Improved turnaround time for Clinical Liaison Inbox responses!!
- Care Coordination Manual in process (coming very soon!)

Please take a moment to complete the 2024 CC Satisfaction Survey via the link or QR code

MnCHOICES Updates

Launch Updates:

- DHS Rolling Launch: July 1 – Have **100%** of staff conduct **all work** within the MnCHOICES Revision application.
    - Legacy tools sunsetting after 7/1
    - Exceptions:
        - Mid-year contacts and other support plan updates continue to be completed on legacy tools before completing the reassessment within MnCHOICES.
        - MnSP is available until 9/30 to complete RS tools for assessments conducted prior to 7/1/24.

Application Updates:

- MSHO MSC+ Care Coordinator role will have all the permissions a certified assessor does

Resources to Know:

- MnCHOICES Guidance
- MnCHOICES Job Aid
- Connect/Connect + Medicare: Assessment Checklist MnCHOICES
- MSC+/MSHO Assessment Checklist MnCHOICES
- MnCHOICES Requirements Grids will be updated 7/1/24
    - Legacy grids will retire

7.1.24 Requirements Grid Changes:
Important Changes

All Products

- Addition of sections
  - Communication Form – DHS-5841
  - Medical Assistance Eligibility Renewals
  - Transferred Member between UCare Delegates without product change
    - THRA is no longer required if there is an active HRA/support plan
- Updated sections
  - Transferred Member from a Different MCO
    - Allow completion of support plan with a THRA if it is not received from transferring CC
  - 90-day Grace Period after MA becomes inactive
    - Connect/MSC+: only required to complete assessments due during grace period
    - Connect + Medicare/MSHO: No change, all CC activities required
- General updates
  - Added more language around MnCHOICES requirements and steps
  - Community non-MnCHOICES requirements grids will be removed eff 7.1.24

MSC+/MSHO Community Requirements Grid

- Change in condition to early reassessment in TOC section and admission over 30 days
- Functional needs update allowed for EW

MSC+/MSHO Requirements Grid for Institutionalized Members

- Addition of section
  - Change of CC within the Same Entity

Transfer Members:
Functional Needs Assessment (FNU)

When a member is new to UCare and the last assessment was a FFS revised MnCHOICES Assessment resulting in EW within the past 365 days or a 65th birthday assessment that resulted in EW, transfer FNU can be used.

Transfer FNU Process:

Enter CC change activity for all members opened to EW with a change in CC.

Reached:

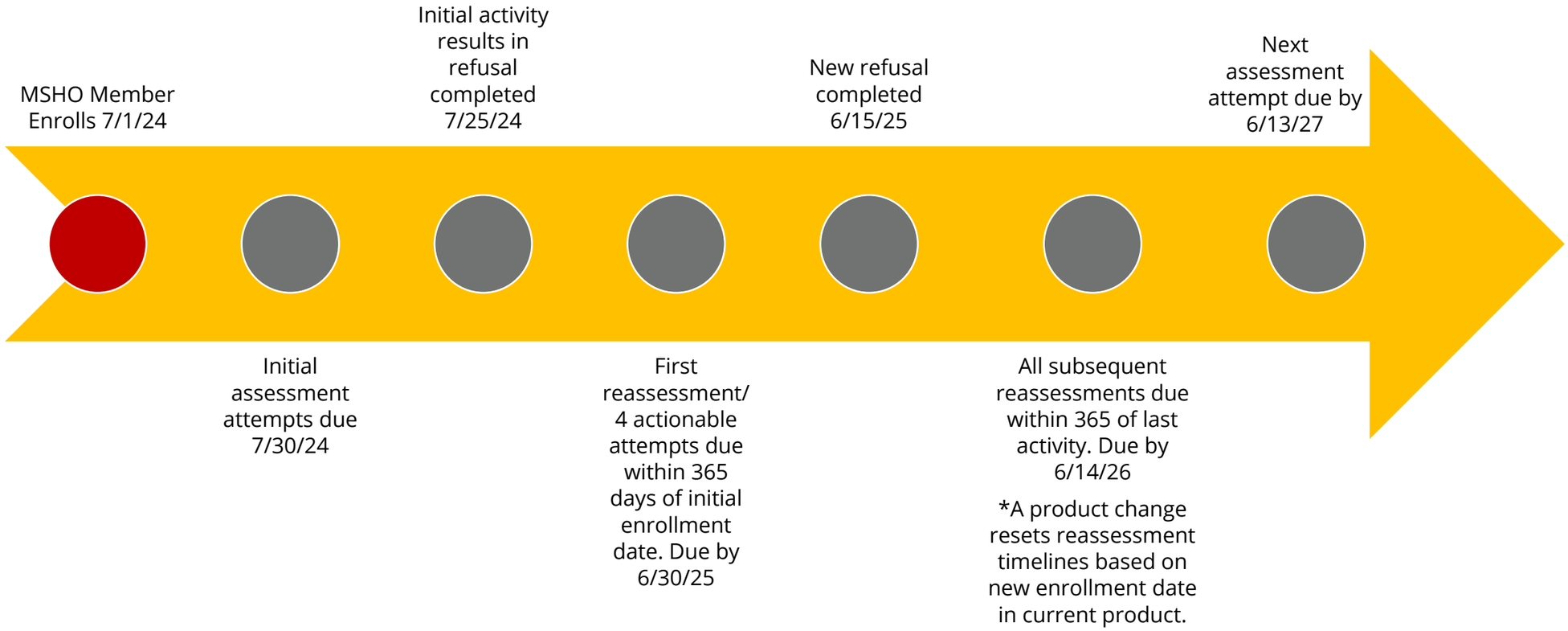
- Start a new MnCHOICES Assessment and complete the "assessment information section"
  - **Recipient Identifier:** Current Recipient/Change
  - **Assessment Type:** Functional Needs Update (FNU)
    - **Note:** Add reason for assessment type (Ex: New UCare member with current MnCHOICES Assessment)
- Change assessment status to "Start MnCHOICES Assessment"
  - Complete the "Staying Healthy" section of the assessment
    - **Note:** The remainder of the assessment should carry over from the previous assessment. Update areas as needed.
  - Submit assessment until status is "Approved by MMIS"
    - Do NOT enter THRA activity in MMIS
- Complete a new Support Plan – MCO MnCHOICES Assessment
  - Submit Support Plan until the status is "Plan Approved"
  - Add member to Monthly Activity Log (MAL)

Unable to reach/Refusal

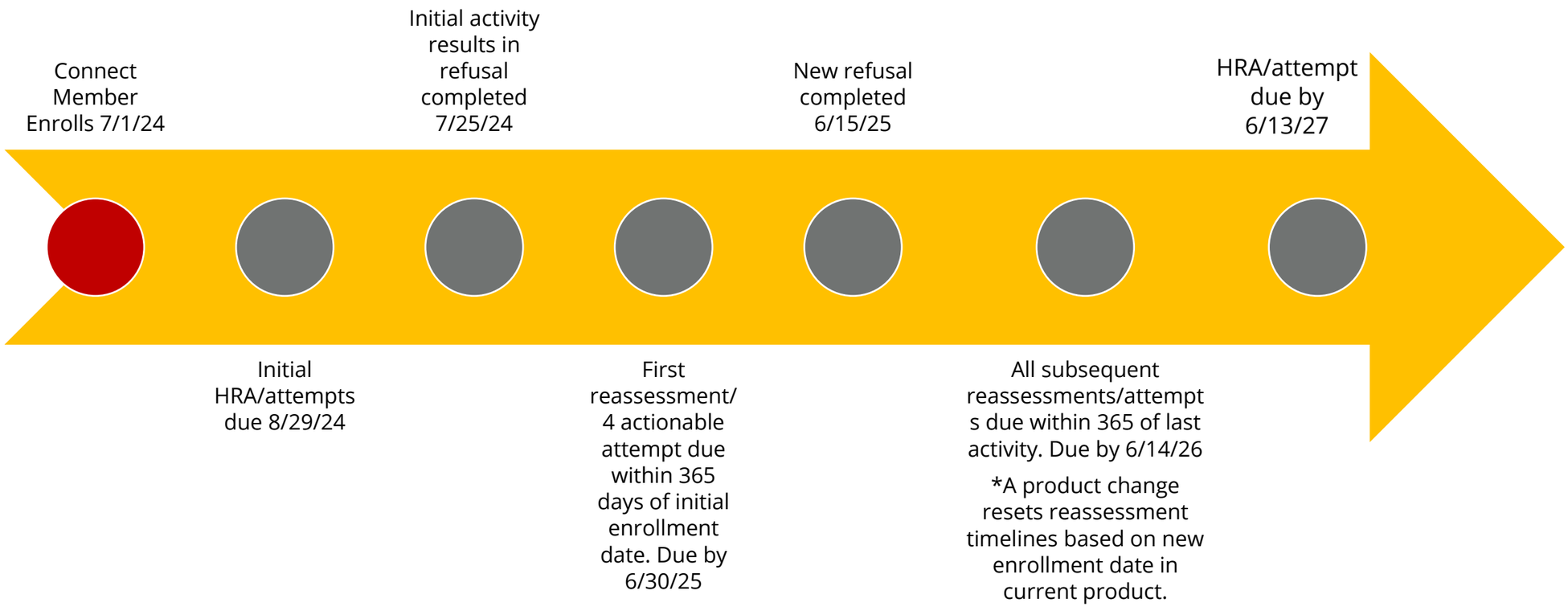
- Complete an Unable to Reach or Refusal Support Plan.
  - If there was a previous Support Plan, carry over the goals.
  - Attach completed Unable to Reach or Refusal Support Plan in MnCHOICES
  - Attempt to complete the Transfer-FNU at the next successful contact.
  - Do not close waiver

Assessment Timelines – MSC+/MSHO

When the first HRA attempt is a UTR or Refusal the first reassessment is due within 365 days of the enrollment date. All subsequent reassessments are due within 365 days of the last activity date unless reset by a product change resulting in another UTR or refusal.



Assessment Timelines – Connect / Connect + Medicare



For more information See: Assessment Timelines Job Aid

Connect Members turning 65

Connect/Connect + Medicare care coordinator role:

- Provide education on changes in benefits/insurance
- Confirm the member has identified their Primary Care Clinic (PCC) and discuss the importance for accurate assignment
  - Complete PCC Change form if update needed
- Describe the difference between MSC+ and MSHO
  - Eligible members must actively choose MSHO, or they will automatically default to MSC+
- Discuss the potential of the member receiving a change of care coordinator
  - Provide a warm handoff if possible
- Remind the member they will get a new ID card(s) and to share with medical providers and pharmacy
- If UCare is not offered in the member's county for MSC+/MSHO, assist in finding other options. See the DHS DHS-4840-ENG (state.mn.us) for MCO choices by county
- Collaborate with CADI Wavier case manager
  - Member may benefit from remaining on the CADI waiver
- Address the transition of PCA from County to Care Coordinator
  - Verify current provider is in the UCare network
- Send DHS-6037 if a member is transferring to a new care coordinator

MSC+/MSHO care coordinator role:

- Confirm the member has identified their Primary Care Clinic (PCC)
- Remind the member they will get a new ID card(s) and to share with medical providers and pharmacy
- A THRA can be completed when the 65th birthday assessment results in transitioning to the Elderly Waiver (Follow the Functional Needs Update (FNU) process for Fee-For-Service to MCO transfers)
  - All other outcomes require a new assessment to be completed

Resources to share:

Senior Linkage Line: 1-800-333-2433
Comparison Grid: MSC+/MSHO
Numbers to know
2024 MSHO Member Guide
2024 MSC+ Member Guide

People Powered Health Plans

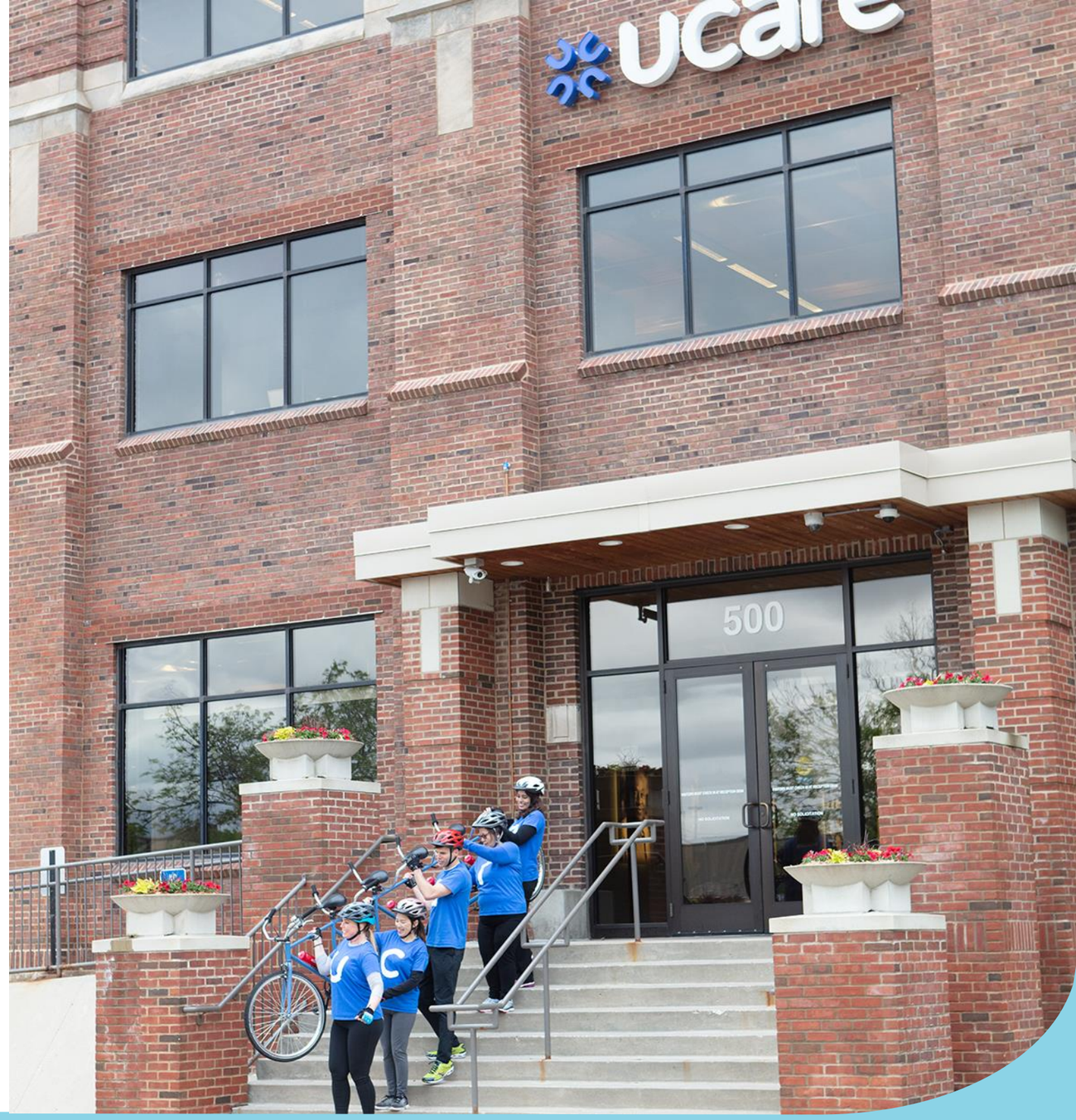
UCare offers two senior health plans:

- Minnesota Senior Care Plus (MSC+) A mandatory prepaid Medical Assistance Program for people over age 65. MSC+ replaces fee-for-service Medical Assistance (MA). All care covered by Medical Assistance is covered by MSC+. Members may or may not have Medicare A/B/D coverage.
  - Note: Dual eligible members may elect to keep their MA and Medicare separate. In this case – Medicare is the Primary (first payor) insurance and UCare's MSC+ is Secondary (second payor)

- UCare's Minnesota Senior Health Options (MSHO) A voluntary Minnesota Health Care Program for MA and Medicare eligible individuals. MSHO combines both MA and Medicare into one health plan administered by UCare.

Both MSC+ and MSHO have the benefit of an assigned Care Coordinator.

To Learn More:
DHS Health Care Programs & Services: Health Care Programs and Services
MSC+/MSHO Comparison – Member Handout



Understanding Gaps in Care Reports!

Understanding how a member is using health care can provide Care Coordinators essential information to help members receive the best care!

Gaps and Measures are addressed in the day-to-day work of care coordinators

- Annual Assessment
  - Physical Health
  - Preventative Care
  - Vision, medications
- Support Plan
  - My Goals
  - Barriers to achieving goals: What gets in the way?
- Transition of Care
  - Address primary care
  - Post hospitalization follow up care
  - Mental health care visit after hospitalization

Prepare before a visit:

- Review for noted gaps from report
- Gaps data provides talking points for reminders, health education and the opportunity to assist with identifying obstacles and barriers the member may have in closing a gap

Measure Summary on Gaps in Care Report

Measure	Abbreviation
Annual Wellness Visit (18 + y.o. completed AWV in current year)	AWV
Breast Cancer Screening (50-70 y.o. screening completed every 2 years)	BSC-E
Colorectal Cancer Screening (45-75 y.o. completed per type of screening i.e.: colonoscopy every 10 years, Cologuard every 3 years)	COL
Annual Dental Visit (18 + y.o. completed dental exam)	DEN
Annual Eye Exam with Diabetes (18-75 y.o. w/DM dx completed retinal/dilated exam or w/in prior year or hx of bilateral eye enucleation completion)	EED
Annual Hemoglobin A1C with Diabetes (18-75 y.o. w/DM A1C <8.0%)	HBD
Annual Kidney Eval with Diabetes (18-85 y.o. w/DM completed kidney eval)	KED
Statin Use with Cardiovascular Disease (21-75 y.o. w/ASCVD an received statin therapy – med adherence)	SPC
Statin Use with Diabetes (40-75 y.o. w/ DM received statin therapy – med adherence)	SUPD
Transition of Care Patient Engagement (18 + y.o. completed f/u visit with provider w/in 30 days of discharge)	TRC
F/U after ED visit with Multiple Chronic Conditions (18 + y.o f/u visit with provider w/in 7 days)	FMC
All Cause Readmissions (18 + y.o. TOC to prevent readmission w/in 30 days of discharge)	PCR
Medication Adherence: Diabetes, Hypertension, Statins only (18 + y.o. 80% compliant)	-

Gaps in Care Report Detail

Measures												
BCS-I	MostRecent BCS	COL	MostRecent COLColo	MostRecent COLFlexSig	EED	MostRecentEE	KED	MostRecentKE	TRC ENGAGEMEN	MostRecent TRC Engagement	DEN	MostRecentDE
0		0			1	10/17/2023	0	1/22/2024	NULL		1	2/14/2024
NULL		NULL			NULL		NULL		NULL		0	12/5/2023
NULL		0			NULL		NULL		NULL		0	1/4/2021
1	3/22/2024	1	3/29/2021		1	1/29/2024	0		NULL		1	1/22/2024

0=Needs outreach, is noncompliant for the measure

1=Does not need outreach, is compliant for the measure

NULL=Does not need outreach, does not qualify for the measure

Non-Incentive Measures							
AWV	MostRecentAV	GSD (fka HBD)	MostRecentGSD (fka HBD)	SPCTHERAP	MostRecentSPCTherapy	SUPD-U	MedAdhereDiabetesStatus
0		1		NULL		1	
0	1/20/2022	NULL		NULL		NULL	ON SCHEDULE
0		1		NULL		NULL	
0		1		NULL		0	ON SCHEDULE - AT-RISK

Annual Wellness Visits remain “0” until the member completes in CY 2024.

README | gaps detail | med adhere detail | rates summary | cy2024 panel members

Website Updates

MSC+/MSHO

Letters

MSC+ Letters

Appointment Reminder Letter

Care Plan Letter Hmong | Somali | Spanish

Care Plan Signature Letter Hmong | Somali | Spanish

MSHO Letters

Forms

Assessment and Support Plan Forms

2024 MAL

IHRA | Example IHRA

IHRA Support Plan | Example IHRA Support Plan

Support Plan Sign Sheet

UTR Support Plan Word | PDF

Refusal Support Plan Word | PDF

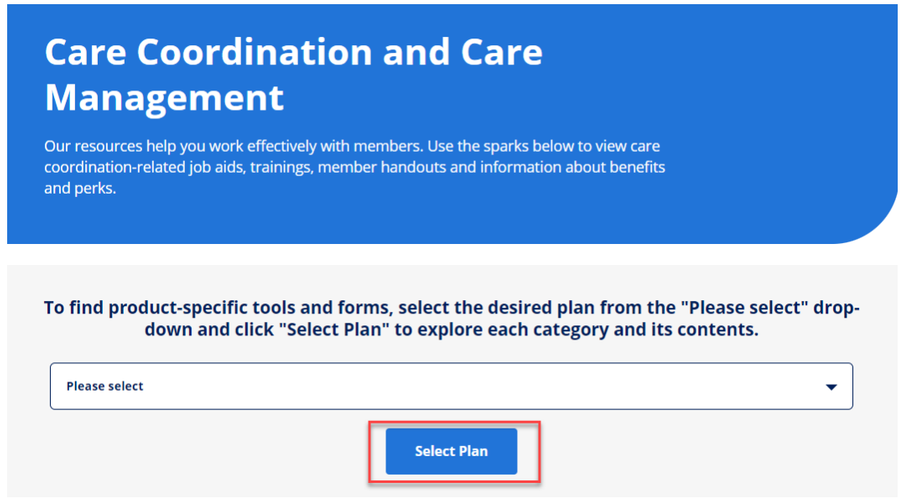
Other Forms

Death Notification Form

PCC Change Form

ROI Form

NEW: Elderly Waiver



Connect/Connect+ Med

Letters

Connect Letters

Connect + Med Letters

Forms

Assessment and Support Plan Forms

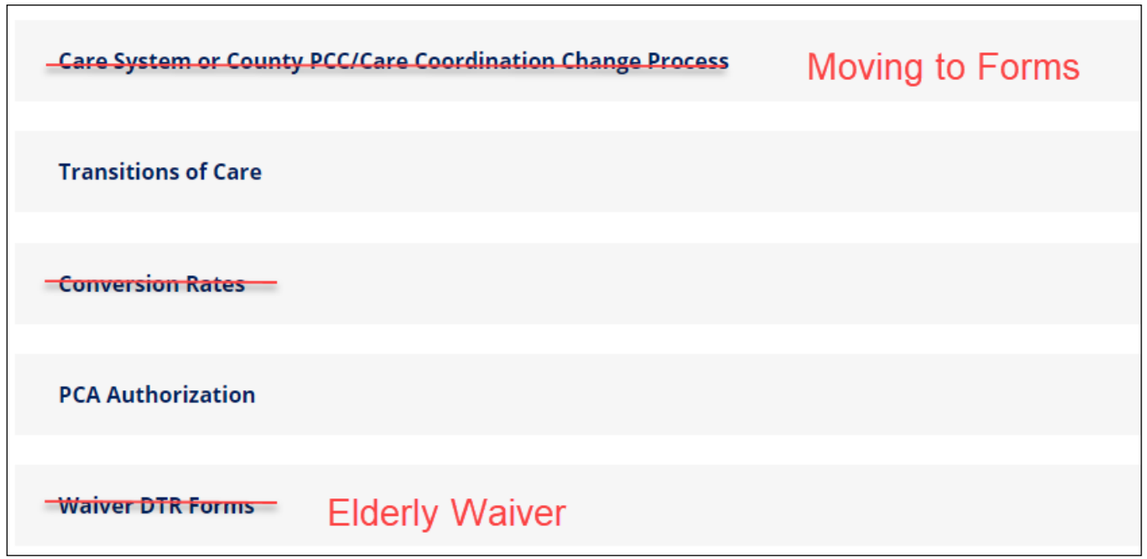
Other Forms

Death Notification

PCC Change Form

ROI Form

MSC+/MSHO EW Drawer



Elderly Waiver

EW Service Authorization

- WSAF
- WSAF T2029
- **NEW:** EW T2029 Equipment and Supplies Guide
- **NEW:** EW T2029 Equipment and Supplies Coverage Process
- HH Communication Form (Extended Home Care Auth)
- **NEW:** EW Rate Calculations Tool
- CBSM EW Conversion Rate Link

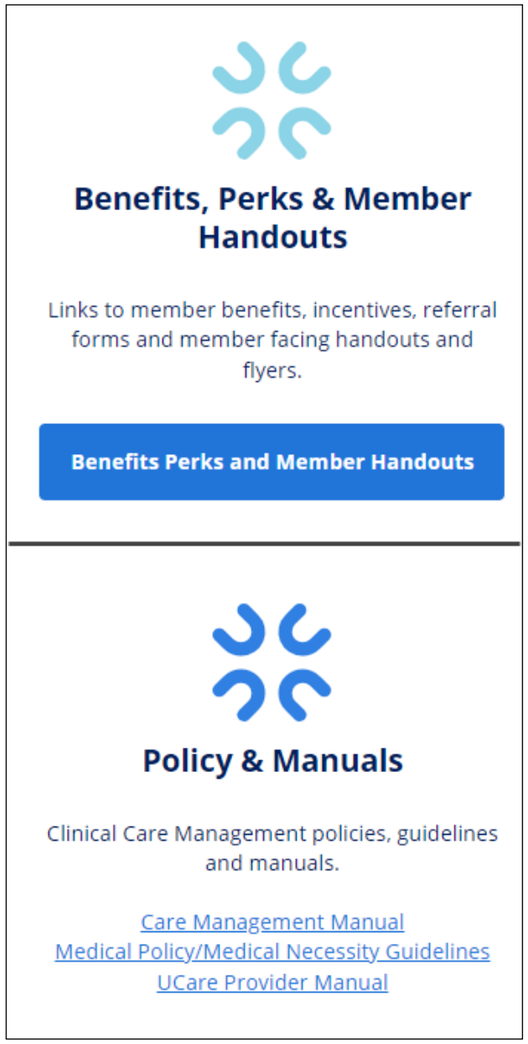
NEW: CDCS Toolkit

- CC CDCS Guidelines | CC CDCS Checklist
- Notice of Technical Assistance Form
- Member Guide to CDCS Expenditures | Member Agreement and Checklist

EW DTR Forms and Instructions

- Waiver DTR Form | Instructions
- EW DTR Reason Code Tool

Website Updates



Benefits, Perks & Member Handouts Spark – reformatting

NEW HEADERS

CT+M and MSHO

Adult Dental Kit Order Form
AA/NA Transportation Request Form
Grocery Ride Auth Online Form
Medication Toolkit Order Form
Reemo Smartwatch and/or Blood Pressure Monitor Order Form

MSHO

GrandPad Order Form
LSS Healthy Transitions Authorization Form Word | PDF
Memory Kit Order Form
Mom Meals
Supplemental Benefits Authorization Form
Stress & Anxiety Kit

MSC+ and MSHO

Strong and Stable Kit (removed from the MSC+ page and moved here)

Policy & Manuals Spark

NEW: MSC+/MSHO CC Manual

NEW: Connect/Connect + Med CC Manual

2. UCare's Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+)

UCare's Minnesota Senior Health Options Overview

Minnesota Senior Care Plus Overview

Care Coordination Resources and Requirements for MSC+ and MSHO

MSC+ and MSHO Care Coordination Manual (coming soon!)

EW T2029

Prior to submitting the Waiver Service Approval Form, care coordinators must ensure that the Elderly Waiver is the payor of last resort and work with the UCare network DME provider to determine if a provider's order is needed and obtain the HCPC needed for authorization. Review the MHCP: Supply and Equipment and the CBSM for information related to coverage under MA and EW.
All items indicating "YES" under Medicare and/or Medicaid (MA) eligible must first be submitted under the member's medical benefit and denied prior to consideration for coverage under the Elderly Waiver, except for Nutritional Supplies (see notes). If the item can potentially be covered under Medicare/MA, DO NOT submit a T2029 Waiver Service Approval Form until you have received confirmation that the item is not eligible for coverage under the member's medical benefit.

Supervisor Consultation and Approval Instructions:

For the following situations, the notes on the T2029 Equipment and Supplies Waiver Service Approval Form must include an attestation stating case was reviewed with a supervisor and approved. For items that are marked as eligible for coverage under Medicare and/or Medicaid, the service description must also include an attestation indicating that item did not meet criteria for medical coverage:

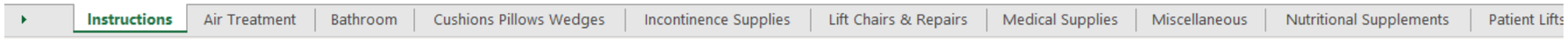
1. Chair portion of lift chair over $950 (reminder: EW does not pay for upgrades, i.e., massage, heat, etc.)
2. Any single item over $500
3. Item(s) listed as NO to EW in "Elderly Waiver Eligible" column and the care coordinator is requesting an exception with supporting documentation and approval from Supervisor
4. Item(s) listed as Yes to "Medicare and/or Medicaid Eligible" column and the care coordinator is requesting coverage with EW funds
5. Anywhere indicated in the NOTES detail for the item
6. Item is not listed on T2029 Equipment and Supplies Guide and CC is uncertain if it meets the EW service criteria as outlined in the MHCP and CBSM manuals

Quick Tab Links

Air Treatment	Bathroom	Cushions/Pillows	Incontinence Sup.	Lift Chairs	Medical Sup.	Miscellaneous	Nurtitional Supp
Patient Lifts	Repairs	Scales/Weight Mgt	Skin Care	Walking Device	Walker Upgrades & Accessories	Wheelechairs & Scooters	Tele-Health

Resources

CBSM: Specialized Equipment and Supplies
CMS- National Coverage Determination for DME
DME List of Specified Covered Items (list subject to face to face requirement)
DHS MHCP Billing Policy Overview
DHS MHCP: Equipment and Supplies Guidance
MHCP Enrolled Providers – Nursing Facilities Provider Manual: Equipment and Supplies



New Requirement:

Items over $500 require Supervisor – new checkbox on WSAF forms

NEW: EW T2029 Equipment and Supplies Guide
NEW: EW T2029 Equipment and Supplies Coverage Process

MN EAS Reminders

- UCare will continue to send the DAR – end date TBD
- Upload your panel into EAS at least monthly
- Check EAS daily for admission/discharge notifications
- Not all notifications in EAS will require a TOC
  - ER visit – no hospital admission
  - Hospital floor/unit changes (Ex: ICU to Med Surge)
  - MRI or X-Ray
  - Outpatient Procedures

Documents in other languages

- Current languages for letters
  - Hmong, Spanish, Somali
- Current translated documents
  - How to Safely Dispose of Medication
  - Where to Go For Care
  - Unable to Reach Member Letter
  - Care Plan/Support Plan Signature Letter
  - Change of Care Coordinator Letter

Coming Soon: Support Plan Translation Request Form

MDH Audit and Part C Validation

MDH Audit: Thank you for your rapid and thorough responses! It is greatly appreciated.

Coming soon: Part C reporting comparison information. Delegates will be able to see how they compare to other delegates.

REPORTS

- Streamlining delivery of reports
- Centralized file location in the SecFTP
- Receive less emailed reports from various addresses
- Improve timeliness of reports
- Updates to follow

Coming Soon! Fall 2024

MSC+/MSHO Extended Break

10:05-10:20

SNBC Accessibility Survey

- Per the 2024 SNBC MCO contracts, MCOs shall conduct a DHS-approved accessibility survey and analyze the responses received. The MCO shall implement a follow-up plan to address specific issues identified in the SNBC disability survey.
- UCare topic: Member facing information on UCare's website
- Details:
  - Survey administration July – August
  - Could receive via mail or email
  - Half of SNBC members will in included
- CC's can help encourage the completion of the survey

SNBC Accessibility Survey

ucare

We invite you to take a survey about UCare's website.

Thank you for choosing UCare!

Help us understand how easy it is for members to find and use UCare's website by filling out this electronic survey. Taking the survey is optional—you don't have to do it. There are no right or wrong answers either. We'll use your feedback to help make our services better.

UCare's website

Q01. Have you ever used UCare's website (**ucare.org**) to find information?

Survey Example

Envelope

10-minute Break

10:10-10:20

Mental Health & Substance Use Disorder Services Road Show

Presenters: Malorie Potter, Crysil Dougherty, and Kathryn Schaefer

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MSS Leadership Team

Jennifer Andersen | MSS Clinical Operations Director

Malorie Potter | Clinical Manager

Shelby Marshall | Operations Manager

Lynn Price | Community Manager

Kathryn Schafer | Restricted Recipient Supervisor

Crysil Dougherty | MSS Case Management Supervisor

Bea Rademacher | MSS Child & Adolescent Case Management Supervisor

Alycia Lopez | Access Supervisor

Triage Coordinators

Receive incoming calls from members looking for assistance with locating in-network providers specific to mental health or substance use services

Support FUH (follow up hospitalization) process by preparing member cases for follow-up by CM/CACM* teams

Call clinics to determine what specific mental health or substance use services providers offer and if they accept new clients

*CM/CACM – Case Management/Child & Adolescent Case Management

Access Coordinators

1. **Receive incoming calls from members requesting assistance with scheduling mental health or substance abuse appointments**
2. **Gather information about the member's needs & preferences (culturally specific, gender, etc.)**
3. **Provide follow-up to members calling our external help line with mental health and substance use concerns.**
4. **Assist members in completing appropriate referrals and paperwork for appointments.**
5. **Call in-network clinics with the member on the line to help schedule appointments.**
   - **They will follow-up with members after the appointment to determine if further assistance is necessary.**
6. **Schedule transportation for members to methadone treatments at Vahalla Clinic/Brainerd or Clear Path Clinic/Duluth.**

Contact Information

Access

Email: MHSUDaccess@ucare.org
Phone: 612-676-6811

Triage

Email: MHSUDtriage@ucare.org
Phone: 612-676-6533

Case Management

Crysil Dougherty, RN, MHA, BSN, PHN, PMH-BC | Supervisor

The Case Managment Team

Mental health and substance use case management for adult members.

Manager
Malorie Potter

Supervisor
Crysil Dougherty

Senior Case Managers

- Katie Mowan
- Anna Harrison

11 Case Managers

- Ann Niebuhr
- Holly Hancks
- Julie Sagen
- Katie Mowen
- Lacey Ducklow
- Leslie Andry (also supports FUH/EAS)
- Michelle Stassen
- Shannon Stuart
- Sylvie Tamfu
- Traci Page
- Yvonne McIntosh

3 FUH/EAS Case Managers

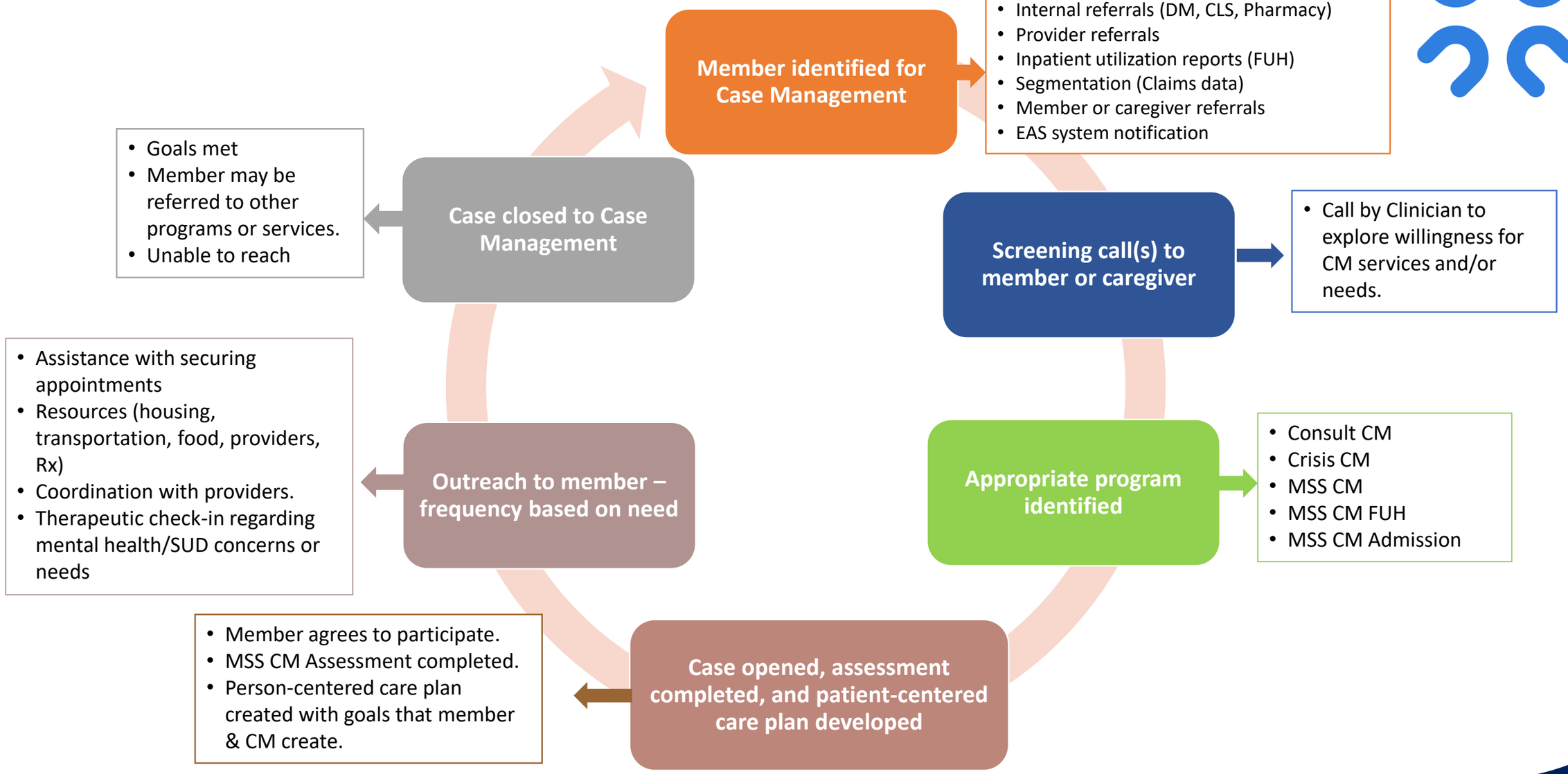
- Anna Schmidt
- Janice Henkemeyer
- Regina Schmidt

What We Do

- Provide trauma informed, person-centered telephonic support to UCare members with mental health and substance use disorder diagnoses.
- Collaborate with members and providers to ensure members receive the care they need.
  - Our model embraces a holistic approach, we focus on mental health, SUD and social factors.

- Assist with transitions of care, especially following mental health inpatient stays.
- Arrange, refer to, and find services including, but not limited to:
  - Mental health and substance use inpatient/outpatient treatment facilities
  - County-based resources
  - Therapy and Psychiatry
  - Help with unstable housing and food shortages

Case Management Lifecycle



MSS CM Program Types

MSS CM

Main case management program for members identified as needing additional support w/ MH or SUD concerns

MSS CM LAIA

To provide support to members who receive a long-acting injectable antipsychotic

MSS CM FUH

Focus on meeting HEDIS measures for members who have recently discharged from a mental health inpatient stay

MSS CM Admission

Follow-up from a recent admission for non-FUH reasons such as medical, LTC, TCU, SUD, IRTS

MSS CM Consult

For dually managed members' care coordinators who need short-term support from a MH professional

LAIA Program (Specialty)

LAIA = Long-Acting Injectable Antipsychotic

Purpose: To provide support to members who receive long-acting injectable antipsychotics (LAIA) to improve medication adherence as well as lab work related to their treatment and as it relates to QI4 reporting and NCQA requirements.

Background: Persons with behavioral health challenges have higher co-morbidities than the average population. Members on LAIAs have additional needs for screening for co-morbid conditions such as hyperlipidemia and diabetes. QI4 Factor 6 identifies that UCare will meet NCQA national 75th percentile benchmarks for this testing. There are multiple barriers to this population receiving this screening.

FUH (Follow-up after Hospitalization)

FUH team focuses on meeting HEDIS measures:

- The percentage of **discharges** for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses AND who had a follow-up visit with a mental health provider. Two rates are reported:
    - The percentage of **discharges** for which the member received follow-up within **30 days** after discharge.
    - The percentage of **discharges** for which the member received follow-up within **7 days** after discharge.
- Clinicians contact hospitals and/or members to ensure follow-up after hospitalization occurs and the member has the appropriate support and resources.
- Staff utilize daily FUH report as well as EAS notifications of referrals.

Eligible Plans

We recently opened our program to ALL UCare products

We will also provide consult support or co-management for UCare members enrolled in any other case management or care coordination programs.

Criteria for MSS CM – is my member eligible?

If you're unsure – reach out!

How to Refer a Member or Contact Us

MH/SUD Case Management Referral Form

Email

MHSUDcasemanagement@ucare.org

Please provide the member # and name with a brief summary or description of the situation.

Mental Health and Substance Use Disorder Triage Line

612-676-6533 or 833-276-1185 toll free

QUESTIONS
on Case
Management?

Restricted Recipient Program

2024

Restricted Recipient Program Overview

Foundation of Restricted Recipient Program (RRP)

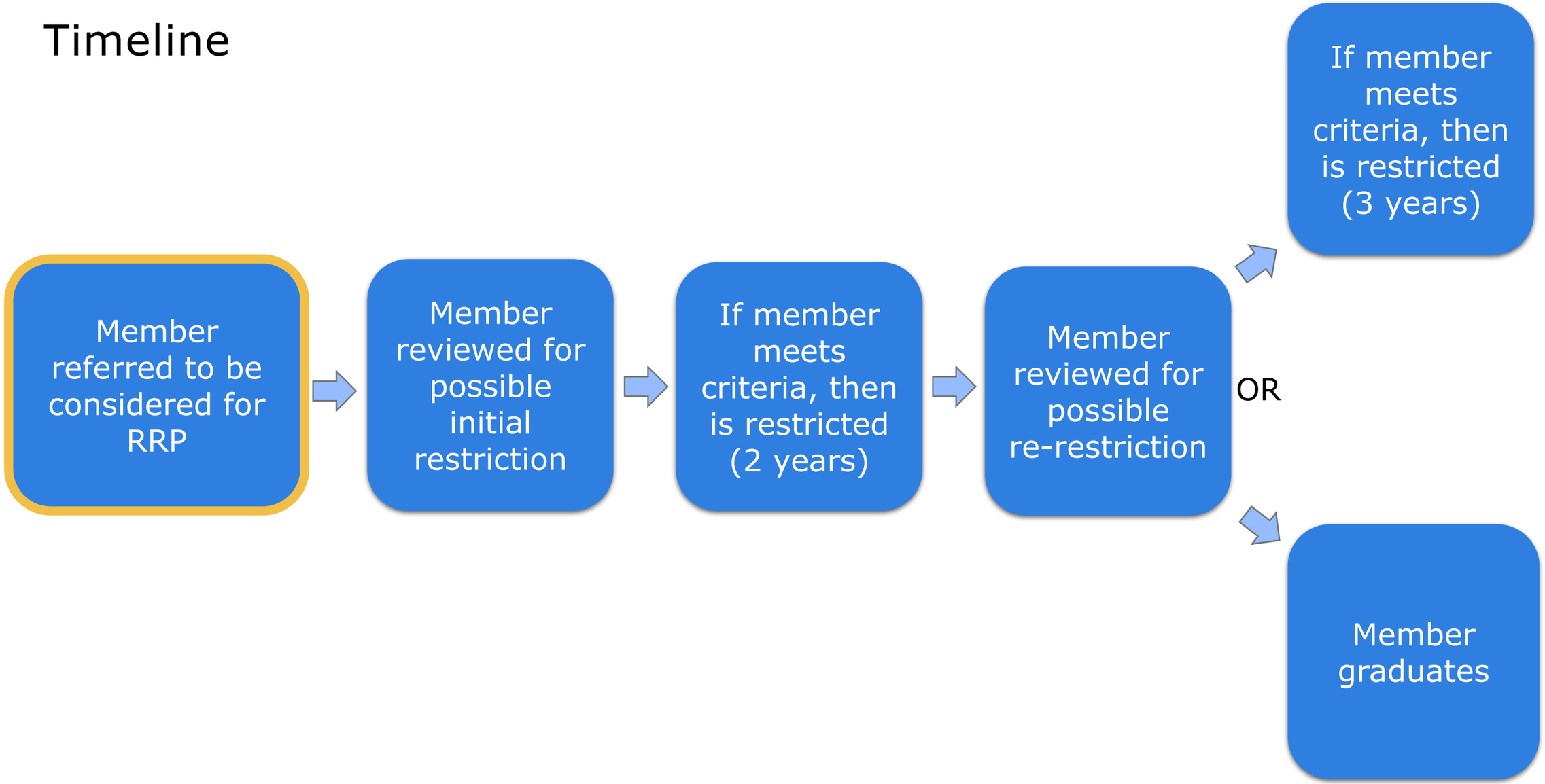
- RRP was created by Minnesota DHS coordinate a recipient's medical care and decrease costs.
- MN State Statues
  - Outline the program.
  - States the reason a member can be restricted.
  - PCA*: Cannot use PCA Choice; must use a traditional agency.
- Universal Restricted Recipient Program (URRP) stays in effect as member's coverage between managed care organizations and/or DHS fee-for-service.

*Personal Care Attendant

Restricted Recipient Program Overview, cont'd

- Our regulator is the DHS Office of the Inspector General.
  - Administers DHS fee-for-service RRP.
  - Oversees managed care organizations' RRPs.
- Purpose of RRPs:
  - Identify Minnesota Health Care Program (MHCP) recipients that are abusing/misusing MHCP services.
  - Guide members in using their health benefit in appropriate and effective ways.
  - Acts as safety net for high risk/high need group of members.
- Length of RRP:
  - Initial restriction is 24 months.
  - Re-restriction is 36 months.

Timeline


Member referred to be considered for RRP
Member reviewed for possible initial restriction
If member meets criteria, then is restricted (2 years)
Member reviewed for possible re-restriction
OR
If member meets criteria, then is restricted (3 years)
Member graduates

Referrals

Members eligible for initial restrictions

Minnesota Health Care Programs:

Special Needs Plans

PMAP

MNCare

Connect/Connect+

MSHO/MSC+

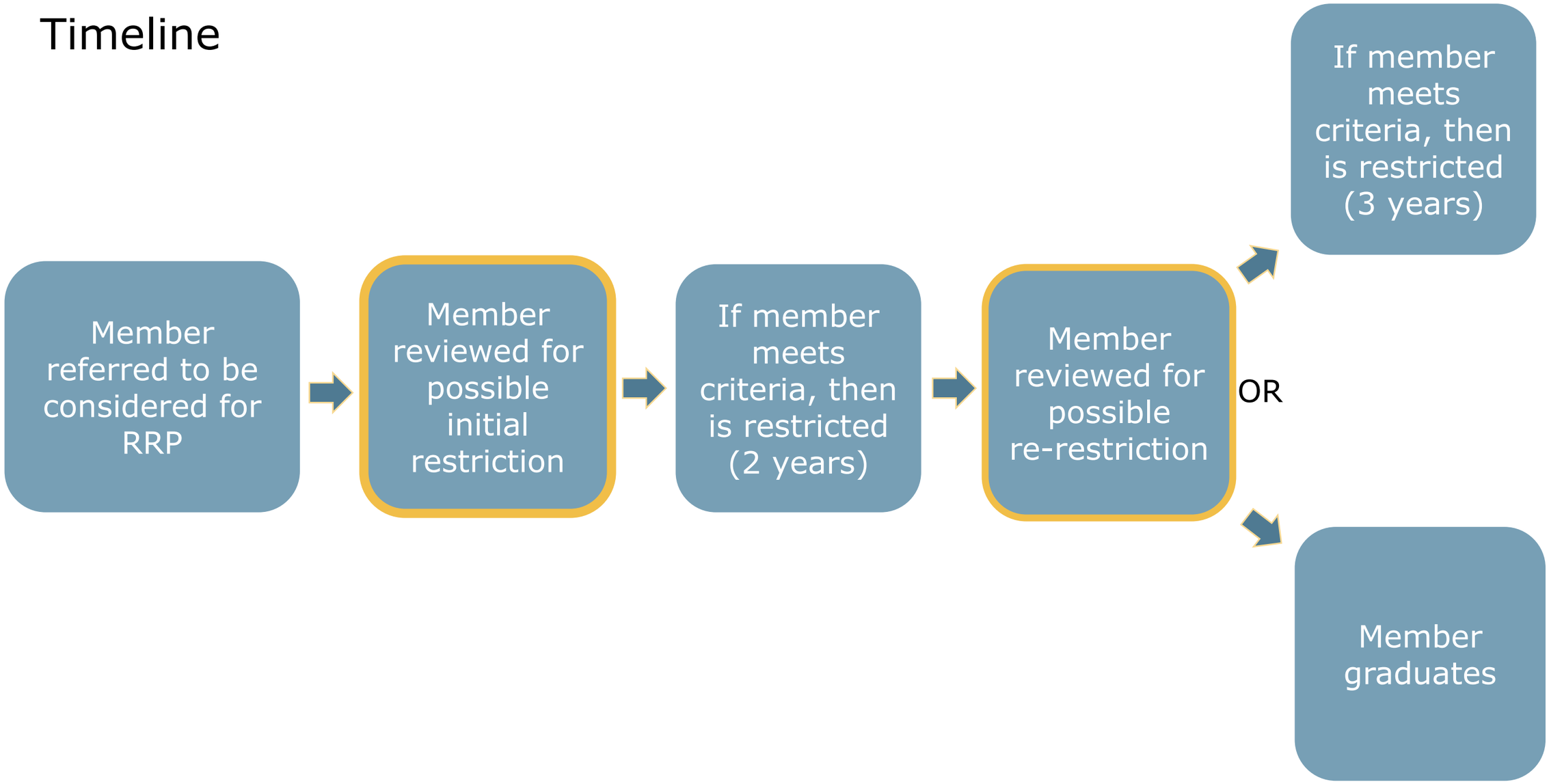
External

- Referrals from clinics/hospitals/etc.
- RRP Intake Form

Internal

- Referrals from other UCare teams
  - Email: restrictedrecipient@ucare.org
- Reports

Timeline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Possible Restriction Reviews

- 12 month look-back
  - Claims
    - Office visits, ED visits, inpatient admissions, prescriptions
- Prescription Monitoring Program (PMP) report
    - Controlled substances and Gabapentin
- Obtain collateral information when needed
  - Verifying information with pharmacy
  - Follow-up with referral source

Reason Codes

B1. Not medically necessary

B2. Duplicate services

B3. Continued behavior after warning

B4. Altered/duplicated MHCP ID card

B5. Used another's MHCP ID card

B6. Someone else used MHCP card

B7. Forged or changed prescription

B8. Misrepresented symptoms

B9. Incorrect eligibility information

B10. False information about health services

B11. Obtained services by false pretenses

B12. Obtained potentially harmful services

B13. ER use for non-emergent care

B14. Med Trans outside of local trade area

B15. Cancelled services to avoid spenddown

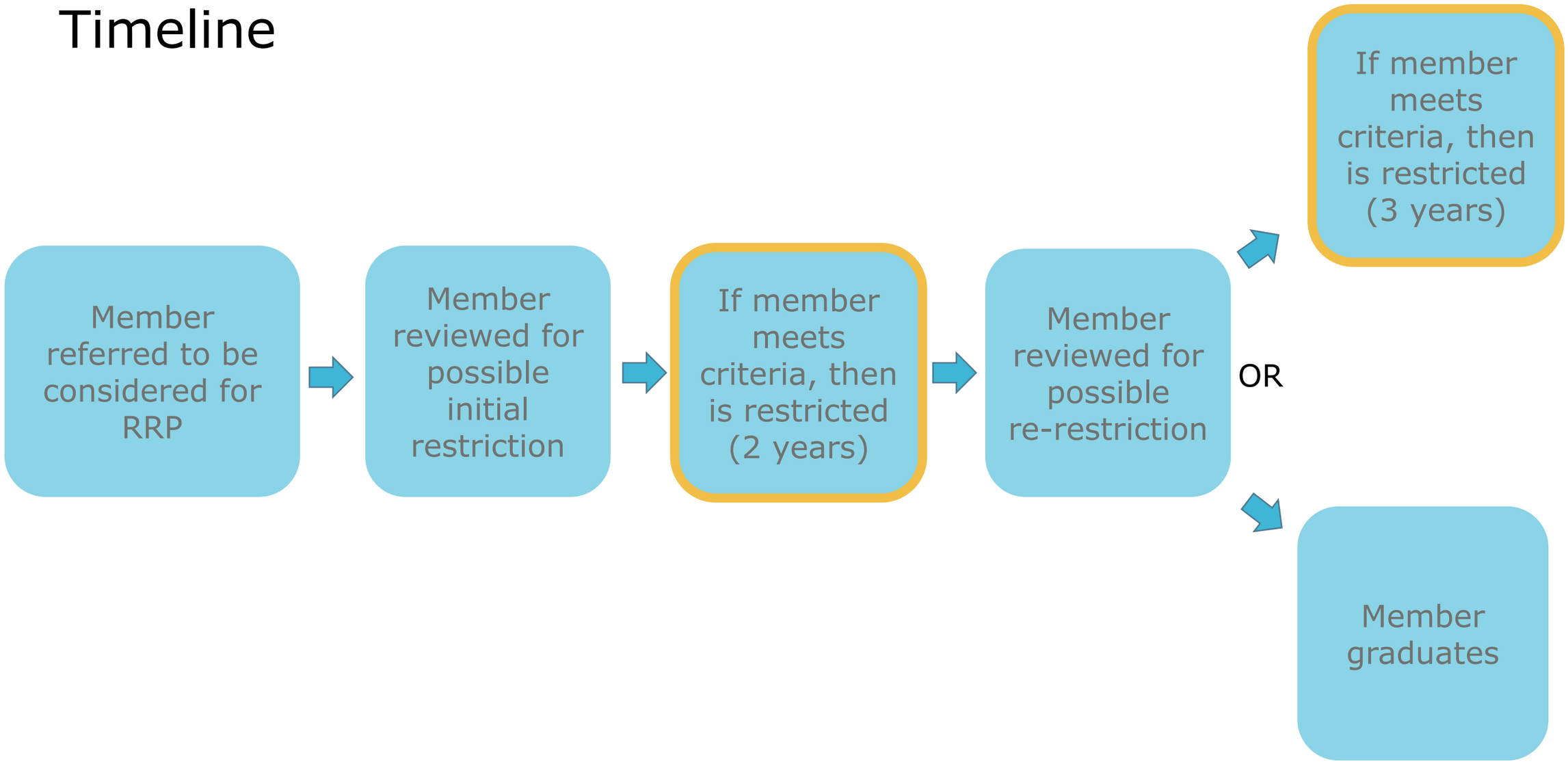
C1. No Referral to Physician/Providers

C2. ER Use for Non-emergent Care

C3. Used Wrong Pharmacy

C4. Used Wrong Providers/Clinics

Timeline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Member graduates

Where can a RRP member get care?

Designated providers

- Primary care provider/primary care clinic
  - Designed to be the hub of the member’s care and ensure member has an appropriate care team.
  - PCP/PCC can authorize additional providers including primary care partners and specialty providers.
- Hospital
  - Member should only go to designated hospital for ER care.
- Pharmacy
  - Member can only fill at their designated pharmacy.

Managing an RRP member

RRP processes:

- Complete lockdowns for initial and re-restriction.
- Process PCP partner and specialty referrals.
- Process change of provider forms (PCP/PCC/hospital/pharmacy).
- Follow-up on admissions to treatment centers and hospitalizations.
- Assist members in obtaining medications.
- Assist with claims payment issues.
- Work RRP Macess queue
  - Reconsideration form submitted requesting claims payment.
- Appropriately documenting our work, creating/updating authorizations, and updating our pharmacy benefit manager.

Managing an RRP member

- Communicate and share knowledge between:
  - Members, providers, living facilities, member's professional supports, and UCare staff
- Offer case management
  - Began rolling out case management to in 2/2023
  - Holistic approach
    - Assessment
      - Physical health
      - Mental health
      - Substance use
      - Basic needs
      - Professional supports
    - Care Plan
    - Routine contact/follow-up with the member

How do Care Coordinators know if a member is restricted?

- MNITS

Restricted Recipient Program

Please call the PCUR unit for additional information. The telephone number is 1-800-657-3674 or 651-431-2648.

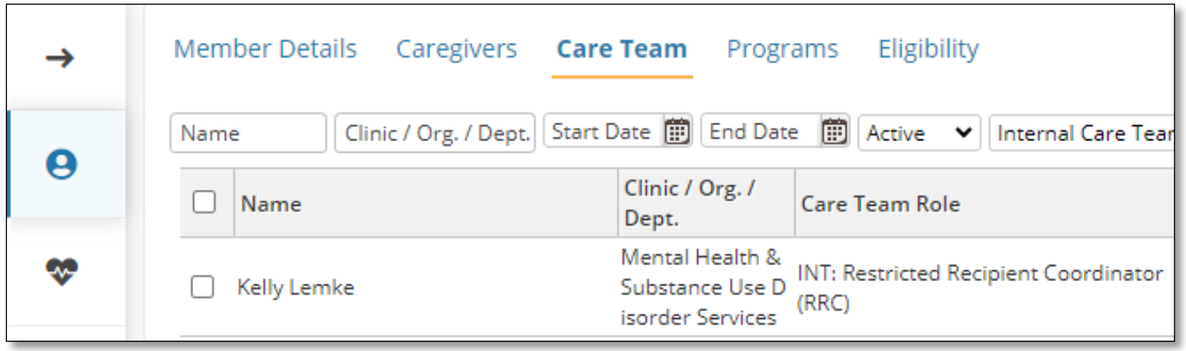
- Provider number 1245272608, CARLOS JAIME ADAMS is a provider for a Restricted Recipient for: **Physician Services** , **Nurse Practitioner Services**
- Provider number 1184670044, M HEALTH FAIRVIEWCLINIC - MIDWAY is a provider for a Restricted Recipient for: **Physician Services** , **Diagnostic Lab** , **Nurse Practitioner Services**
- Provider number 1699752915, FAIRVIEW SOUTHDALE HOSPITAL is a provider for a Restricted Recipient for: **Inpatient Hospital** , **Outpatient Hospital** , **Physician Services** , **Diagnostic Lab**
- Provider number 1497760714, WALGREENS PHARMACY #02142 is a provider for a Restricted Recipient for: **Pharmacy**

- Guiding Care (UCare internal staff)
  - Program
  - Care Team

- Navitus (UCare internal staff)
  - Pharmacy and prescriber inclusion restrictions entered into the Eligibility Information

Restricted Recipient Program

08/13/2023 Status **Active** Referral Source:
N/A **RR - Internal**



Contact Information

RRP main line (voicemail) 612-676-3397

RRP fax 612-884-2316

RRP email Restrictedrecipient@ucare.org

Members should be transferred to the RRP mainline

Do not give out RRC staff emails or last names

Restricted Recipient Program Team

Restricted Recipient Coordinators (RRC)

- Jessica Graves (Senior)
- Katherine Canale
- Kelly Lemke
- Susan Martin (Senior)
- Ifeoma Okolo
- Kerian Stenstrom
- Laura Thompson
- Sarah Umberhandt
- Leyna Velzke
- Krista Rainer (Senior Auditor)

Administrative Coordinators (AC)

- Michael Vu
- Teri Johnston

Supervisor

- Katie Schaefer

Thank you!

Questions?

ICBS:
Intensive Community-Based Services

What is ICBS?

- ICBS is an intensive, community-based, Mental Health and Substance Use feet-on-the-street case management program.

- Case managers go to the member’s home, hospital, treatment location, or wherever the member is residing.

Our ICBS Partners

Mental Health Resources

Serves 7 metro counties: Anoka, Hennepin, Ramsey, Washington, Carver, Scott, & Dakota

Human Development Center

Serves St. Louis, Lake, & Carlton counties.

Northern Pines

Serves Crow Wing, Morrison, Todd, Wadena, Cass, & Aitkin counties.

Zumbro Valley

Serves Olmsted, Filmore, Dodge, Mower, Winona, Freeborn, Steele, Goodhue, & Wabasha counties.

Vail Place

Hennepin, Ramsey, parts of Scott & Anoka counties.

Canvas Health

Serves Isanti, Chisago, Pine, Kanabec, & Mille Lacs counties.

What Does ICBS Assist With?

- Mental Health stabilization and services
- Substance Use Disorder resources and referrals
- Access to food resources
- SMRT referrals and follow-up
- Referrals to MNChoices assessments
- Assistance with finding stable housing
- Referrals to short term supports (ex. IRTS*)
- Assistance with finding employment
- Culturally appropriate services

* IRTS: Intensive Residential Treatment Services

Care Coordinator and ICBS Partnership

Care Coordinators remain involved in the member's care.

ICBS is short-term lasting approximately 3-6 months.	Regular collaboration between CC and ICBS CM.

ICBS CM are included on the member’s interdisciplinary care team.

ICBS CM focuses on meeting the member’s mental health and substance use disorder needs.

Products Eligible for ICBS

- **PMAP**
- **MNCare**
- **Connect**
- **Connect + Medicare**
- **MSHO**
- **MSC+**

How To Refer A Member

- Obtain member permission.
- Member must have a Mental Health or Substance Use Disorder diagnosis.
- No SUD information can be released on the ICBS referral form without a signed ROI form completed by the member.
- Complete referral form located HERE*
- Questions? Reach out to Malorie Potter and she will assist you.

PRO TIP: Bookmark this form on your browser(s).

GEDWorks

UCare members can earn their GED for no fee via GEDWorks, through funding provided by UCare.

Eligibility requirements

- MinnesotaCare (MnCare), Prepaid Medical Assistance (PMAP), Connect|Connect + Medicare
- Not enrolled in an accredited high school or have a high school diploma.
- Either over the age of 19, or if 17 or 18 years old with an approved age waiver.*

What is included?

- A dedicated advisor to provide support every step of the way
- Unlimited practice tests and study materials
- Official GED credential tests
- Access to bilingual (English and Spanish) advisors, tests and study materials

Direct members to ged.com/ucare to apply.

* The waiver form is included in the application process for those aged 17 and 18. Applicants will be notified by email if their waiver is approved.

QUESTIONS?

Medication Therapy Management (MTM) Program Overview 2024

Presenters: Diane Koetz- MTM Clinical Pharmacist & Emily Taber- TOC Clinical Pharmacist

Objectives

- Pharmacy Quality Team structure and goals
- Define Medication Therapy Management (MTM)
- Comprehensive Medication Review (CMR)
- Transitions of Care (TOC)
- Referral process
- Setting member expectations

Definitions

MTM = Medication Therapy Management

CMR = Comprehensive Medication Review

MRP = Medication Reconciliation Pharmacist

TOC = Transition of Care

Pharmacy Quality Team

- Main Focuses
  - Support for pharmacy-related quality metrics (Stars, HEDIS, QRS)
    - Adherence, SUPD, SPC, QRS INR Monitoring, CMR Completion Rate, Display Measures (Opioid/polypharmacy measures, etc), Transitions of Care, more
    - External and internal initiatives
  - Support all MTM related services (program re-design in 2021):
    - Oversight of external network
    - Performance of CMR and MRP (TOC) services directly to members

Pharmacy Quality Team Roles

Role	Responsibility
MTM Pharmacists	Support CMR completion for Medicare contracts and other MTM initiatives, as well as pharmacy Star Measures
TOC Pharmacists	MTM services within 30 days of hospital discharge for Connect+Medicare, MSHO, and UCare Medicare Classic
Operations Supervisor	Oversight of operations team
Operations Coordinators	Support PharmDs, regulatory requirements (materials, etc.), audit/oversight of external network, data review
Pharmacy Navigators	Proactive member engagement to support pharmacy initiatives
Member Engagement Specialist	Member engagement for CMR scheduling and enrollment into pharmacy initiatives

What is Medication Therapy Management (MTM)?

- MTM is a service available for members to help them get the most from their medications
- Members can meet one-on-one (in person or on the phone) with a pharmacist to review all prescriptions and over-the-counter medications to make sure they are safe, effective, and convenient to use
- Eligible UCare members have MTM coverage at no cost to them regardless of deductible
- For Medicare – directly tied to Star Ratings (therefore, some different intricacies to the program)
- **Active outreach occurring for Medicare Part D plans to support CMR completion rate**

What is Medication Therapy Management (MTM)?

- Why am I taking these medicines?
- What time of day should I take my medicines?
- Are there any drug-interactions that I should know about?
- Are my medicines working?
- Are they still indicated for my condition(s)?
- Am I experiencing side effects?
- My prescriptions are expensive, are there ways I can save money?

www.ucare.org/mtm

MTM is Not:

- Prescription dispensing
- Addressing billing issues at the pharmacy (ie. refill too soon)
- Prescription refill requests
- Pressuring a member to change their medications
  - We make suggestions, but there is no obligation to change anything
  - We provide recommendations to the member
  - We reach out to the provider if necessary and/or if the member requests we do so
- Going against a member’s medical provider(s)
  - We work WITH the providers to help members get the most out of their medication regimen

Eligibility

Member Plan Type	MTM Eligible	Special Notes
Medicaid Prepaid Medical Assistance Program (PMAP), MinnesotaCare, Minnesota Senior Care Plus (MSC+) and UCare Connect (SNBC)	✓	• UCare follows guidance from the Minnesota Department of Human Services (DHS)
Dual-eligible Medicaid MSC+, PMAP Duals, and UCare Connect Duals	✗	• Medicare benefits are through an outside payer, therefore MTM services must be provided through them
Medicare UCare Medicare Plans, UCare Medicare Group Plans, EssentiaCare and UCare Medicare with M Health Fairview & North Memorial Health	✓	• All members with Part D benefits are eligible through a UCare pharmacist or an in-network pharmacist
Dual-eligible Medicare UCare's Minnesota Senior Health Options (MSHO) and UCare Connect + Medicare	✓	• All members with Part D benefits are eligible through a UCare pharmacist or an in-network pharmacist
Medicare Value UCare Value and UCare Value Plus	✗	• Not eligible without Part D benefits
Health Exchange and Individual & Family Plans UCare Individual & Family Plans, UCare Individual & Family Plans with M Health Fairview	✓	• Eligible for MTM services through an in-network pharmacist

Source: UCare Provider Manual (February 8, 2023)

Who Can Provide MTM?

- Internal Pharmacist Team:5 MTM Pharmacists and 2 TOC pharmacists
- Medicare: MSHO, C+M, UCare Medicare, EssentiaCare, FVNM, Aspirus
- External: See Next Slide
- Other LOB can be connected with these

- For any questions about MTM, email pharmacyliaison@ucare.org

Current External MTM Partners

Health Systems	Community Pharmacies
Allina	Thrifty White
M Health Fairview and Entira Clinics	Geritom
North Memorial	Sterling/Astrup*
Hennepin Healthcare	Guidepoint
Essentia	St. Paul Corner Drug*
St. Luke's Duluth	
CentraCare	
Health Partners and Park Nicollet	
Mayo	
Cuyuna	
Mille Lacs*	

*Medicaid and IFP Only. No Medicare

Transitions of Care (TOC) Pharmacy Service

- Dedicated to MSHO, C+M, and Medicare Classic members with a recent hospitalization
- Targeting members within 30 days of hospital discharge or transitional care unit discharge.
  - Prioritization for member outreach is based on:
    - Readmission risk score
    - Number of medications
    - Number of chronic conditions

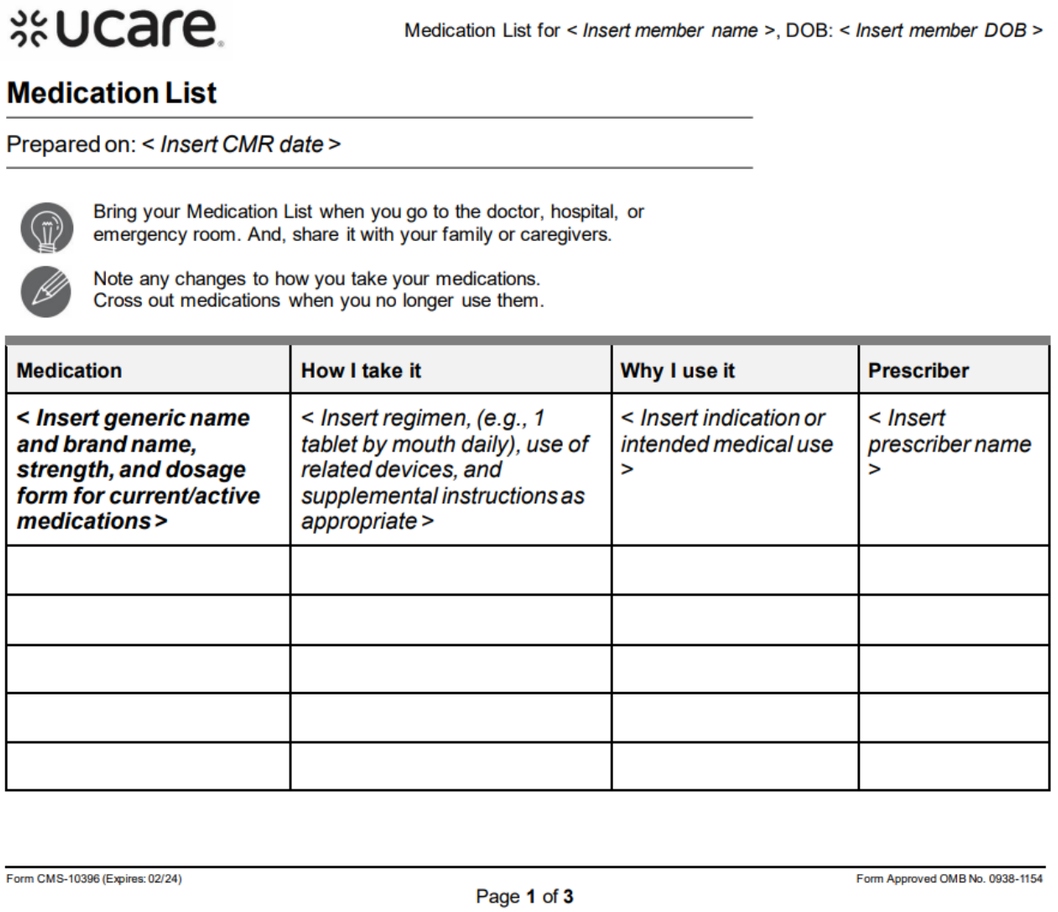
TOC Pharmacist Role

- A complete comprehensive review of medications with member
  - **Provide in-depth counseling of new medications added post-discharge**
  - Look for ways to make medication regimen more simple or effective
  - Identify and resolve gaps in care
  - **Communicate with providers after ALL visits to let them know a medication reconciliation was completed and provide any recommendations if applicable**
  - Mail member a medication list and any information or recommendations discussed during the visit
  - Follow-up with member, clinic, and pharmacies when appropriate

Goal of service is to reduce hospital readmission rates and improve member experience with their medications

What happens after a CMR or TOC visit?

- Member will receive the following via the mail
  - Personalized medication list
  - Medication action plan
    - Defines what drug therapy problems were identified
    - Suggested next steps member should take
- Provider(s) are contacted on an as needed basis



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Medication List for < *Insert member name* >, DOB: < *Insert member DOB* >

Medication List

Prepared on: < *Insert CMR date* >

Bring your Medication List when you go to the doctor, hospital, or emergency room. And, share it with your family or caregivers.

Note any changes to how you take your medications. Cross out medications when you no longer use them.

Medication	How I take it	Why I use it	Prescriber
< Insert generic name and brand name, strength, and dosage form for current/active medications >	*< Insert regimen, (e.g., 1 tablet by mouth daily), use of related devices, and supplemental instructions as appropriate >*	*< Insert indication or intended medical use >*	*< Insert prescriber name >*

Form CMS-10396 (Expires: 02/24)

Page **1** of **3**

Form Approved OMB No. 0938-1154

MTM/TOC Referral Process

- Email the pharmacy team!
  - Send to: pharmacyliaison@ucare.org
  - Subject: MTM referral
  - Body:
    - Hello,

      Please contact member to schedule a medication review.

      Member name:

      Member ID # or DOB:

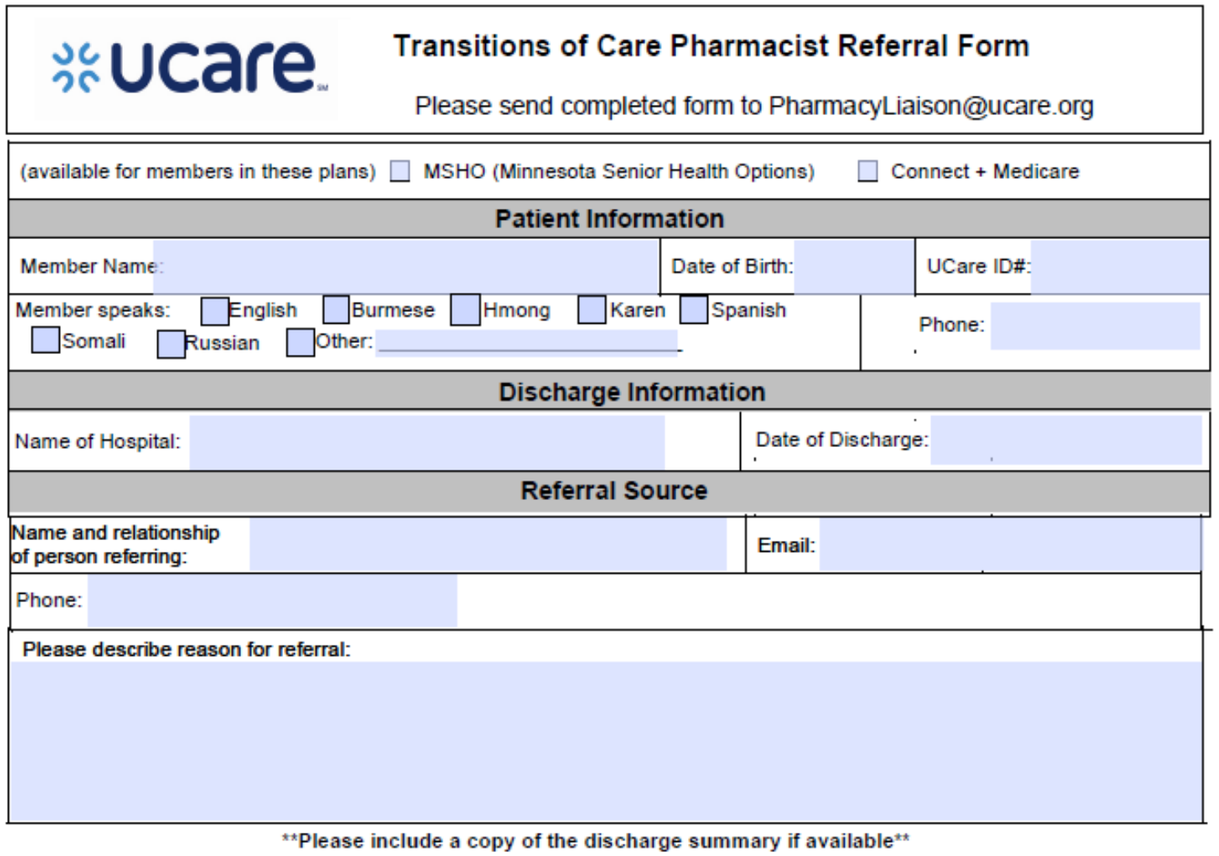
      Annual CMR or TOC visit:

      Additional Notes/Reason for Referral if applicable:

Please refer members that you think would benefit from this service!

Alternative TOC Referral Process

- Referral form will be available on the UCare Care Coordination and Care Management page on the UCare website
  - https://home.ucare.org/en-us/providers/care-managers/
  - Select MSHO or UCare Connect + Medicare
  - In the “Transitions of Care” heading find “Transitions of Care Pharmacist Referral Form”



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Transitions of Care Pharmacist Referral Form

Please send completed form to PharmacyLiaison@ucare.org

(available for members in these plans) ☐ MSHO (Minnesota Senior Health Options) ☐ Connect + Medicare

Patient Information

Member Name: | Date of Birth: | UCare ID#:

Member speaks: ☐ English ☐ Burmese ☐ Hmong ☐ Karen ☐ Spanish ☐ Somali ☐ Russian ☐ Other: _____ | Phone:

Discharge Information

Name of Hospital: | Date of Discharge:

Referral Source

Name and relationship of person referring: | Email:

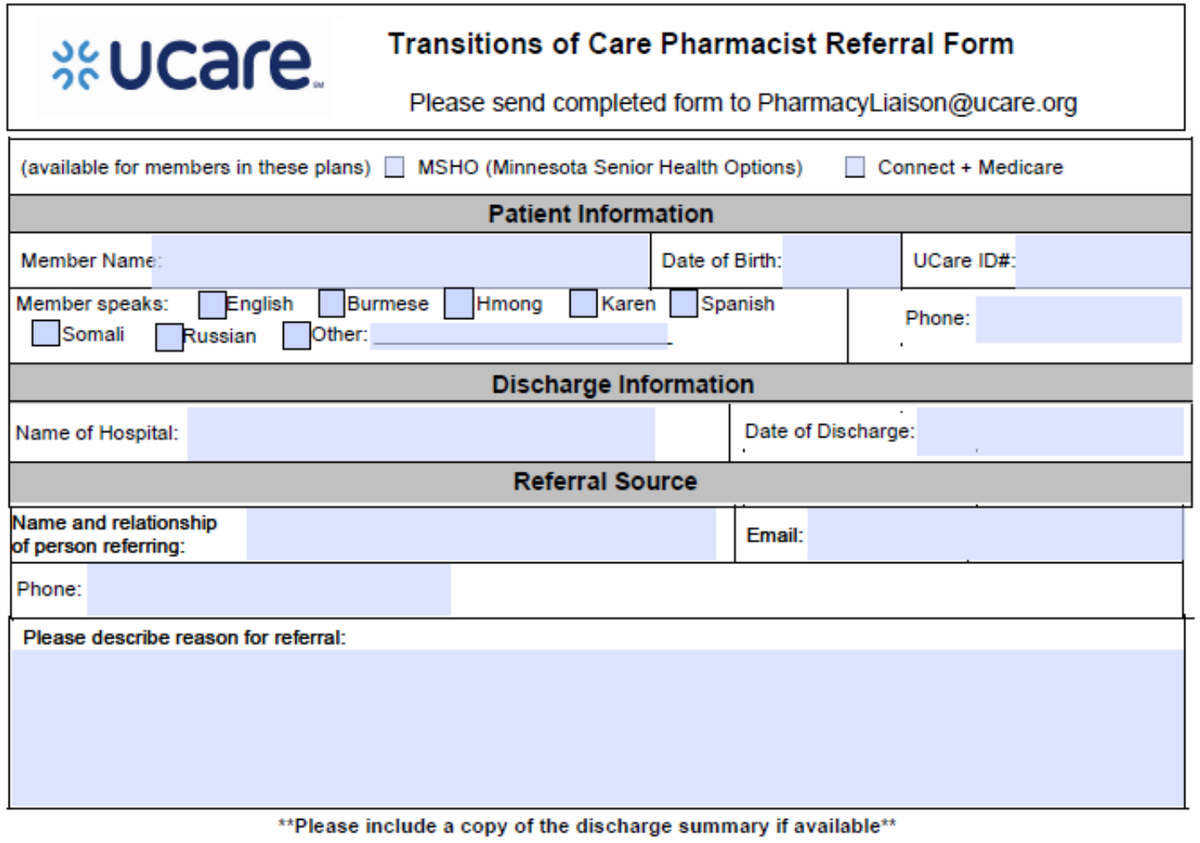
Phone:

Please describe reason for referral:

Please include a copy of the discharge summary if available

TOC Referral Process

- Fillable PDF to provide the member and discharge information
- Email the completed form to the email address identified on the referral form
- Include a copy of the discharge summary if available
- Email notification will be sent back once the referral process is completed



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Transitions of Care Pharmacist Referral Form

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Discharge Information

Name of Hospital:	Date of Discharge:

Referral Source

Name and relationship of person referring:	Email:
Phone:	

Please describe reason for referral:

Please include a copy of the discharge summary if available

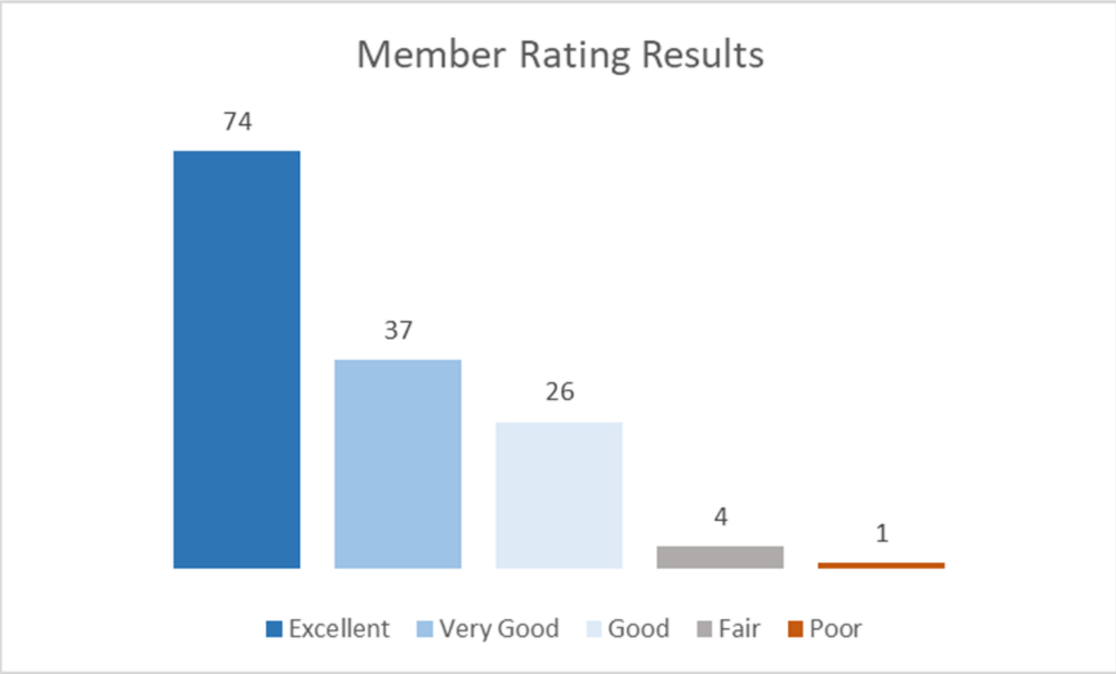
Please refer members that you think would benefit from this service!

Setting Member Expectations

- Member will be called within 1-2 business days after a referral is placed to schedule a visit with the pharmacist at their convenience
  - The call will likely come from an unknown number
- Visits are completed with a pharmacist over the phone and can be anywhere from 15-60 minutes long
  - This is based off the members preference, how many medications they take, and how many questions they have.
- There is no cost for this service
- After the visit, member will receive a personalized medication list and a medication action plan
- A CMR is recommended once a year and a TOC visit is recommended after every discharge

Member Feedback

2023 Member Satisfaction Survey



- I appreciate the yearly contact and discussion
- The pharmacist was excellent in reviewing my medications and answering questions.
- I always enjoy talking to my clinical pharmacist.
- I appreciate the information on newer alternatives to the medication I am taking - to discuss with my doctor.
- I wish had known about this service sooner.

What Type of Interventions are Recommended?

Drug Therapy Problems Interventions Definition Table	
Intervention	**Examples**
Indication	Why do I take a medication? Do I still need a medication?
Efficacy	How do I know the medication is working? Is there something that would work better?
Safety	Are there any safety concerns with my medications? Are there safer alternatives?
Convenience	Am I able to take my medications as prescribed? Is there an alternative that better fits into my life and would be easier to take?
Education	Learning more about medications and disease states
Referrals	Providing resources to other important services
COVID	Providing miscellaneous needs/resources related to the COVID-19 pandemic including disease education, preventative care, mental health concerns

The goal of an MTM visit is to be an additional resource available to the member, providing a patient centered visit in hopes of finding the best outcomes with their medications. The goal is not to work against their providers. We do not make changes to their medications, but we can provide tools to better their medication experience or offer recommendations when appropriate.

Questions?

Additional Resources

Medicare Details

- **Members are eligible if they meet the following criteria:**
  - Take eight or more prescribed or maintenance medications for chronic condition(s)
  - Have at least three chronic health problems, including:
    - UCare: chronic heart failure (CHF), diabetes, dyslipidemia, end stage renal disease, rheumatoid arthritis
    - EssentiaCare: asthma, chronic heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, dyslipidemia, hypertension, osteoporosis
  - Likely to spend at least $4,935 in 2023 on your Part D medications
- **What are the limits of the service**
  - One CMR is recommended per calendar year
- **Who provides the service?**
  - UCare pharmacists
  - Pharmacists within contracted local health systems
- **Automatic enrollment for a medication review**
  - Receive a letter from UCare
  - May also receive phone calls with more information
    - UCare pharmacy team member
    - Health System contact
- **Participation is voluntary and anyone can opt out of the MTM program at any time**
  - Call 612-676-6536 or
  - Toll Free at 1-855-931-5272 and select option2
  - and select option2

Medicaid Details

- **Who is eligible?**
  - Members taking prescriptions to treat or prevent one or more chronic medical conditions.
  - If they have Medicare, MTM must be covered under their Part D plan (MSC+ Dual, Connect Dual)
- **Who provides the service?**
  - Pharmacists who are registered with DHS and have contacted UCare to be set up in claims system for billing.
- **How are members contacted for the service**?
  - Members may be referred by their physician or pharmacist
- **What is the cost of the services?**
  - Provided at no cost to members
- **What are the limits on the service?**
  - One initial visit with up to 7 follow-ups per year

Welcome Letter Example

ucare

<<Patient_First_Name>> <<Patient_Last_Name>> <<Current_Date>>
<<Patient_Address_1>>
<<Patient_Address_2>>
<<Patient_City>>, <<Patient_State>> <<Patient_Zip_Code>>

Dear <<Patient_First_Name>> <<Patient_Last_Name>>:

UCare has good news! You are eligible for your annual comprehensive medication review with UCare's Medication Therapy Management program, recommended by Medicare. Your medication review consists of a discussion with a specially trained pharmacist to help make sure you are getting the most out of your medications at no additional cost to you. This can be completed in-person, over the telephone or virtually.

Get all your questions answered during your review, including:

1. **How do I know that my medications are working?**
2. **Are there any side effects that I should know about?**
3. **Am I taking too many medications?**
4. **My prescriptions are expensive, how I can save money?**

After the medication review, we will mail you an action plan and medication list to discuss with your doctor during your next visit.

A pharmacy team member will call you for the review. ≤[If Mapped to a Health System: If you have not yet received a call, you can schedule an in-person or phone visit with <<Clinic Full Name>> at <<Clinic Phone Number>>]>. ≤[If Mapped to UCare or Not Mapped: Or, you can complete the review over the phone by calling a UCare pharmacist at 612-676-6536 and select phone option 2, 8:00 am – 4:00 pm Central Time, Monday – Friday.]>

CONNECT WITH OUR TEAM

We're here to help. If you have questions or want to opt out of the program, call us at 612-676-6536 (TTY 1-800-688-2534) or toll-free 1-855-931-5272 and select phone option 2. We're available 8:00 am – 4:00 pm CT, Monday – Friday. You can also visit **ucare.org/mtm** for more information.

Just so you know – you are automatically enrolled in our MTM program and can opt out at any time, or you can respond to our team with your best availability for your review – whatever works best for you.

Thank you for choosing UCare.

Sincerely,

Your Medication Therapy Management Team,
UCare Pharmacy Department

H2456_10309_122022 accepted
H5937_Y0120_10309_122022_C U10309A (12/2022)

500 Stinson Blvd NE, Minneapolis, MN 55413 | 612-676-6500 | fax 612-676-6501 | **ucare.org**

Front

<First name> <Last name>
<Address>
<Address>
<City>, <State> <ZIP>

Perf

Fold

UCare Medication Therapy Management

Connect with a pharmacist about your medication review

Your response is appreciated.

To participate or opt out of this program:

Call **1-612-676-6536 (TTY 1-800-688-2534)** and select option 2 from 8 am – 4 pm, Monday – Friday

Or detach card, fill out and return in the enclosed business reply envelope

UCare has good news. It's time for your **annual comprehensive medication review** — at no additional cost to you. Talk to a specially trained pharmacist to ensure your prescriptions, over-the-counter medications and herbal supplements are safe, effective, affordable and easy to use. Get started by calling our team or filling out and returning this postcard to UCare. You can opt out at any time.

ucare

Back

ADA Advisory

No English? **1-800-203-7225**
1-800-688-2534 (TTY)

Discrimination is against the law. UCare does not discriminate because of race, color, national origin, creed, religion, sexual orientation, public assistance status, marital status, age, disability or sex.

UCare's MSHO (HMO D-SNP) is a health plan that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in UCare's MSHO depends on contract renewal.

H2456_12389_012023 accepted
H5937_Y0120_12389_012023_C

U12389 (02/2023)

Fold

Perf

Today's date: _____ <memberID/pmdPatientID>

First name: _____ Last name: _____

Check one:

☐ I would like to complete my medication review. Please see my availability and contact information below:

Best day/time: _____ _____

Phone number: _____ _____ _____

☐ I would like to opt out of the Medication Therapy Management program for this calendar year. I do not want anyone to contact me or my doctor about this program, but I understand I can re-enroll at any time.*

*I attest that I am the designated beneficiary or a legally authorized representative.

Thank you from the UCare Medication Therapy Management team.

Front

<First name> <Last name>
<Address>
<Address>
<City>, <State> <ZIP>

Perf

Fold

UCare Medication Therapy Management

Get help from a pharmacist to get the most from your meds

Your response is appreciated.

To participate or opt out of this program:

Call **<1-612-676-6536> (TTY 1-800-688-2534)** and select option 2> from <8 am – 4 pm, Monday – Friday>

Or detach card, fill out and return in the enclosed business reply envelope

We missed you

Unfortunately, we've not been able to reach you about an opportunity to review your medications with one of our specially trained pharmacists through our Medication Therapy Management (MTM) services here at UCare.

Your plan recommends participating in this program (or service) each year and we want you to take full advantage at no additional cost to you. Get started by calling our team or filling out and returning the attached card. You can opt out at any time.

ucare.

Back

ADA Advisory

No English?

1-800-203-7225
1-800-688-2534 (TTY)

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UCare's MSHO (HMO D-SNP) is a health plan that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in UCare's MSHO depends on contract renewal.

<SMID>

<U10505 (02/2023)>

Fold

Perf

<[memberID/pmdPatientID]>

Today's date: _____

[First name: _____ Last name: _____]

I would like to complete my medication review. Please see my availability and contact information below:

Best day/time: _____ _____

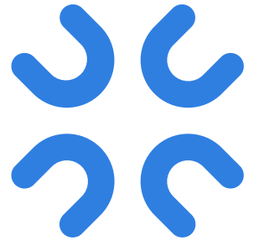
Phone number: _____ _____ _____

Thank you from the UCare Medication Therapy Management team.

UCare Disease Management

Presenter: Liz Sperr

Disease Management Programs



Asthma
Virtual Support Program (Cecelia)
Asthma Education Program (UCare)
IVR/Text Education Program
Newsletter
Asthma Action Plan
Brook Health Mobile App

COPD
Virtual Support Program (Cecelia)
Brook Health Mobile App

CKD
Virtual Support Program (Cecelia)
Brook Health Mobile App

Diabetes
Virta Diabetes Reversal Program
Virtual Support Program (Cecelia)
Health Coaching (UCare)
IVR/Text Education Program
Newsletter
Brook Health Mobile App

Hypertension
Newsletter
Brook Health Mobile App

Migraine
Health Coaching (UCare)
Brook Health Mobile App

Heart Failure
Health Coaching (UCare)
Telemonitoring
Brook Health Mobile App

Chronic Care Improvement Program (CCIP)
Newsletter (4x per year)
Brook Health Mobile App

Coming Soon! Weight Management
Virtual Support Program (Cecelia)
Newsletter
Brook Health Mobile App

Disease Management Contact Info and Referral Information

DM Contact Information

- Phone Line
  - 612.676.6539
  - 1.866.863.8303
- Email
  - Disease_mgmt2@ucare.org
- Fax
  - 612.884.2467

- UCare.org>UCare for Providers>Policies and Resources>Clinical Support Resources
  - UCare® - Disease Management

DM Referral Guide

- DM Email: Disease_mgmt2@ucare.org
- DM Voicemail: 612.294.6539 or 866.863.8303
- DM Referral Forms: https://www.ucare.org/providers/policies-resources/disease-management

Identify Condition	Asthma	Diabetes	Heart Failure	Migraine	COPD CKD
DM Program Types	Asthma Education Asthma IVR/Text	Health Coaching Diabetes IVR/Text	Health Coaching Telemonitoring	Health Coaching	Health Coaching
Send Referral to DM for Review & Program Placement	• DM Email • DM Voicemail • DM Asthma Referral Form	• DM Email • DM Voicemail • DM Referral Form	• DM Email • DM Voicemail • DM Referral Form	• DM Email • DM Voicemail • DM Referral Form	• DM Email • DM Voicemail • DM COPD & CKD Referral Forms
Referral Outcome	DM will review referral for program eligibility, facilitate program enrollment for member, and respond to referring party via email or phone call regarding referral outcome				

Brook mobile app downloading instructions available at ucare.org/brook. No referral required.

Disease Management Referral Outreach

Referral Received	Referral Sent for Member Follow-up	Member Outreach

• Referral received via DM email inbox or voicemail box
• Referral reviewed for DM program eligibility & program placement if applicable
	• Referral sent to UCare or DM vendor/delegate health coach, asthma educator, or vendor clinician for direct follow-up with member
	• Notification sent to referring party regarding referral outcome & program placement via email or phone
		• Health coach, asthma educator, or vendor clinician performs telephonic outreach to member and offers program to member
		  • If member enrolls, the health coach, asthma educator, or vendor clinician reaches out to complete program enrollment process
		  • If member declines or is UTR, screening closed

Referral outreach is for all UCare & vendor/delegate DM programs		

Member Communications

Disease Management Member Communications

Program/Vendor Partner	Type	
Brook Health	• Email • Home mail (this summer)	
Cecelia Health (Asthma, COPD, CKD, Diabetes) *Weight Management: new program mid-summer*	• Outbound Calls • Emails	• Home mail • Text message
Member Newsletters (Asthma, Diabetes, Hypertension, Weight Management, CCIP)	Asthma, diabetes, hypertension, weight management: Twice per year, home mail CCIP: Quarterly home mail	
UCare Health Coaching and Education Programs (Asthma, Diabetes, Heart Failure, Migraine)	• Home mail letters • IVR	• Outbound Calls • Home mail brochure
Virta Diabetes Reversal Program	• Email • Home mail (this summer)	

Disease Management Member Communications- Web Pages

Program/Vendor Partner	Web Page
Brook Health	• ucare.org/brook
Cecelia Health (Asthma, COPD, CKD, Diabetes)	• Asthma: ucare.org/asthmaprogram • COPD: ucare.org/copdprogram • CKD: ucare.org/ckdprogram • Diabetes: ucare.org/diabetesprogram
UCare Health Coaching and Education Programs (Asthma, Diabetes, Heart Failure, Migraine)	• Managing Health Conditions | Programs and Support | UCare • Member Registration page: Health Coaching education| Personalized Coaching | UCare
Virta Diabetes Reversal Program	• ucare.org/virta

Virta Health Diabetes Reversal Program

Virta Health Diabetes Reversal Program

- Virta is a nutritional therapy clinic that helps members lower blood sugar, lose weight and rely less on prescription drugs.
- Nutrition education: meal plans, shopping tips, recipe guides
- Medical supervision from a Virta physician, nurse or physician’s assistant
- Health coaching
- Daily support via Virta’s mobile app and health tools
- Diabetes testing materials (meters, strips)
- For more information:
  - Members apply at ucare.org/virta
  - Virta Training Video

Brook Health Companion

UCare is teaming up with Brook to help you manage your diabetes and/or blood pressure from your phone with the Brook Health Companion. Available at no cost to you, this app lets you chat with dietitians and health experts in real time to help you turn your health goals into sustainable habits.

- **Keep accountable**
  Chat with health coaches 24/7, 365 days a year. No appointment needed.

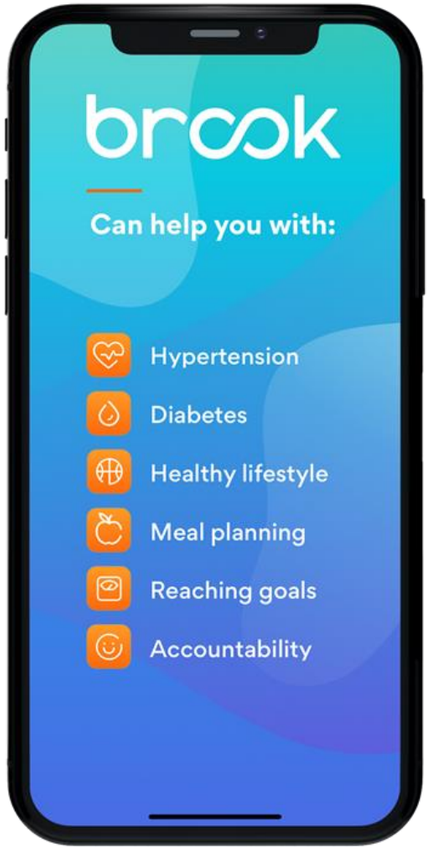
  Improve your numbers
  Get support with weight, blood sugar, blood pressure and more.

  Reach health goals
  Discover what works best for you and get help sticking to it

  Get active
  Find ways to fit activity into your daily life and track your progress

  Eat right for you
  Work with dietitians to find the best meal plan for you

  Get helpful reminders
  Schedule reminders to take your medication and check your blood sugar or blood pressure



For more information:

- Brook mobile app downloading instructions available at ucare.org/brook. No referral required.
- Brook Training Video

DM Program Grids

DM Programs

Program	Description
Asthma IVR/Text Program	• Scheduled Interactive Voice Response or text message education • IVR/text schedule: 1 call/text a week or 1 call/text every 30 days
Asthma Education Program	• Telephonic outreach and education with a UCare asthma educator or Cecelia Health registered respiratory therapist • Assessment of self-monitoring, self-management, and medication adherence. Encouragement of Asthma Action Plan. • Average 1 call a month for 6 months • Children and adults ages 5-64
Brook Health Companion App	• Mobile app for help with managing general wellness, diabetes, hypertension, and other chronic conditions • In app coaching; medication, blood pressure or blood sugar check reminders • To learn more and to download the app, visit ucare.org/brook
CKD Support Program	• Telephonic outreach and education with a Cecelia Health registered dietician • Guidance, education, and support to help prevent or slow down the progression of CKD and make healthy food choices. • Average 1 call a month for 6 months
COPD Management Program	• Telephonic outreach and education with a Cecelia Health registered respiratory therapist • Assessment of self-monitoring, self-management, and medication adherence. Encouragement of COPD management plan. • Average 1 call a month for 6 months
Diabetes IVR/Text Program	• Scheduled Interactive Voice Response or text message education • IVR/text schedule: 1 call/text a week or 1 call/text every 30 days
Diabetes Health Coaching	• Telephonic outreach with a UCare or Cecelia Health health coach • Partner to discover barriers, vision for the future, establish behavior change goals, empower to achieve goals • Average 1 call a month for 6 months
Heart Failure Health Coaching	• Telephonic outreach with a UCare health coach • Partner to discover barriers, vision for the future, establish behavior change goals, empower to achieve goals • Average 1 call a month for 6 months
Migraine Management Program	• Telephonic outreach with a UCare health coach • Partner to discover barriers, vision for the future, establish behavior change goals, empower to achieve goals • Average 1 call a month for 6 months

*All programs are Adults 18+ except noted with asthma programs

Microsoft Word - 03. DM Programs Grid.docx (ucare.org)

DM Program Eligible Products

	Connect	Connect + Medicare	Medicare – Fairview North Memorial	Medicare	MNCare	MSC+	MSHO	PMAP	UCare Fairview IFP	UCare IFP
Asthma IVR/Text Program	X	X			X			X	X	X
Asthma Education Program	X	X			X			X	X	X
Brook Health Companion App	X	X	X	X	X	X	X	X	X	X
CKD Program	X	X	X	X	X	X	X	X	X	X
COPD Program	X	X	X	X	X	X	X	X	X	X
Diabetes At-Risk IVR	X	X	X	X	X	X	X	X	X	X
Diabetes Health Coaching	X	X	X	X	X	X	X	X	X	X
Heart Failure Health Coaching	X	X	X	X	X			X	X	X
Migraine Management	X	X			X	X		X		

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Language Assistance Services: UCare provides translated documents and spoken language interpreting free of charge.

UCare Health Ride Transportation

Presenters: Amber Jackson, Brent Forbord, Kathy Engeldinger & Trent Brier

UCare Health Ride Transportation

- UCare transportation provides Non-Emergency medical transportation for medical and dental appointments
- Traditionally Healthride books about 100-200k legs a month, and averages about 1200-2000 calls a day.
- Healthride is staffed for normal ride bookings Monday through Friday **7AM- 8PM,** and Saturday & Sunday for urgent/emergency transportation **8AM-4:30PM.**

Reference: UCare Health Ride

Best Practices for Booking a Ride

UCare's policy requires the member or member representative to call two full business days in advance for a NEMT ride. We do however book same day ride (SDR) and next day ride (NDR) on a case-by-case exception based on the urgent need of ride.

If the primary care provider is over 30 miles or the specialist care provider is over 60 miles, an LDE (long distance exception) is needed. Health Ride needs at least two full business days to do the back-end work on an LDE. Dental does not require an LDE but may require appointment verification.

Always have the member First and Last Name, (UCare)Member ID number, Account-File address & Phone number available when you call.

NEW: Transportation Member Flyer | Transportation Job Aid

Transportation in Qryde

- Qryde is the current booking software used by UCare Health Ride.
- Qryde allows UCare Healthride to send member notifications via text, voice, or email for ride booking confirmation, ride change, and ride cancel.
- Qryde member portal: the member portal allows members to request a ride, view rides both future and past, and cancel a future ride.
- Qryde Care coordinator portal: The CC portal allows CCs to request rides for their members, view future and past rides, and cancel a ride.
- Member application. Coming soon

With the portals what rides need to be called in?

Requests for a same day or next business day ride will need to be called into the call center. Current policies and exceptions will still apply.

Any ride that needs a Long-Distance Exception- LDE (over 30 miles for primary and over 60 miles for specialist).

Bus pass requests.

What is NOCCS?

Notification, Online Chat, Care Coordinator, Scheduler

- No Available Provider – When a transportation provider can't be found for a future ride, it is sent to this group, who continues to search for a provider. This group has a 68% success rate in finding providers for rides that would have otherwise been denied.

- Notifications & Grocery – ensures authorizations and configurations are set for Notification and Grocery initiatives.

- Bus Pass – manages the bus pass process, ensuring members receive bus passes, if that's their method of transportation.

- WeCare - Supports Care Coordinators with booking rides for members. Proactively book rides for members with ongoing transportation needs to a given facility.

- Scheduler Team - Supports and builds relationships with our transportation providers by researching, educating, and supporting with QRyde regarding turn backs, capacity volume, methadone standing orders, retro rides, and billing issues.

- Methadone Authorization Team - The MAT team are uniquely trained to serve our members that travel to and from their methadone appointments.

Proactive LDE Follow-ups

- Long Distance Exception (LDE) member follow-ups help UCare Health Ride to ensure there are no lapses in transportation services.
- Member outreach is conducted to verify the current LDE prior to it expiring.
  - This proactive approach reduces negative member impacts to care when the LDE is still needed.
- After all required verification is completed, the LDE is extended.
- If it is determined the LDE is no longer needed, it is left to expire.

Questions?

Thank you

Thank you for your Feedback!

- Quarterly Care Coordination Meeting Feedback Survey

Your feedback helps us improve our meetings each quarter and provide information relevant to care coordinators in a way that is digestible. We appreciate you!

MSC+/MSHO Presentations

(SNBC Optional)

PCA/CFSS Updates

Presenter: Esther Versalles-Hester

PCA Communication Form Revisions

- Updates have been made to the existing PCA communication form.
- Additional field added for care coordinators to confirm that a "CFSS to PCA" conversion worksheet was completed for members identified with a HCR of P,Q or R.

Clear Form

ucare

PERSONAL CARE ASSISTANCE (PCA) COMMUNICATION FORM

Incomplete, illegible, or inaccurate forms will be returned to sender. All applicable information must be included for timely processing of the request. Please allow up to 14 calendar days for processing of this request.
Form must be completed by UCare Care Coordinator.

Fax form and relevant documentation to: 612-884-2094

For questions, call: 612-676-6705 (To reach a representative, choose option 2 and then option 4)

E-Mail: ucarepca@ucare.org

MEMBER INFORMATION:	
Name:	Date of Birth:
Member ID:	PMI:

CARE COORDINATOR INFORMATION:	
Care Coordinator Name:	
Phone:	Fax:
Email:	

COPY OF RECENT PCA ASSESSMENT:	
☐ Fax to Care Coordinator	☐ Secure Email to Care Coordinator

PCA SERVICES REQUESTED:	
New or Current LTCC/ MnChoices/EW Date Span:	TO
Service Description: Service Description	
ICD-10 Code(s):	
Approved PCA Units Daily:	Home Care Rating:
*CFSS to PCA conversion worksheet completed for Home Care Rating of P, Q, or R?	☐ Yes ☐ No
Start Date:	End Date:
PCA Agency Name:	PCA Agency UMPI/ NPI #:
Phone:	Fax:

Detailed description of reasons for request (e.g., current XX hours daily, increase by XX hours to Total XX hours daily x 45 days, 2nd PCA agency information). If the assessment results in a reduction, termination, or denial of services, please provide a detailed description below. * *i.e., member no longer meets a dependency in an ADL, Complex Health, or Behavior.*

Community First Services and Supports Updates

- On 10/1/2024, DHS plans to begin CFSS implementation.
  - *People who receive services will transition from PCA to CFSS upon reassessment.*
- Communication from DHS was received on 5/9/2024 which has initiated and reinstated project planning for go live readiness.
  - *UCare has developed an internal cross departmental project team to meet the DHS go live timeline.*
- DHS has scheduled meetings with MCO's to discuss implementation, training as well as provider tiered payment methodology.
  - *UCare has designated representatives/sponsors on the CFSS committee.*
- DHS has issued a request for public comments on CFSS policy manual.

LSS Healthy Transitions Service

A Lutheran Social Service of Minnesota program in partnership with UCare

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Presenter: Lisa Beardsley

Lutheran Social Service of Minnesota

Lutheran Social Service of Minnesota

LSS Healthy Transitions Service

Readmission Prevention Benefit

- Supplemental benefit available to qualified Minnesota Senior Health Options (MSHO) members

In-home support following a hospital stay

- Targeting older adults living independently with frequent hospital admissions

Service provided by a trained staff

- Certified Community Health Worker (CHW)

Lutheran Social Service of Minnesota

Impact

Care Coordinator Highlight

Grateful for the collaboration

George had a history of being non-compliant with medications and hoarding them. He was hospitalized for a hypertensive emergency caused by overdosing on a blood pressure medication. He denied making mistakes and declined home RN visits to help manage medications.

The care coordinator was glad to hear we would be going in home and attempting a med review. The CHW was able to build trust with George over the visits and on the 3rd one, he allowed a med review and we talked about why he won't allow help. From here, the CC was given all the information collected and produced a plan. The CHW helped implement the plan at the final home visit.

The CC shared how grateful she was for the teamwork and flexibility of getting in home.

Successful Transitions from Hospital to Home

In-home support during the first 30 days after hospital discharge is critical

Visits will begin within 72 hours upon notification of discharge

Community Health Worker's schedule all visits and provide ongoing communication to Care Coordinators throughout 30 days

4 weekly visits:

- Visit #1 In-home visit (2 hours)
- Visit #2 Phone call (60 minutes)
- Visit #3 In-home visit (2 hours)
- Visit #4 Phone call (60 minutes)

Services Provided

- Personal Health Record (PHR)
- Home Safety Assessment
- Nutrition Review
- Resource Sharing
- Communication with Care Coordinator following each touch point

Referral Process

Care Coordinator is notified of discharge and discusses Post Discharge LSS Healthy Transitions benefit with the member during their transition of care discussion.

AND

LSS is notified of discharge on DAR and will reach out to the UCare Care Coordinator to see if the member is home.

Once the member has discharged

- The Care Coordinator will complete the referral form
- Referral is sent to LSS email – LSSHealthyTransitions@lssmn.org or Fax 651.310.9449
- CHW will contact Care Coordinator to confirm receipt of referral – OR –
- Admin. Specialist will reach out to Care Coordinator to verify member information from DAR list.
- CHW will call the member to schedule visit #1

Once the 1st visit is scheduled:

- LSS CHW will update the Care Coordinator
- Care Coordinator completes the Service Agreement

On going communication:

- LSS CHW sends update to Care Coordinator after each visit
- Care Coordinator will enter notes into members care plan as necessary

Service Process

Impact

Healthy Transitions Services

Frances was referred due to multiple admission with-in a few months due to fluid overload.

While talking with Frances, the CHW noticed some confusion and misunderstanding surrounding the cause of the fluid overload. There were instructions to weigh herself daily and watch for an increase of 3lbs. in 24 hrs. or 5lbs in 5 days. She had not started this and was unsure why it needed to be done.

The CHW and Frances spent time at each visit talking about CHF and making sure Frances was weighing herself each morning and recording it. CHW printed off a weight management booklet for her and taught her how to use it. At the 4-week visit, Frances was successfully using the booklet. She even called the RN line when she had a 3 lb. weight gain in 24 hrs.

She just needed some 1:1 education and encouragement.

Survey Outcomes– LSS Healthy Transitions

Pre-service

Post-service

- 89% of members reported a stable or increased understanding of their health diagnoses.
- 86% reported a stable or increased understanding of how to take their medications.
- 78% have a stable or increased understanding of how to reduce future hospital stays.
- 86% report that they have remained stable or have been eating more regularly scheduled meals.

Survey Outcomes – LSS Healthy Transitions

Satisfaction

Satisfaction surveys showed that 100% of individuals completing service believed their Community Health Worker explained things to them in a way they understood and were satisfied with their experience.

Our Goals

Reducing hospital readmissions and empower members to stay healthy and independent

Being a source of extra coaching and support during the transition from hospital to home

Are to be a resource for the member by providing additional in-home care by supporting your work!

Contact Information:

LSS Healthy Transitions Service

1605 Eustis Street, Suite 406

Saint Paul, MN 55108

Phone: 800-200-0986

Email: LSSHealthyTransitions@lssmn.org

Questions?

Connect/Connect + Medicare

SNBCClinicalLiaison@ucare.org

612-676-6625

MSC+/MSHO

MSC_MSHO_Clinicalliaison@ucare.org

612-294-5045