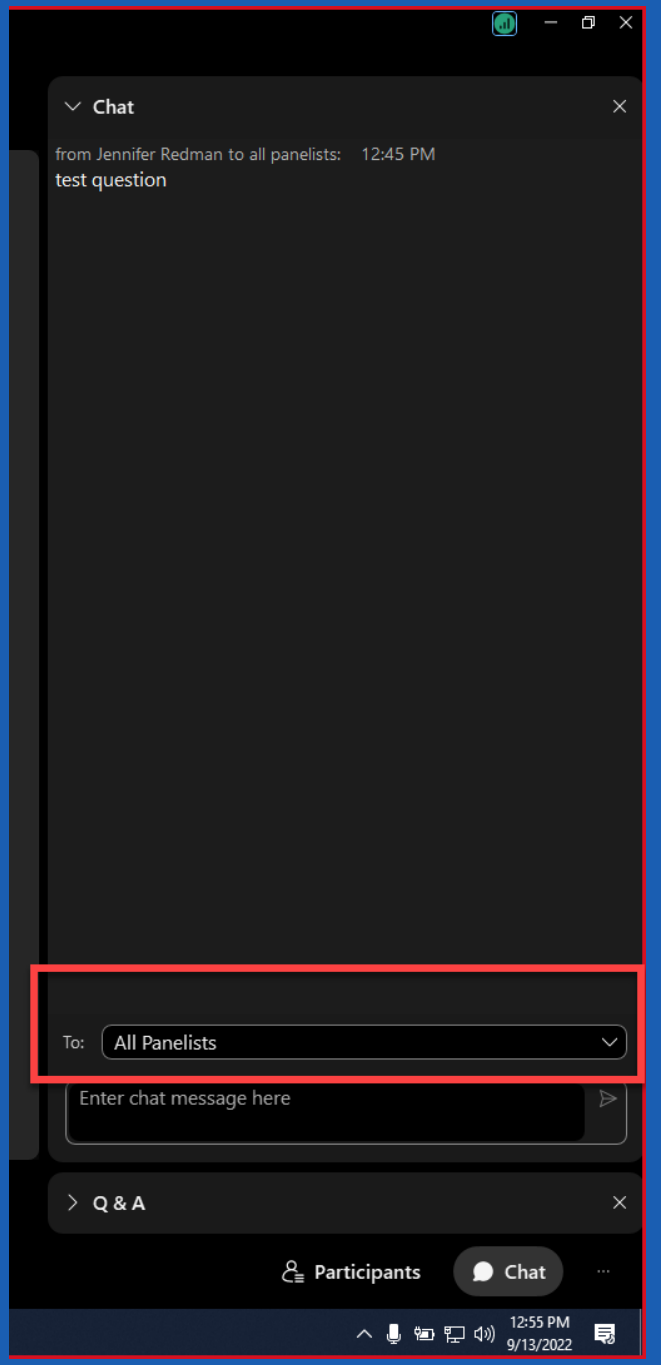

ucare®

UCare
Connect/Connect + Medicare & MSC+/MSHO

3rd Quarterly All Care Coordination Meeting

September 10th, 2024

Questions welcome!



Today's Agenda

Time	Topic	Audience	Presenter
9:00-9:05	Welcome	All	Clinical Liaisons
9:05-9:40	Care Coordination Updates	All	Clinical Liaisons
9:40-9:55	CC Model of Care	All	Dawn Sulland
9:55-10:10	CC Survey Results	All	Jennie Paradeis
10 Min Break			
10:20-10:45	Disease Management	All	Marie Sherwood, Pamela DeTienne
10:45-10:55	Health Promotions: CVS to Healthy Benefits + Visa Transition	All	Lexi Ruehling
10:55-11:05	Dental Vendor Transition	All	Bryan Strotbeck
11:05-11:15	Point Click Care Updates (MN EAS)	All	Jennie Paradeis
MSC+/MSHO Presentations (SNBC Optional)			
11:15-11:20	EVV	MSC+/MSHO	Esther Versalles-Hester
11:20-11:35	CFSS	MSC+/MSHO	Esther Versalles-Hester, Samantha Rue
11:35-11:45	In Lieu of Services (ILOS)	MSC+/MSHO	Dawn Sulland
11:45-12:00	Q&A	All	Clinical Liaisons

Care Coordination Updates

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.

UCare Product	Meeting Type	Date	Time
MSC+/and MSHO Connect/Connect + Medicare	UCare Quarterly All Care Coordination Meeting	December 10	9 am – 12 pm
MSC+/MSHO and Connect/Connect + Medicare	CEU Event (optional)	November 12	10 am Person Centered Training
MSC+/MSHO	Office Hours (optional)	October 22	12:30 pm – 1::30 pm
Connect/Connect + Medicare	Office Hours (optional)	October 22	11:30 am – 12:30 pm

Quality Review Findings

What Trends We See

Transitions of Care (TOC)

Connect + Medicare and MSHO:

- Completing the 4-pillars
  - Follow-up appointment with PCP
  - Managing their medications
  - Warning signs and symptoms
  - Use of Personal Health Care Record
- Notifying the PCP of the TOC
- Sharing Support Plan with the receiving setting

Connect and MSC+:

- Following up with the member upon return to their usual care setting

Task	CT+Med & MSHO	CT & MSC+
TOC Log (within one business day of notification)	X	
Follow up with member/responsible party with each transition (within one business day of notification)	X	
TOC notification Fax to PCP	X	
Follow up with ICT	X	
Follow up with member/responsible party upon return to usual setting (within one business day of notification)	X	X
4-pillars	X	
Document all follow up efforts	X	X

TOC Resources:
TOC Scenarios Job Aid
UCare Transitions of Care Pharmacist Referral Form
LSS Healthy Transitions (MSHO Members)
Post-Discharge Meals Referral Form (MSHO Members)

Quality Review Findings

What Trends We See

Collaborating with a Disability Waiver Case Manager

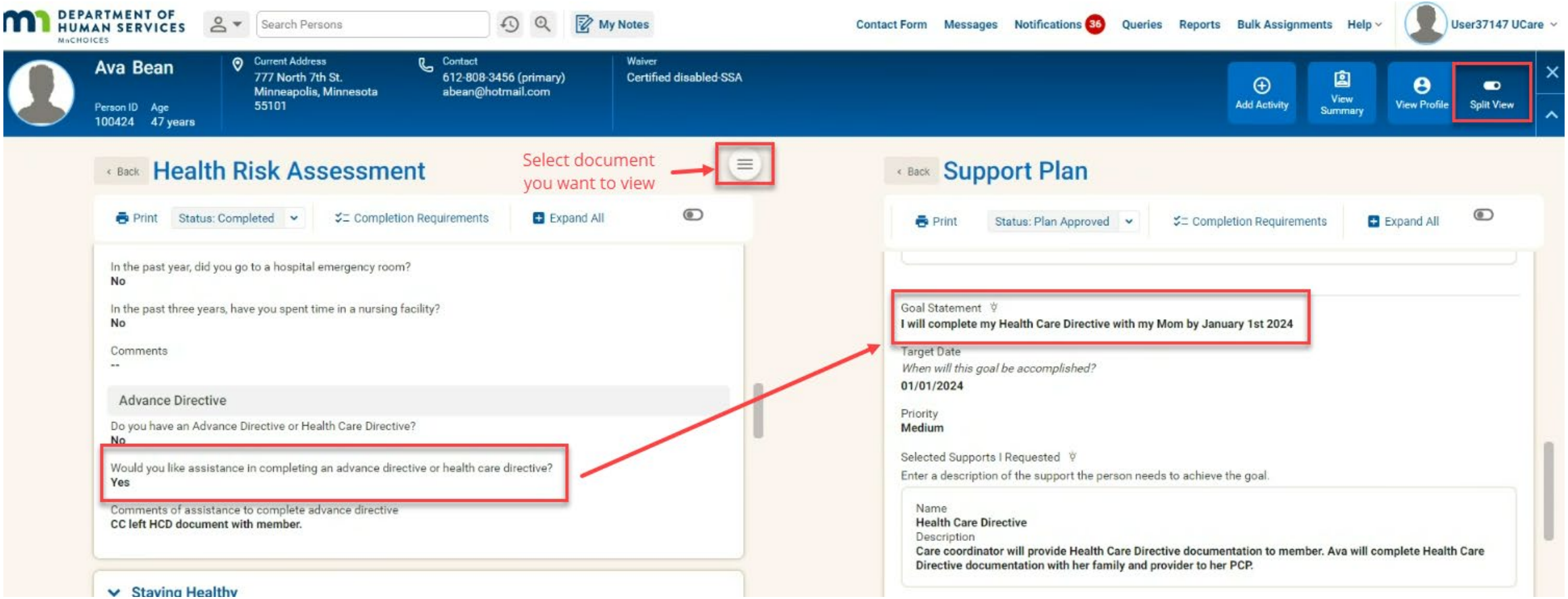
Care Coordinator Requirements	
Documents review of MnCHOICES Support Plan	☑
Share CC Support Plan with waiver CM	☑
TOC communication – provide updates*	☑
Provide DHS-5841 for State Plan Services	☑
Collaborate, Communicate, Assist*	☑

* Also required for BHH and PCP

Quality Review Findings

What Trends We See

Needs from the Assessment Addressed on the Support Plan



Quality Review Findings

What Trends We See

Writing Specific SMART Goals

Being specific should answer the following questions:

- What needs to be accomplished?
- Who is responsible for it?
- What steps need to be taken to achieve it?

Not Specific: To be pain-free

Specific: I would like to decrease my foot pain score from 8 to 4 within the next year.

For more information: Job Aids
- SMART Carte
- SMART Goal Job Aid
- MnCHOICES Guidance

Quality Review Findings

What Trends We See

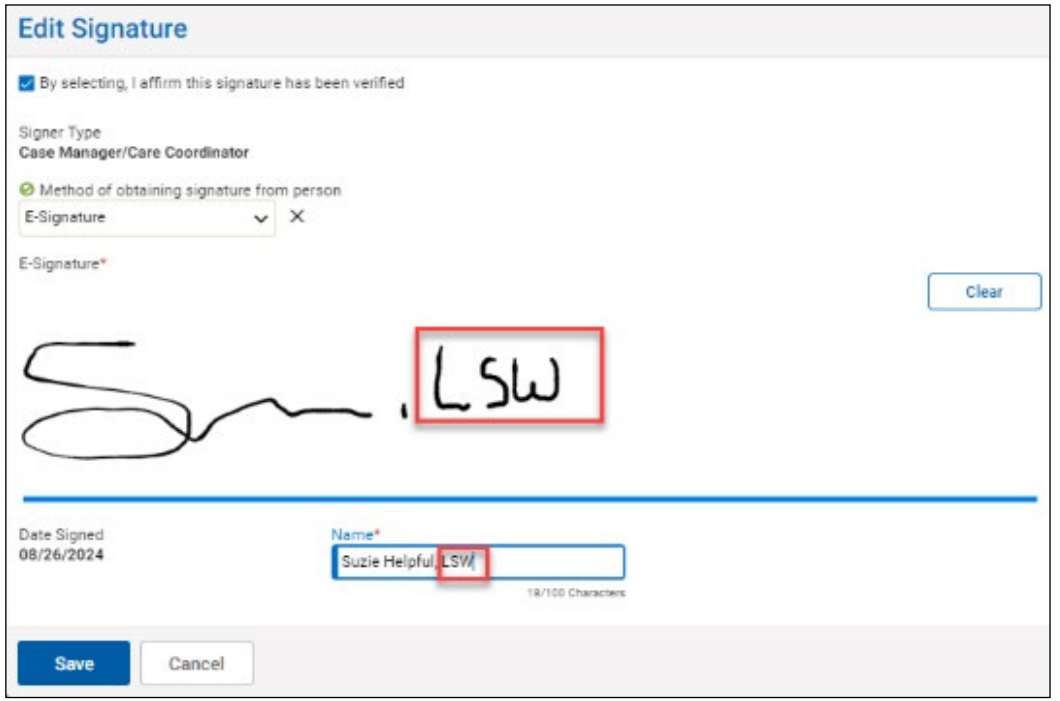
Signing Care Coordinator (CC) Credentials

This can be done by:

- Signing directly in the MnCHOICES wet signature box
- Printing the signature section when mailing to the member and hand-writing CC's signature and credentials before attaching it to the support plan

This is required because:

- UCare's Model of Care requires CC's have the appropriate credentials to provide care coordination and document credentials on the support plan
- CMS will audit based on UCare's MOC requirements



MnCHOICES Reminders & Trends

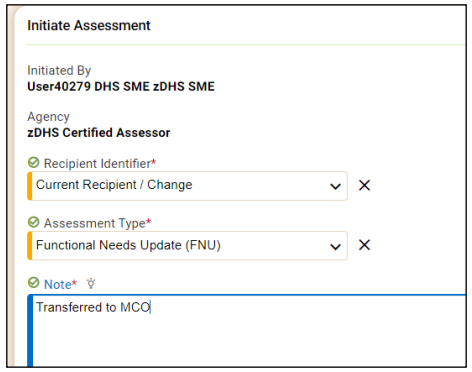
Updating assessment date when pulling data into a new assessment

Entering THRA activity in MnCHOICES

Reference: Assessment Checklists

Requirements Grid Updates

New and Transfer Members



FFS to MCO with PCA transfer

- Follow FNU process in MnCHOICES
- Do not enter into MMIS

NEW: Updates effective 10/1/24

- Requirement changed from calendar days to business days for initial assignment outreach & CC changes

Coming soon:

- Transfer Member Job Aid: MSC+/MSHO
- THRA/FNU Decision Tree
- Revised MnCHOICES Guidance

Requirements Grid Updates

MnCHOICES Support Plans

Support plan types

Support Plan-Other	Support Plan-HRA	Support Plan-MCO MnCHOICES Assessment
• Will be accepted as long as all auditable elements are included. • Will be reminded to complete most current forms	• Most recent/appropriate version of the support plan for HRAs	• Most recent/appropriate version of the support plan for MCO MnCHOICES Assessments

Sharing support plans at the time of a transfer

Anytime a new support plan is created for a member, a copy must be shared with the member and ICT members as indicated by the member.

- Completing FFS to MCO transfer
- Transfer without a support plan
- Transfer where CC determines the support plan is not adequate

Requirements Grid Updates

MnCHOICES Support Plans Continued

Revising Support Plans at Reassessment

A true "living document"

New functionality: One support plan can be revised year after year.

1. Create an initial support plan
2. Revision at mid-year (update goals)
3. Revision at reassessment (end/continue goals)
    a. Do not delete goals at this time
4. Revision at mid-year (delete goals ended at last revision and update active goals)
5. Repeat 3-5 ongoing until the form has been updated and a new form must be created

For more information: Job Aids

- MnCHOICES Guidance

Requirements Grid Updates

90-Day Grace Period

Connect + Medicare/MSHO

- Receives care coordination for 90 days after MA terms
- Complete reassessments due during the 90-day grace.
  - EW only: Enter in MMIS when member reinstates to MSHO
- Stays on enrollment roster until the grace period ends
- End date on the roster with a valid date shows future term dates

Gende	Birth Date	End Date	Living Statu	Health Stat
Female	9/1/1953	10/31/2024	Community Based	

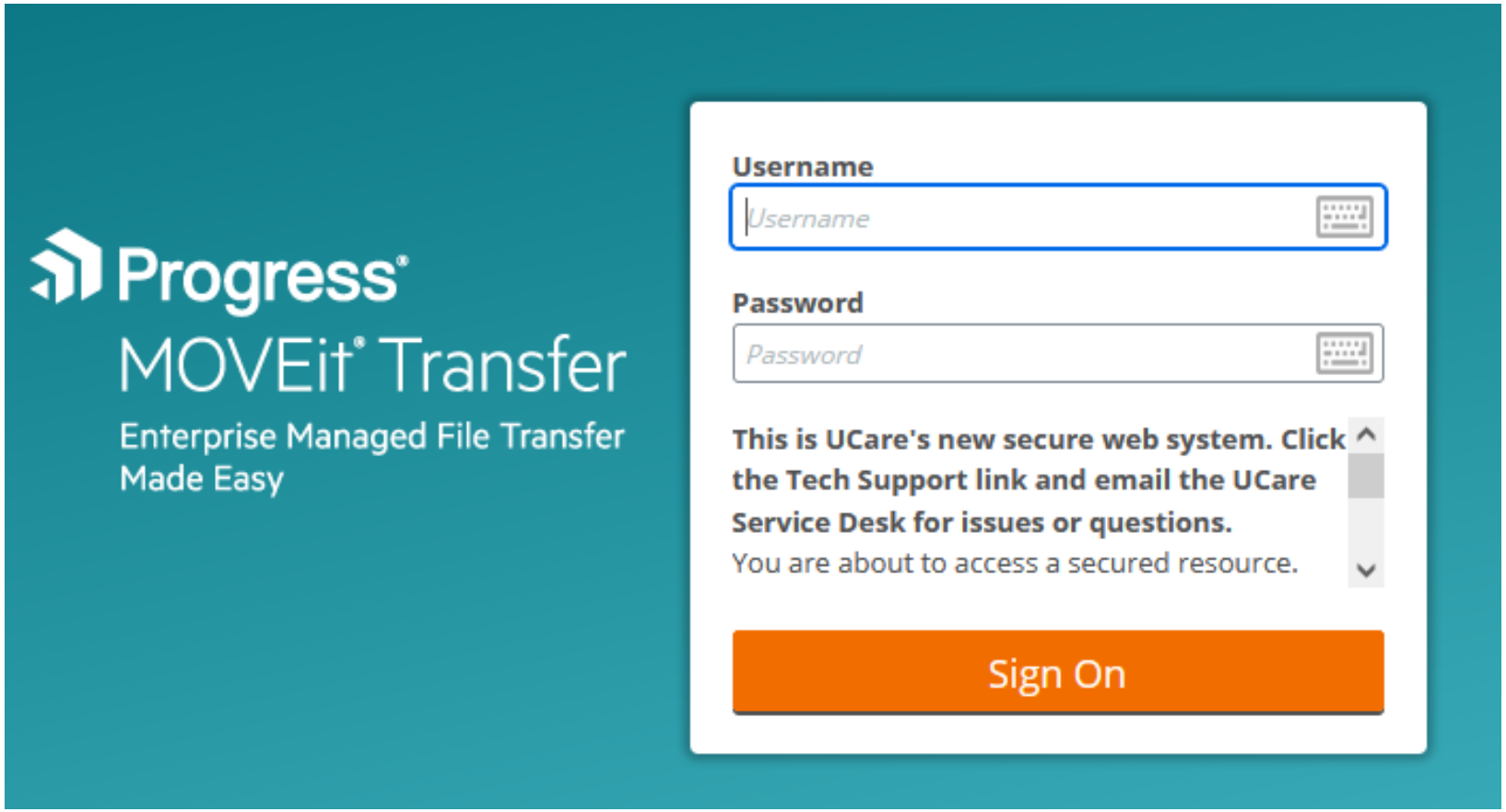
Connect/MSC+

- Complete reassessments due during 90-day grace.
  - EW only: Enter in MMIS when member reinstates to MSC+
- Monitor for re-enrollment
- New 7/1/24: All other care coordination tasks may discontinue

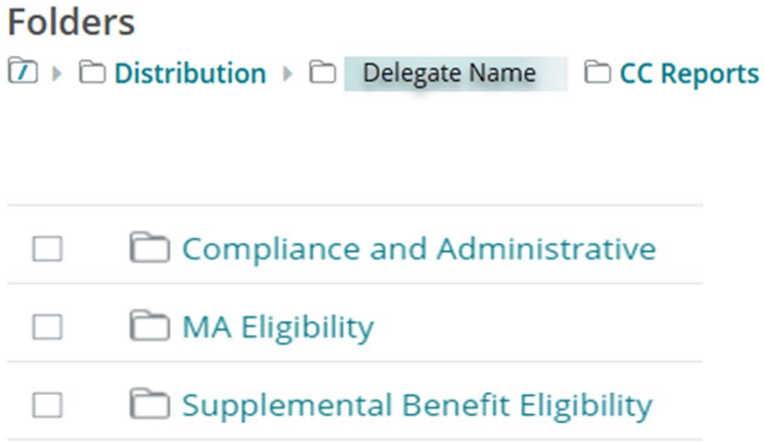
NEW 10/1/24: If a Connect + Medicare or MSHO member's 90-day grace period ends early, the member will fall off the roster, and CC may discontinue Care Coordination.

- If a CC is able to document confirmation from a member or member's Financial Worker that MA will not be reinstated, care coordination may end.
  - E.g., member moved out of state, incarcerated, no longer financially eligible for MA per Financial Worker

SecFTP Report Update



SecFTP Report Subfolders



Gaps in Care/Quality Action List

Supplemental Benefit Eligibility

- Grocery Ride and Utility Allowance Eligibility (CT+MED/MSHO)
- GrandPad Eligibility (MSHO)

MA Eligibility

- Future Termination/MA Eligibility
- Members Turning 65 (CT/CT+MED)
- New to MSC+/MSHO with disability waiver CM
- Spenddown Report (MSHO)

Compliance and Administrative

- SNBC NU Codes and Late HRA (CT/CT+MED)
- EW/NF Discrepancy Report (MSC+/MSHO)
- Date of Death (EW)
- Repeated Hospitalization and ER Admissions (CT+ MED and MSHO)
- Clinic Closure Report

SecFTP Instructions Guide

Name of report	Report Subfolder	MSHO	MSC+	CT	CT +	Report Purpose / Delegate Call to Action
Gaps in Care /Quality Action List	not in sub folder of CC reports - in "Gaps in Care Reports"	X	X		X	Identifies members part of the MSHO/MSC+ quality measures or the gaps in care initiative and the progress made to closing the gaps. CC to use this when working with members to know if they currently have gaps in these measures.
GrandPad (MSHO only) and Grocery Ride (CT+/MSHO)/Utility Allowance Eligibility (MSHO)	Supplemental Benefit Eligibility	X			X	**GrandPad**: Eligibility list includes members UCare has a documented depression diagnosis on file with UCare for delegates to check prior to submitting a referral for a GrandPad through the MSHO supplemental benefit. CCs can use this to identify eligibility of their MSHO members for GrandPad. **Grocery Ride:** To provide care coordinators with members who are eligible for grocery transportation benefits in order authorize transportation for MSHO/CT+ members. **Utility Allowance:** To provide care coordinators with members who are eligivle for the Utility Allowance supplemental benefit for MSHO members.
Members Turning 65 (CT/CT+MED)	MA Eligibility			X	X	Identifies members who are turning 65 in the next few months. The report can help the SNBC CC with getting requirements completed: oProvide education oConfirm the member has identified their Primary Care Clinic (PCC) oDescribe the difference between MSC+ and MSHO oEligible members must actively choose MSHO, or they will automatically default to MSC+ oDiscuss the potential of the member receiving a change of care coordinator oRemind the member they will get a new ID card(s) and to share with medical providers and pharmacy oIf UCare is not offered in the member's county for MSC+/MSHO, assist in finding other options. See the DHSDHS-4840-ENG(state.mn.us) for MCO choices by county oCollaborate with CADI Wavier case manager oMember may benefit from remaining on the CADI waiver oAddress the transition of PCA from County to Care Coordinator oVerify current provider is in UCare network oSend DHS-6037 if member is transferring to a new care coordinator
Date of death (EW)	Compliance and Administrative	X	X			Report with members who are deceased and have an open Elderly Waiver span in MMIS. CC to enter an EW exit screening document in MMIS with an effective date of either the date of death or the date of nursing facility admission in cases where the member did not return to the community prior to death. For technical assistance related to the entry of MMIS Screening Documents, submit a request for assistance by using the Service Agreement and Screening Document (SASD) Support Team Portal form DHS-3754.

What is a Health Care Directive?

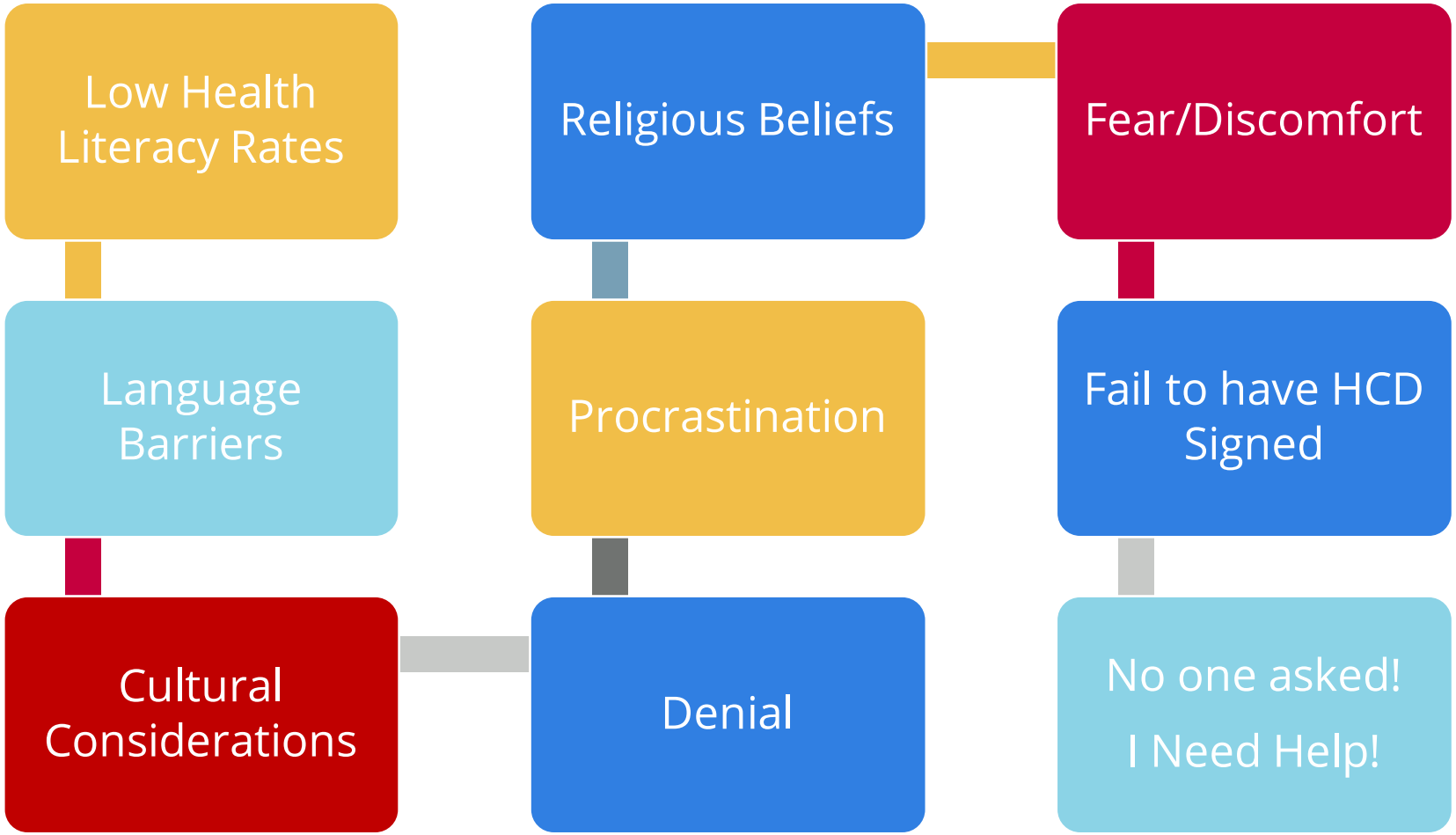
The term for the MN advance directive that combines a Living Will and a Health Care POA that informs others of your health care wishes.

- It is a legal document that allows a person to appoint someone they trust to make medical decisions for them if they become unable to do so
- Under Minnesota law, a competent person over the age of 18 can make a Health Care Directive
- A health care directive becomes “active” when a person is no longer able to speak for themselves or has indicated on their HCD that their “agent” may speak on their behalf even if the person may speak for themselves.

Why Are Health Care Directives Important?

- Aging population – but are important for everyone who wants to have their wishes known
- People are seeking health care alone. The directive guides your physician, family and friends regarding your care at a time when you are not able to provide that information
- A health crisis is unpredictable. It can be difficult to make health care decisions in midst of crisis
- Eases burden for family members/providers
- Reduces fear and worry about health care decisions
- Communicates your wishes when you are not able to

Why Do Some People Not Have a Completed HCD?



Care Coordinator’s Role

- Review previous HRA/Support Plan Health Care Directive notes
- Annually ask member if they have a Health Care Directive
- Provide education, the Health Care Directive form and resources
- Ask if the member wants help completing a Health Care Directive
- Encourage talking with family/assigned agents
- Follow up on any planned discussion
- Transition of Care: Inquire if an update is needed if there has been a significant change of condition
- Document if member does NOT wish to discuss Health Care Directives

HCD Training & Resources

UCare Alternative Decision Makers and Health Care Directives Training:

- Recorded Training
- Powerpoint Slides

Member Handouts:

- Health Care Directive Information- MSC+, Connect, Connect+ Medicare
- Health Care Directive Information- MSHO

Resources:

- Light the Legacy: Health Care Directive Downloads
- Department of Health: Q&A About Health Care Directives
- MN Board on Aging: Advance Directives

UCare Model of Care

Minnesota Senior Health Options (MSHO)

Connect + Medicare

Institutional Special Need Plan (ISNP)

Training Purpose

- Provides information about Model of Care requirements for UCare's Special Needs Plans (SNP)
- Outlines the importance of your role as a care coordinator on the member's Interdisciplinary Care Team
- Explains how to interface with other members of the ICT including primary care providers.
- Training required for new care coordinators and annually thereafter

UCare's Model of Care (MOC)

The MOC's overall goal is to drive improvements in health outcomes and quality of life for members.

UCare's MOC is designed to:

- Increase access to affordable, cost-effective health care
- Improve coordination of care
- Ensure seamless transitions of care
- Manage costs

Why does UCare have an MOC?

It employs interventions to drive improvements in health outcomes and quality of life, which enhances:

- Access to Primary & Specialty Care Providers
- Improved coordination of care
- Seamless transitions of care
- Cost management

UCare's Special Needs Plans (SNP)

These plans serve members residing within UCare's defined service area*:

- Minnesota Senior Health Options Program (MSHO) serves elderly members who are dually eligible for Medicare and Medical Assistance, and 65 or older
- UCare Connect + Medicare Program serves members with disabilities between the ages of 18-64 who are dually eligible for Medicare and Medical Assistance
- Institutional Special Needs Plan (ISNP) serves members 18 and older who are Medical Assistance eligible members who for 90 days or longer have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), or an Assisted Living (AL)

*service area may be different by product

UCare's Special Needs Plans

Integrated products combining Medicaid and Medicare:

- Parts A, B, and D (pharmacy) plus Medicaid benefits
- Members have one ID card
- One phone number for health plan questions
  - MSHO:612-676-6868 or 1-866-280-7202
  - Connect + Medicare: 612-676-3310 or 1-855-260-9707
  - ISNP: 612-676-3600 or 1-877-523-1515

Enrolling in SNP

Enrollment is voluntary, with several ways to enroll:

- Member's county financial worker (MSHO)
- Senior Linkage Line: 800-333-2433 (MSHO)
- UCare's Enrollment: 612-676-3554 or 800-707-1711 (MSHO and Connect+)
- UCare's Sales ISNP team: 612-676-6821 or 877-671-1054 (ISNP)

Connect+ Medicare Member Demographics

Age Range: 18 to 64 years

- Female: 52%
- Male: 48%

Living Arrangements:

- Community: 98%
- Institutional: 2%

Race:

- Asian: 7%
- Black or African American: 23%
- Hispanic: 3%
- Native American: 4%
- White: 63%

ISNP Member Demographics

Age Range: 65-85+ years

- Female: 67%
- Male: 33%

Living Arrangements:

- Institutional: 100%

Race:

- Asian: 2%
- Black or African American: 4%
- Hispanic: 1%
- Native American: 1%
- White: 91%

MSHO Member Demographics

Age Range: 65-85+ years

- Female: 64%
- Male: 36%

Living Arrangements:

- Community: 50%
- Institutional: 11%
- Waiver: 39%

Race:

- Asian: 16%
- Black or African American: 23%
- Hispanic: 3%
- Native American: 2%
- White: 56%

Vulnerable Populations

- **Connect + Medicare**
  - Disabled adults, diagnosed with a physical, developmental, mental illness, or brain injury
  - The majority of the population is diagnosed with serious and persistent mental illness
  - Most of the population have multiple complex, chronic conditions
- **MSHO**
  - Older adults, often frail
  - At risk for readmission to hospital
  - At risk for multiple chronic conditions and polypharmacy
- **ISNP**
  - Older adults that have diseases of aging that are chronic, progressive, or degenerative
  - Dealing with mobility issues or limitations in ability to function independently that are compounded by the existence of multiple co-morbidities and frailty
  - Residing in an institutional setting (long-term care) or at a nursing home level of care (assisted living) and have been receiving or are expected to receive a nursing home level of care for 90 days or more
  - Experiencing some degree of cognitive impairment

Care Coordinators

Care Coordinator qualifications:

- County Social Worker
- Minnesota Licensure:
  - Nurse Practitioner
  - Public Health Nurse
  - Physician Assistant
  - Physician
  - Registered Nurse
  - Social Worker
  - MnCHOICES certified (MSHO)
  - Mental Health Professionals (Connect +)

Care Coordination

The Care Coordinator (CC) coordinates care and services for the member, including:

- Annual health risk assessment (HRA) to evaluate members' medical, psychosocial, cognitive, functional, and mental health needs
- Creating an individualized, person-centered care/support plan (ICP) addressing needs identified by the HRA
- Closing gaps in care, improving quality of life, and meeting the member's individual needs
- Communicating with the Interdisciplinary Care Team (ICT), the team providing health care services for members
- Facilitating care transition protocols

Health Risk Assessment (HRA)

- The HRA provides the Care Coordinator with pertinent information related to all members' **medical, functional, cognitive, psychosocial and mental health needs**.

- The HRA provides insight into:
  - Determining member needs
  - How member manages their health
  - Needed supports to manage overall health
  - Identifying member concerns

Individualized Care/Support Plan (ICP)

- The person-centered information contained in the ICP is used to monitor gaps in the member's **medical, psychosocial, cognitive, functional and mental health needs**.

- The focus is on preventive and maintenance health care services, disease-specific interventions, and health care service coordination. The ICP addresses needs identified in the HRA by:
  - Prioritizing goals
  - Identifying barriers and interventions
  - Identifying and coordinating service needs
  - Identifying ICT members
  - Planning for care continuity, transitions, and/or transfers
  - Updating progress made toward goals/plan
  - Managing ongoing communication between teams

Interdisciplinary Team

- This team consists of:
  - Member and/or appropriate family/caregiver
  - Care Coordinator
  - Primary Care Provider
  - Other providers appropriate to specific health needs (specialists, mental health providers, etc.)
  - Others as identified by member or team

Provider Role on the ICT

- Expectations:
  - Providing appropriate care to the member
  - Collaboration with the Care Coordinator and Specialists
  - Reading through and providing input to the care plan
  - Working with the member to identify meaningful goals
  - Work with the Care Coordinator to identify the most appropriate level of care for members experiencing a transition
  - Supporting members with improving quality of life

Care Coordinator's Role

- Every member is assigned a Care Coordinator
  - The Care Coordinator partners with the member and their ICT
  - All Primary Care Physicians are considered an integral part of the member's ICT
  - The Care Coordinator is the primary point of contact for ICT members, ensuring ongoing communication and coordination

- To find out who the member's Care Coordinator is, call UCare Customer Service:
  - **MSHO:** 612-676-6868 or 1-866-280-7202
  - **Connect + Medicare:** 612-676-6830 or 1-855-260-9707
  - **ISNP:** 612-676-6821 or 1-877-671-1054

Care Transition Protocols

Care transition protocols are in place to improve transitions by reducing fragmented care and avoiding re-hospitalizations.

Care coordinators:

- Coordinate care, improve communication, and share / update the member's ICP
- Assist members, families, facilities, providers, or others with planned and unplanned transitions from one care setting to another
  - Examples include transition from hospital to home, or skilled nursing facility to home
- Follow-up to ensure that the member understands:
  - Any health status changes, discharge instructions, and changes to medication(s)
  - That follow-up appointments are scheduled, including any transportation needs

Care Transitions Protocols

The goal in coordinating care with providers is to improve coordination and communication, reduce fragmented care and avoid re-hospitalizations.

- Providers work with the Care Coordinator before, during and after transition to ensure continuity and coordinated care
- Care Coordinators can be available for questions related to transitions of care guidelines
- Providers adhere to transition protocol guidelines and work with Care Coordinators to reduce readmissions and improve outcomes
- Identify if member has new or changing needs as a result of the transition

Provider Network

- UCare's provider network meets a wide range of needs
  - Members may have care from any contracted provider without referral

- The network includes but is not limited to:
  - Primary Care Providers
  - Specialists and Specialty Care Clinics
  - Dental Providers

Quality Measurement & Performance Management

UCare collects and analyzes data and reports from a variety of sources to measure plan performance including but not limited to:

- Claims, utilization, pharmacy, and demographic information
- HEDIS, CAHPS, Stars, predictive modeling, and evidence-based analytic tools

This information helps UCare to:

- Evaluate the Model of Care annually
- Identify improvements

Outcomes

•The overall goal of UCare's Model of Care is to employ interventions to drive improvements in health outcomes and quality of life for our members. UCare's Model of Care is designed to improve:

- Access to affordable, cost-effective health care, including medical, mental health, preventive, and social services
- Care coordination through alignment of HRA, ICP, and ICT
- Seamless transitions of care across healthcare settings, providers, and health services
- Costs while assuring appropriate utilization of services for preventive health and chronic conditions

- UCare sets specific goals and health outcome objectives, that are measured at least annually. Our goals include preventive goal HEDIS measures, member satisfaction with the plan, improved access, seamless transitions, and improving coordination of care via HRA, ICP, and ICT.

Clinical Practice Guidelines (CPGs)

UCare has clinical practice guidelines for providers to support good decision-making and to improve health care outcomes.

- **Medical CPGs:**
  - Asthma Diagnosis and Management
  - Care of Older Adult
  - Diabetes: Type 2 Diagnosis and Management
  - Management of Heart Failure in Adults
  - Obesity for Adults: Prevention and Management
  - Prenatal Care
  - Preventive Services for Adults
  - Preventative Services for Children and Adults

- **Mental Health and Substance Use CPGs:**
  - Assessment and Treatment of Children and Adolescents with Attention Deficit/Hyperactivity Disorder
  - Assessment and Treatment of Children and Adolescents with Depressive Disorders
  - Management of Posttraumatic Stress Disorder and Acute Stress Disorder
  - Treatment of Opioid Use Disorder
  - Treatment of Patients with Major Depressive Disorder
  - Treatment of Patients with Schizophrenia
  - Treatment of Patients with Substance Use Disorders

Summary

- The MOC is designed to meet the needs of our member population
- Providers play an important role as members of the Interdisciplinary Care Team
- Providers and Care Coordinators work together to improve outcomes and the quality of life for members
- UCare annually evaluates the Model of Care, using data and reports

Next Steps

- If you are viewing live on September 10, you do not need to complete an attestation.

- If you are viewing the recording of the presentation today, please complete the electronic attestation on UCare's website for proof of completion.

Inquiring with U!

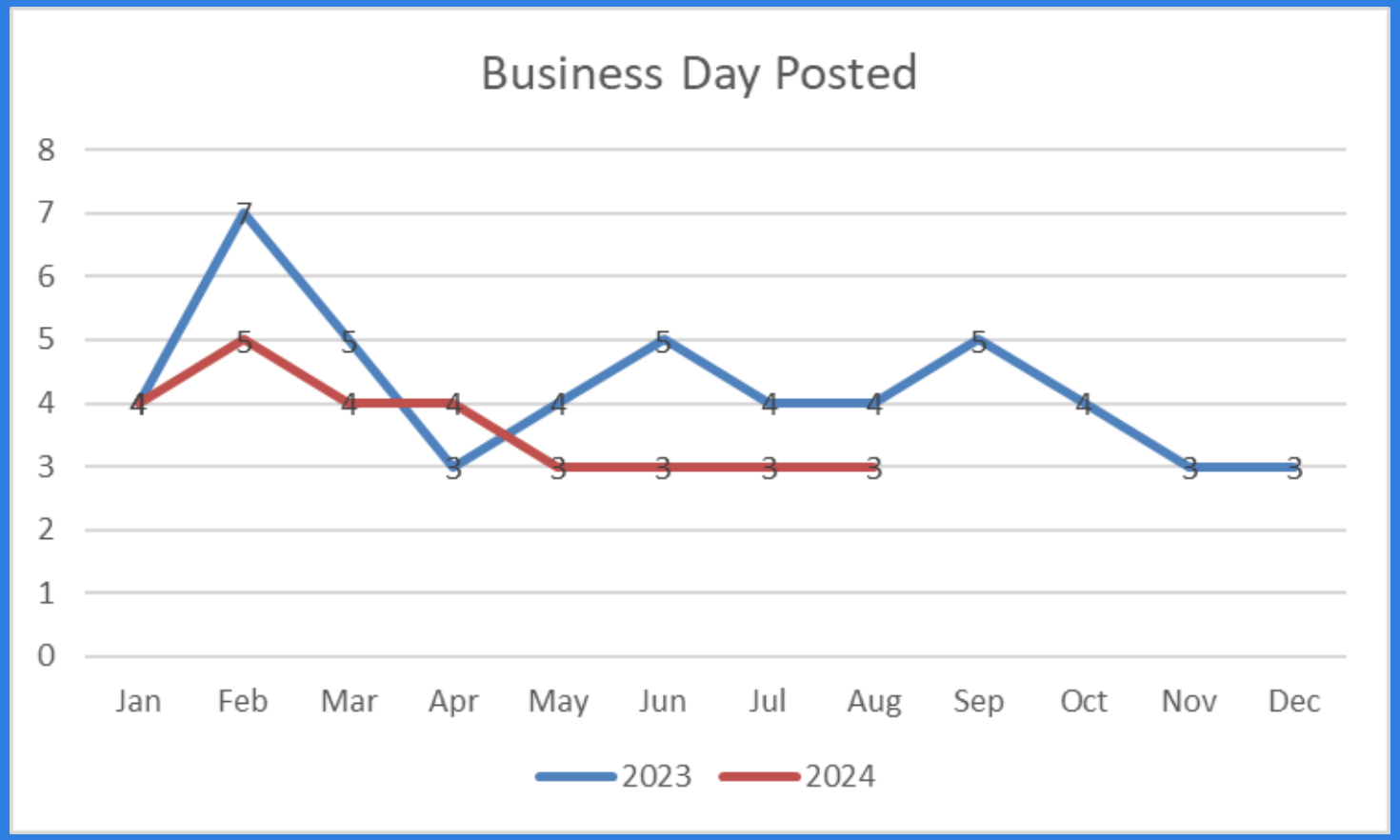
2024 Annual Care Coordination Survey

Jennie Paradeis
Delegation and Enrollment Manager

Last year we heard you say	What we did this year
Website	• Care Coordination Website had continued updates to layouts and combining like areas • Website Overview Training is now available • Included in annual roadshow presentations • Added more links in the newsletter to find referenced information • Translated a number of documents and letters • New CC manual posted!
PCC verifications	• Developed internal processes to increase our ability to identify accurate PCC for new members • Updated internal review processes • This is an area where UCare will continue to look for additional ways to impact the accuracy of PCCs and the process of changes

Member Enrollment Rosters

Timing
- Initial roster posting to delegates by 3rd business day



Improve accuracy
- Manual reviews occurring
- System Enhancements

MSC+ & MSHO

Waiver Service Authorizations

Noteworthy WINS!

- Went up 10% since last year

Action Items

- This was identified as an area where UCare could make additional improvements, and we will continue to look for ways to impact timeliness and responses regarding waiver service authorizations.

Clinical Liaisons

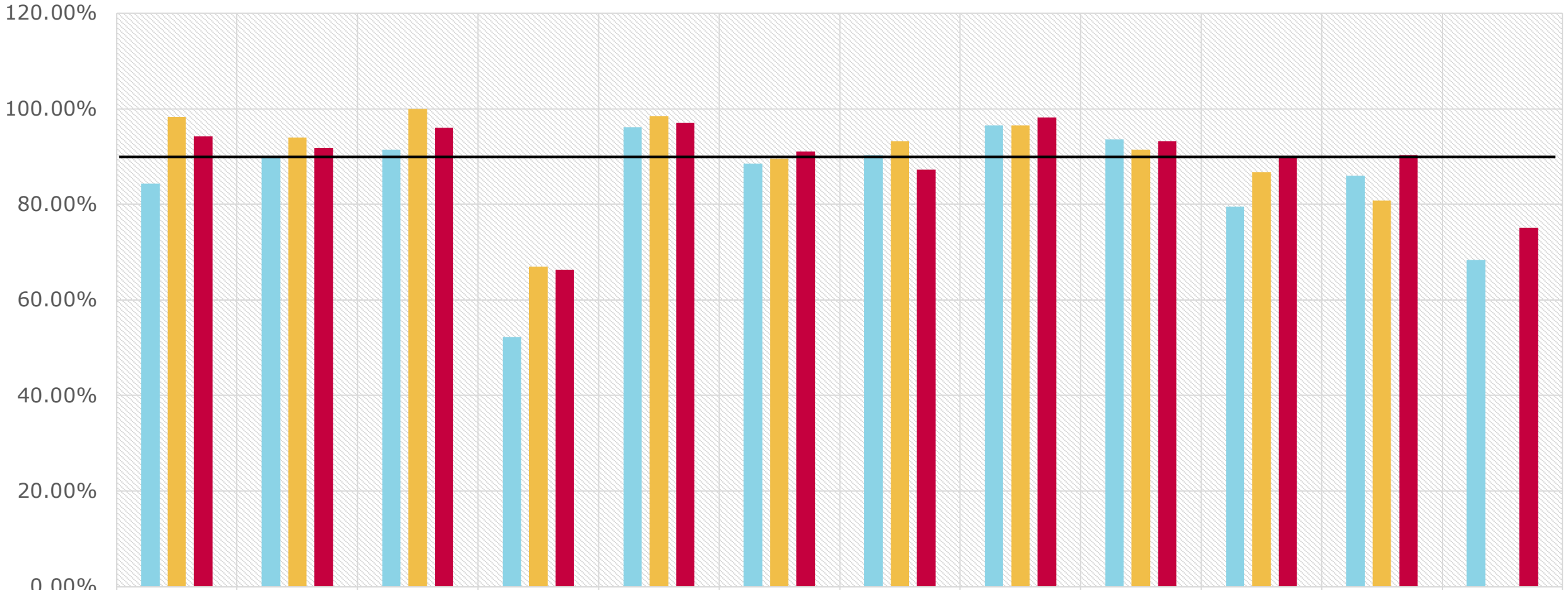
Last year we heard you say	What we did this year
Responses to emails can be vague or delayed	• Clinical Liaisons providing more thorough responses • 24 business hour response time
Requests for checklists/job aids	• Clinical Liaisons continued to work on expanding the current set of available job aids
Supplemental benefits education	• Clinical Liaisons worked with Health Promotion team to provide updated additional/supplemental benefits grids • Supplemental Benefits Training • Reviewed benefits in quarterly meetings, office hours, and annual roadshows

Inquiring with U: 2024 Annual Care Coordination Survey Results

Thank you for your participation in the care coordination survey! Your feedback matters and is incredibly valuable as we continue to grow and improve our care coordination services.

Participation :
340 responses
96% of delegates represented

2022 – 2024 Results



	Connect Navigators	Enrollment Coordinators - CM intake	Enrollment Coordinators - Connect Intake	Enrollment Rosters	Liaisons - Connect	Liaisons - MSHO MSC+	MSS triage line	Newsletter	PCA auths	PCC change process	Waiver Service Auths	Website
2022	84.38%	90.07%	91.43%	52.27%	96.08%	88.54%	90.32%	96.55%	93.55%	79.57%	85.96%	68.32%
2023	98.28%	93.98%	100.00%	67.02%	98.39%	89.50%	93.22%	96.53%	91.45%	86.76%	80.79%	
2024	94.29%	91.87%	96.00%	66.27%	97.06%	91.04%	87.27%	98.15%	93.23%	90.07%	90.24%	75.10%

2022 2023 2024

All Products

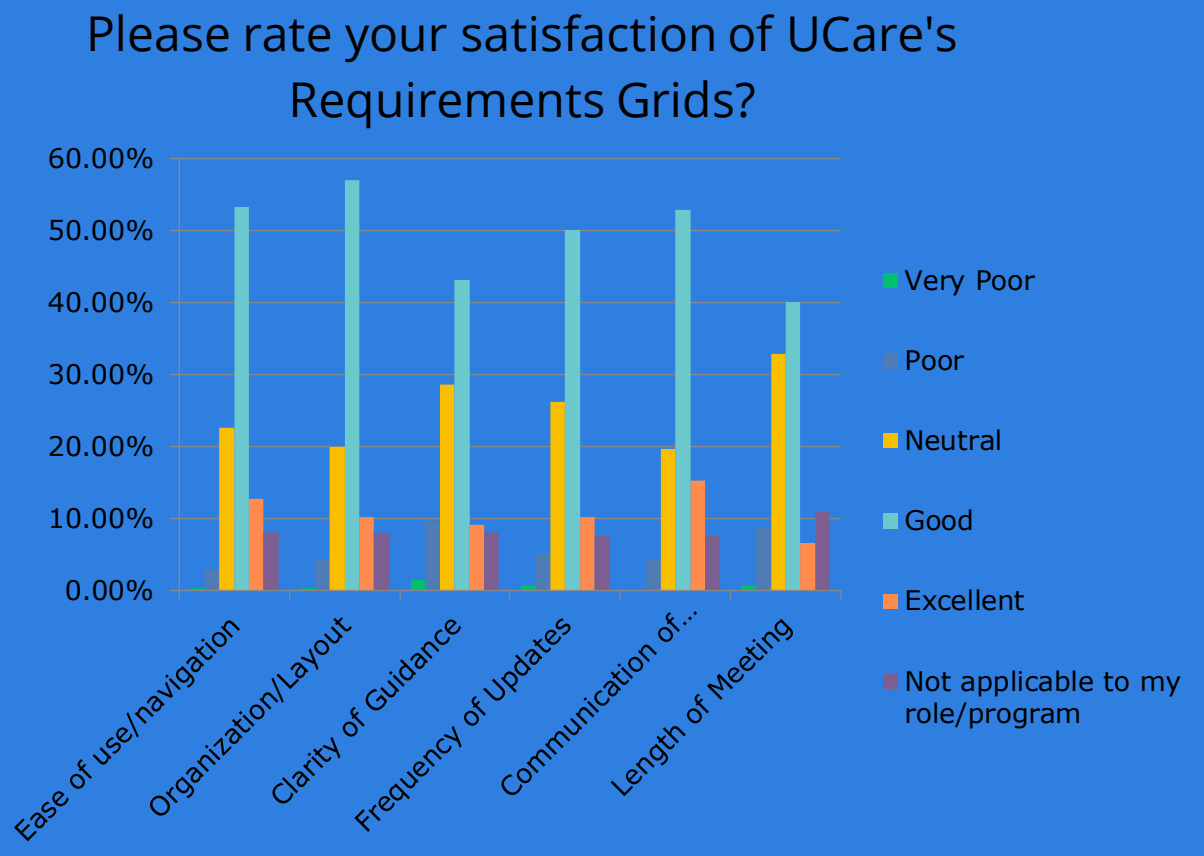
Member Enrollment Rosters & PCC Assignment

Enrollment satisfaction stayed steady from last year. Remains a high priority across the department.

What we're doing:

- Continuing to work with development teams to improve the accuracy and timeliness of rosters.
- Maintain 3rd business day for initial roster posting and review for accuracy.
- Upgrade to the current roster system

All Products
Requirements Grids



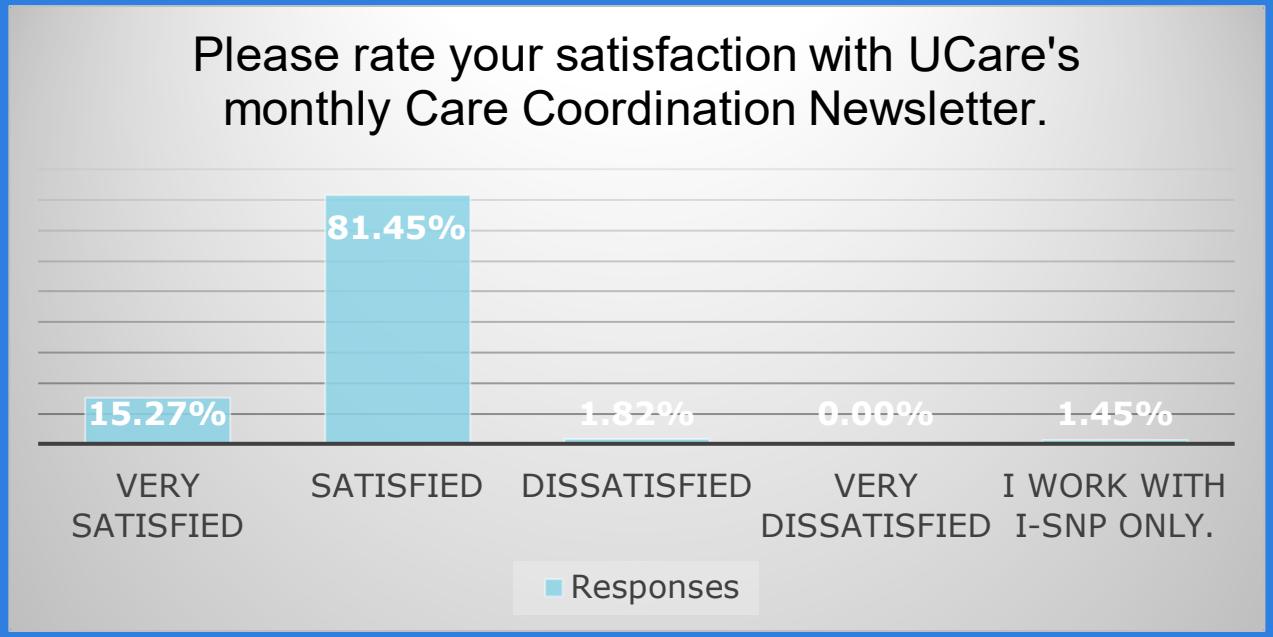
What we are doing:

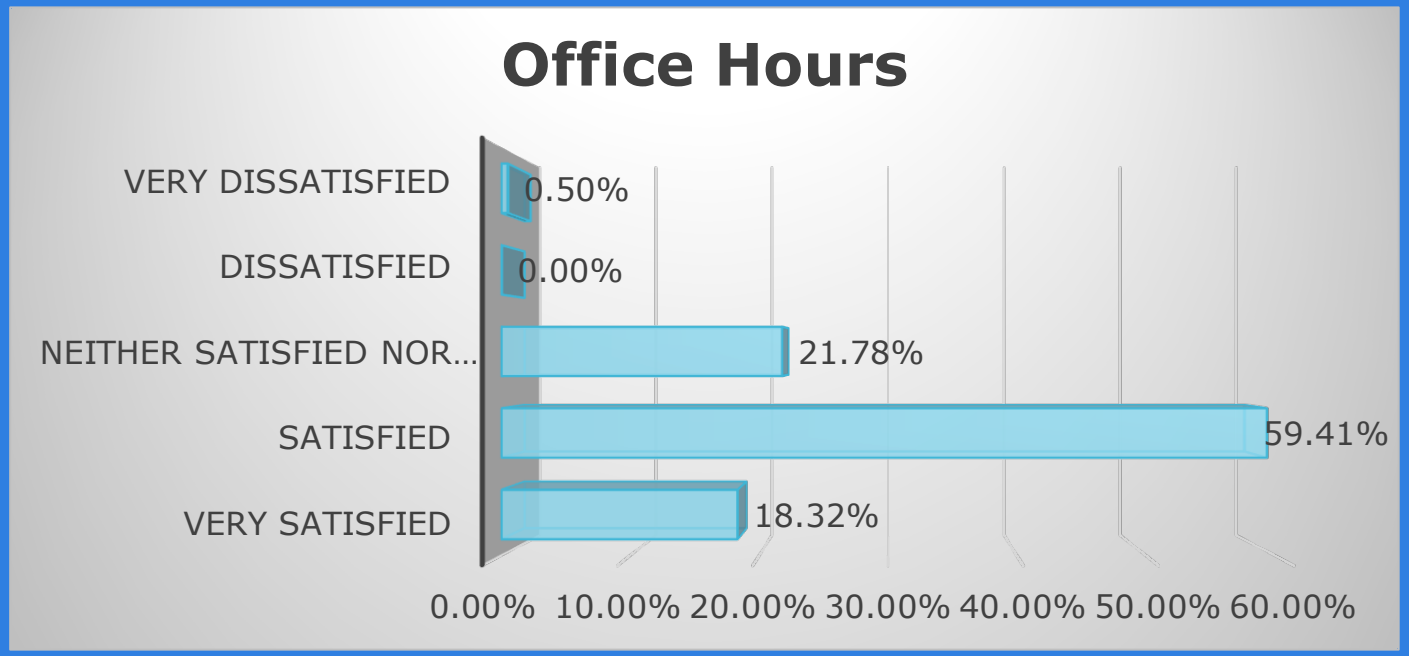
1. Changed the formatting of the Table of Contents to be vertically alphabetical
2. Changed the MSHO Community Grids into 2 grids:
   - Non-EW or PCA-only
   - EW

3. Continue to evaluate clarity and other enhancements

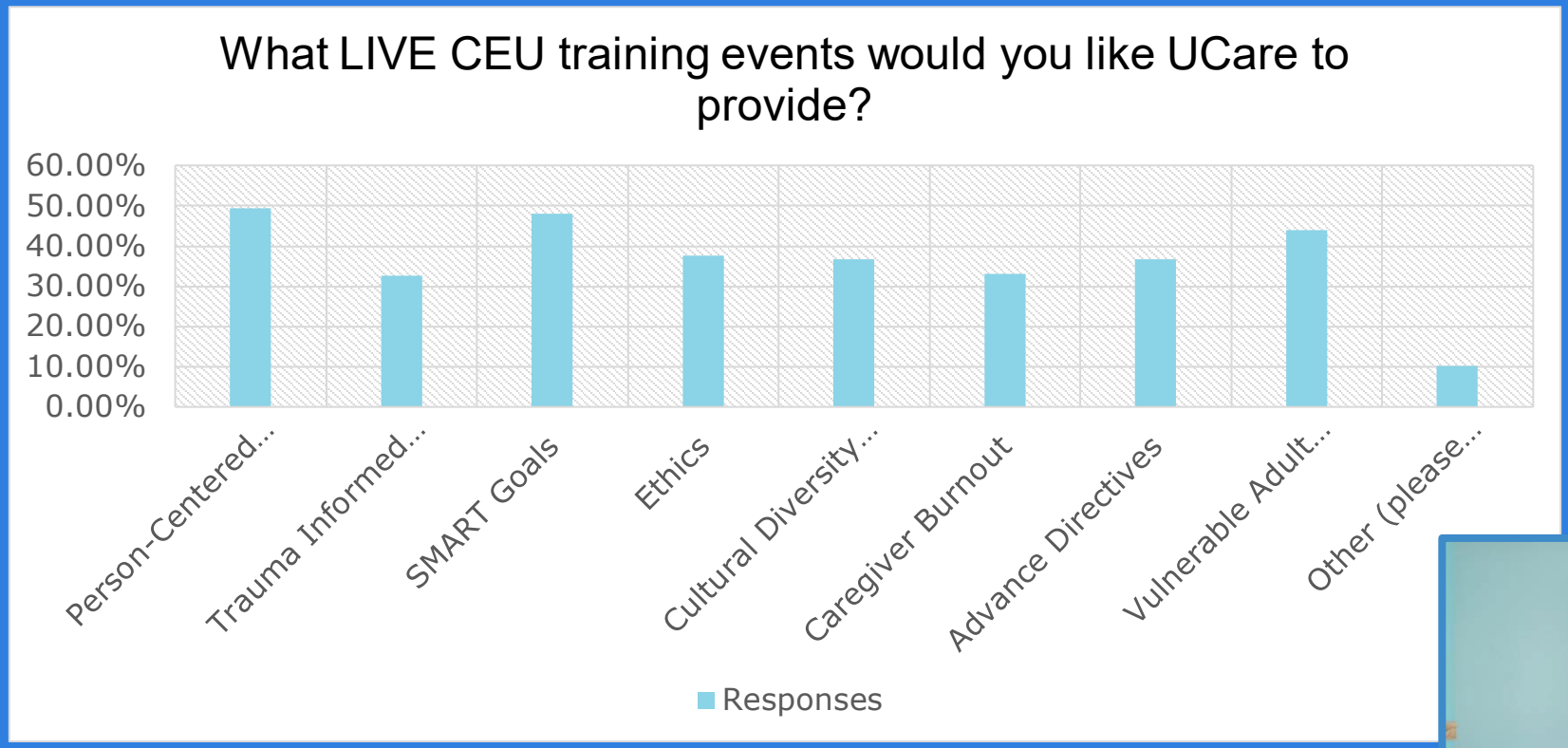
All Products

Office Hours and Newsletter





Future Training Opportunities



Keep it coming!

We welcome you to continue providing feedback. We want to hear from you!

Some ways your feedback can make an impact:

- Annual CC survey
- Post-meeting surveys
- Open communication with your Clinical Liaisons

5-minute Break

10:17-10:22

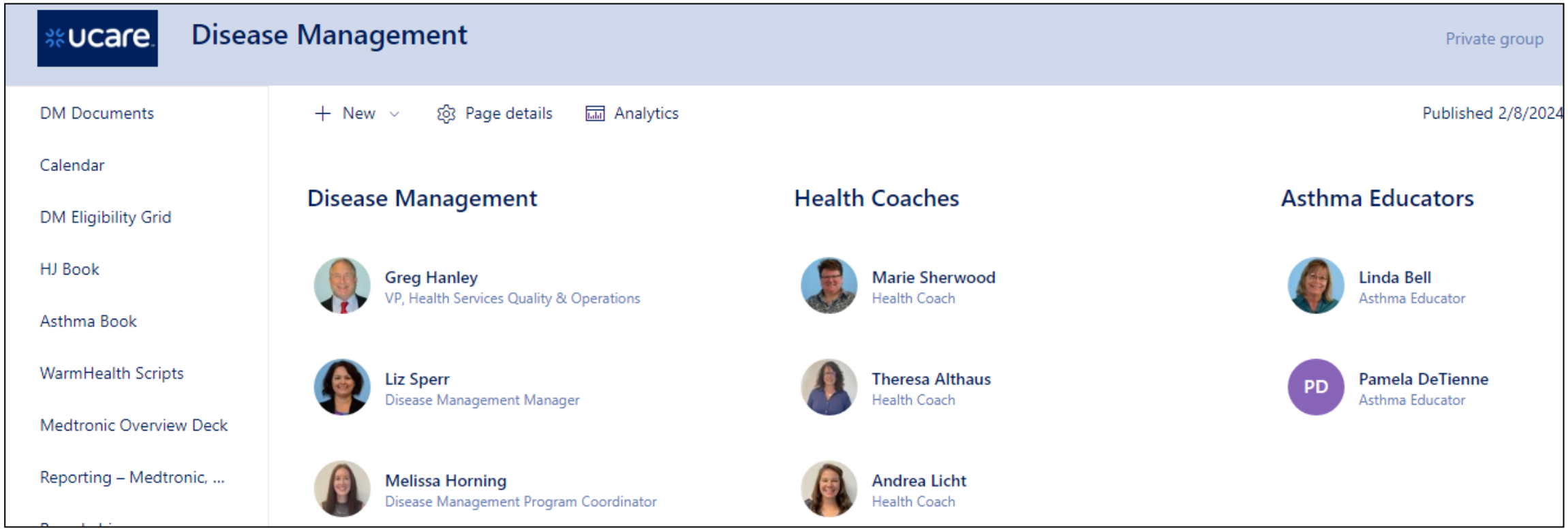
UCare Disease Management Programs

Marie Sherwood & Pamela DeTienne

DM Program Overview

- Population Health Management
  - All programs are part of the Population Health Management Strategy
  - Follow NCQA guidelines for all DM programs
- Utilize Population Health Assessments to guide new program and intervention recommendations
- Members enroll in the program via referrals (CM/CC, HI, self, provider), program letters, program IVR invitation calls and live outreach
- Programs are implemented via UCare health coaches and asthma educators or vendor partnerships

Disease Management (DM) Team



Asthma Programs

Asthma Interventions and Programs

Eligible population for asthma programs:

- Adults and pediatric members (age 5-64) with an asthma diagnosis
- PMAP, MNCare, Connect, Connect+ Medicare, IFP

Asthma Programs
Cecelia Health Asthma Virtual Support Program
Asthma Education Program
Interactive Voice Response/Texting Education Program
Asthma Education Newsletter
Asthma Action Plan Reminder Mailing
Brook Health App

Cecelia Health Asthma Virtual Support Program

- Telephonic outreach
- Assessments of self-monitoring, self-management and medication adherence
- Asthma education and member goal setting
- Evening and Saturday hours
- Member Registration form: Asthma Virtual Support Program | Cecelia Health | UCare

Asthma Education Program

- Telephonic outreach
- Assessments of self-monitoring, self-management and medication adherence
- Asthma education and member goal setting
- Asthma management tools: education materials, pillowcase covers
- PCP receives notification when member enrolls in the program
- Gift card incentive for enrollment and completion of the program
- Referral form: https://www.ucare.org/providers/policies-resources/disease-management

Asthma Education Newsletter

Staying active with asthma

Exercise can sometimes be a challenge for people with asthma. If you struggle with finding the right exercise, yoga may be a good option for you.

Yoga for stress

Stress is a common asthma trigger for some people. Yoga is a low-impact exercise that can help reduce stress. The practice of yoga has two important parts: physical poses and mindful breathing. Through yoga's gentle breathing exercises, you can improve your physical strength while keeping your body and mind relaxed. Breathing exercises can help you cope with the stress, anxiety and depression that may come with asthma.

Holding basic yoga poses can help raise energy levels and strengthen muscles, but it is important to not push yourself if you are uncomfortable in a pose. Beginners—especially those living with asthma—should take their time and avoid any poses that make breathing harder.

Keep your doctor informed

It is best to check with your health care team before attempting any kind of exercise, including yoga. If you do participate in a yoga class, make sure the teacher is fully qualified and understands your needs.

Even if yoga makes you feel better, continue to take your asthma medications as prescribed. Reducing or changing your medications without first checking with your health care team could lead to an asthma flare up.

Source: American Lung Association, Allergy & Asthma network

ucare

Controller and reliever asthma medications — what's the difference?

Medications are an important part of a complete asthma self-management plan. You may use a controller medication, a reliever medication or both. It's important to know the differences between the two medicines as well as how and when to use them.

Controller (preventer) medication reduces inflammation in the lungs and prevents asthma symptoms over a long-term period of time. This treatment is typically used daily to help prevent asthma attacks even when you have no symptoms.

Reliever (rescuer) medication is a fast-acting treatment that opens the airways and quickly relieves severe symptoms, making it easier to breathe again. Reliever treatment helps during an asthma attack. It is not recommended for daily use.

The doses and instructions for how to take these medicines depend on the frequency and severity of your symptoms. Talk to your doctor about what treatment is right for you, especially if you're using reliever medication several times a week to manage your asthma symptoms.

Refill reminder

Don't forget to refill your medications on time each month. Set yourself a reminder on your smartphone or calendar to stay on top of your refills.

Use the label: Save your prescription information so you have it handy when you call your pharmacy to request a refill. If you don't want to save the packaging, simply take a picture of the label or copy the details on a slip of paper.

Resources

Your health is important to us. That's why UCare offers programs and services to help you lead a healthy lifestyle. Check out the resources below and be sure to visit **ucare.org/healthwellness** for more resources.

American Lung Association Helpline

1-800-586-4872
lung.org

Asthma and Allergy Foundation

1-800-7-ASTHMA (1-800-727-8462)
aafa.org

Quit Smoking and Vaping Program

myquitforlife.com/ucare

Transportation help

If you are a PMAP, Connect or Connect Plus Member, or have a child on MinnesotaCare UCare Health Ride provides eligible members with no-cost transportation to and from covered medical, dental and pharmacy visits.

To request a bus pass or schedule a ride, call:
1-800-864-2157
7 am – 8 pm, Monday – Friday

Have this information ready when you call:

- UCare member ID card
- Name, address and date of birth
- Current phone number
- The full name and address of the doctor, clinic, dentist, pharmacy or other care provider you're seeing

Please call Health Ride to schedule your transportation at least two business days before your covered medical, dental or pharmacy visit.

Food access help

Need help applying for SNAP food benefits or finding local food resources? Call the UCare Customer Service phone number on the back of your UCare member ID card to get 1-on-1 help applying for SNAP food benefits and/or finding resources in your community.

Housing

For help with housing benefits, visit **hb101.org** or call 1-866-333-2466. You can also reach out to the Homeowner's HOPE hotline with counselors available 24 hours a day, 7 days a week: 1-888-995-HOPE (4673).

Mental health and substance use disorder help

UCare's Mental Health and Substance Use Disorder Triage and Access Lines offer:

- Help during a crisis
- Referrals to Mental Health and Substance Use Disorder Case Management and other services
- Connections to community resources
- Approvals for mental health services
- A listing of in-network mental health and substance use providers
- Assistance scheduling an appointment with a mental health and/or substance use provider

Call 1-833-276-1185, TTY 1-800-688-2534
8 am – 5 pm, Monday – Friday

If you leave a message outside of business hours, a UCare representative will call you back the next business day.

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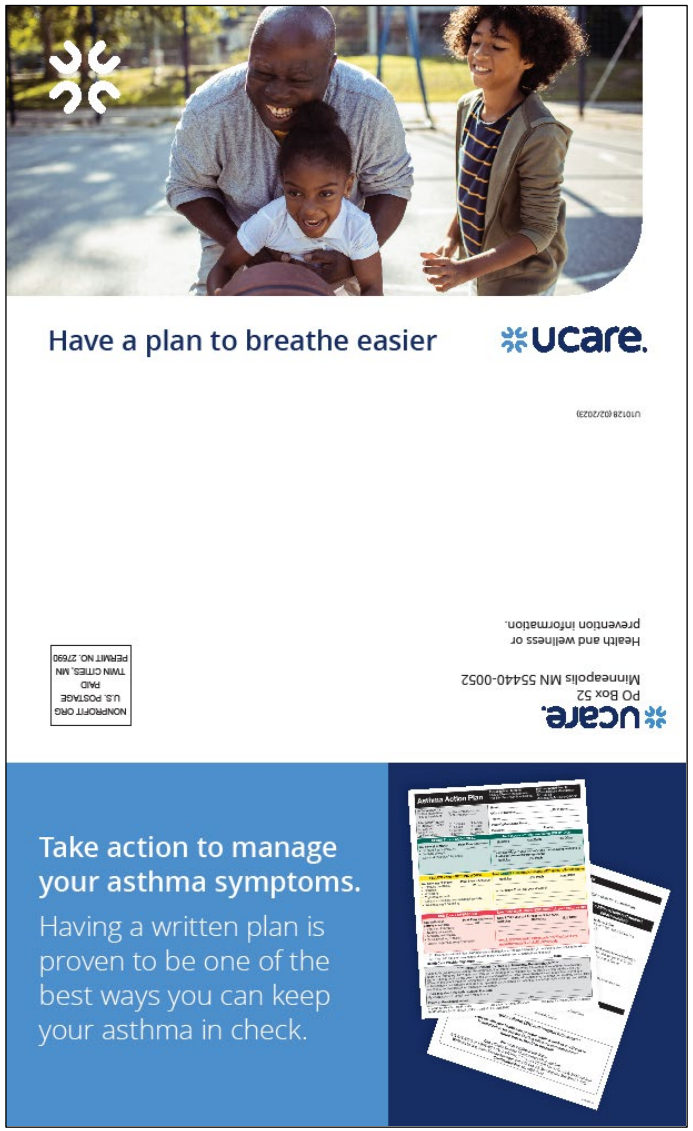
U10433 (02/2022)

Asthma Action Plan Reminder Mailing



Disease Management Programs

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

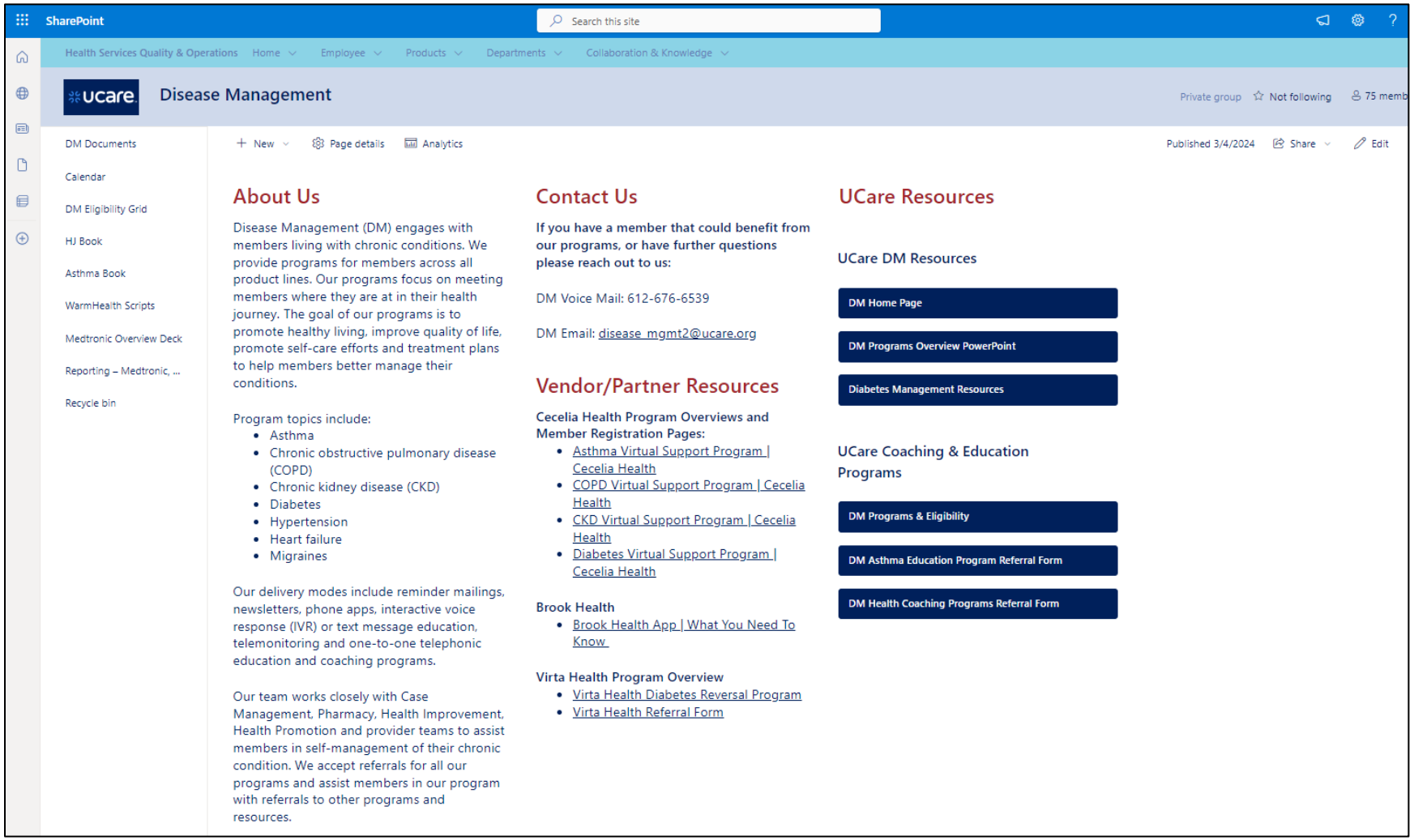
Heart Failure
- Health Coaching (UCare)
- Telemonitoring
- Brook Health Mobile App

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

Weight Management
- Virtual Support Program (Cecelia)
- Newsletter
- Brook Health Mobile App

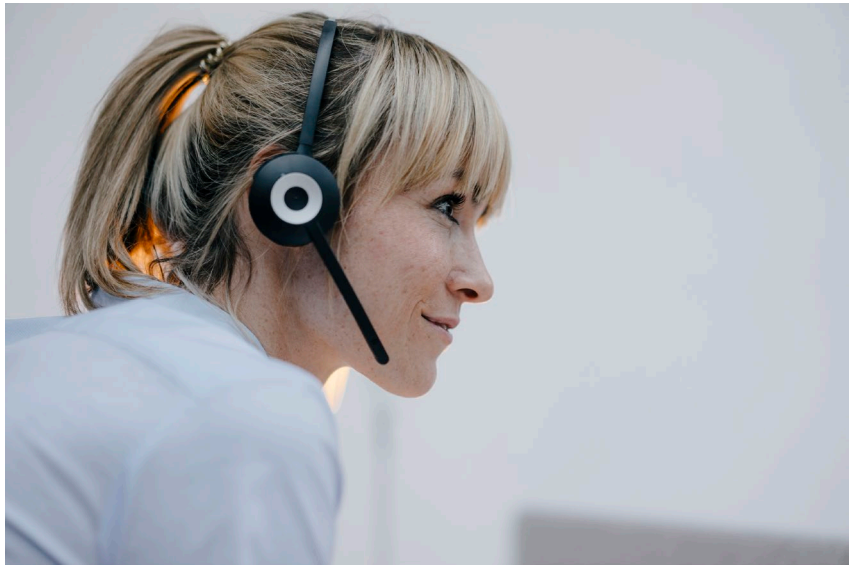
DM Contact Info and Referral Information

Disease Management Resources

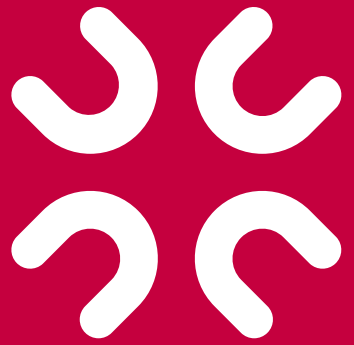


DM Contact Information

- 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 Program Grids

Disease Management (DM) Programs

Program	Description
Asthma IVR/Text Education Program (At-Risk)	• Scheduled Interactive Voice Response (IVR) 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 Virtual 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 Virtual Support 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 Education Program (At-Risk)	• Scheduled Interactive Voice Response (IVR) 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
Weight Management Program	• Telephonic outreach and education with a Cecelia Health registered dietician • Guidance, education, and support to help manage weight loss, with our without medication, and maintain motivation • 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 Education Program (At-Risk)	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 Virtual Support Program	X	X	X	X	X	X	X	X	X	X
COPD Virtual Support Program	X	X	X	X	X	X	X	X	X	X
Diabetes IVR/Text Education Program (At-Risk)	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 Program	X	X			X	X		X		
Weight Management Program	X	X			X	X	X	X		

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

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

DM Success story

UCare member highlight

10/1 Over-the-counter (OTC) Allowance Transition

Health Promotions: Lexi Ruehling

Transition Summary

Health Promotion will be transitioning the Over-the-counter (OTC) allowance for MSHO and Connect + Medicare members onto the Healthy Benefits+ Visa card.

What benefit do these plans have now? CVS OTC; online and over the phone

Which products are affected? MSHO and Connect + Medicare

When is this happening? 10/1/2024

When will members be notified? Transition letters were mailed on 8/26 to notify current MSHO and CT+M members of this program change. New members will see new OTC information on an insert included in member guides starting in September.

OTC Program Details

Current Program with CVS OTC
(1/1-9/30)

Products: MSHO and Connect + Medicare
Dollar Amount: $60/quarter (both products). Use or lose; dollars expire
How members shop:

- A catalog of eligible items is mailed to the members. Catalog orders placed online or over the phone.
- No in-store experience
- No physical OTC card. Dollars are not loaded to their HB+ Visa Card

New Program with Healthy Benefits+ OTC Allowance *(as of 10/1)*

Products: MSHO and Connect + Medicare
Dollar Amount: $60/quarter (both products). Use or lose; dollars expire
How members shop:

- Using their Healthy Benefits+ Visa card – in store, online, or over the phone
  - Participating locations can be found using the Store Finder (via website or app)
    - Locations include CVS, Walgreens, Walmart, and more
  - Healthybenefitsplus.com/ucare
  - Call the number on the back of the Healthy Benefits+ Visa card
- A catalog of eligible items is also available to members

Delta Dental Transition: UCare & DentaQuest Partnership

Bryan Strotbeck

Care Coordination Services

Programs and services listed below are inclusive of our current partnership arrangement:

Program	Program Description	Population	Type of Outreach
Dental Home	Members have ability to choose their primary dental Provider or are assigned to one if they do not self-select.	All enrollees	New member mailings
Appointment Assistance	Members who contact us via our toll-free number saying they need assistance with scheduling a dental appointment will receive live scheduling assistance from a Customer Service Representative (CSR). The CSR will conduct a three-way call to schedule the appointment with the dental office.	All enrollees	Inboard Customer Service call
Member Placement	If the Customer Service Representative cannot assist the caller with locating a participating Provider, the Member will receive follow-up support from our Member Placement team. A representative from this team will work to identify an in- or out-of-network Provider that can meet the Member's needs and provide timely services.	All enrollees	Live calls
Gap in Care	DentaQuest analyzes utilization data every month to identify members who have not had their preventive dental services in the previous seven months.	Any non-utilizer	Robo calls, live calls, and postcards
Healthy Beginnings	Caregiver education consists of age-appropriate oral health care for children ages 0-2. Education topics include oral health home care, the role of healthy baby teeth, proper nutrition, and the importance of early dental care. Caregivers receive a congratulatory quick guide at the child's birth, and educational postcards on the child's first and second birthday. We also help caregivers find a dental provider for the child and provide information about the child's dental benefits.	Children 0-3	Mailer and educational brochures
Chronic Condition	Members with diabetes who have not had a recent dental visit will receive education about the importance of oral health in managing diabetes. We will also help members locate a network dentist and overcome other barriers to receiving care.	Diabetics	Mailer and live calls

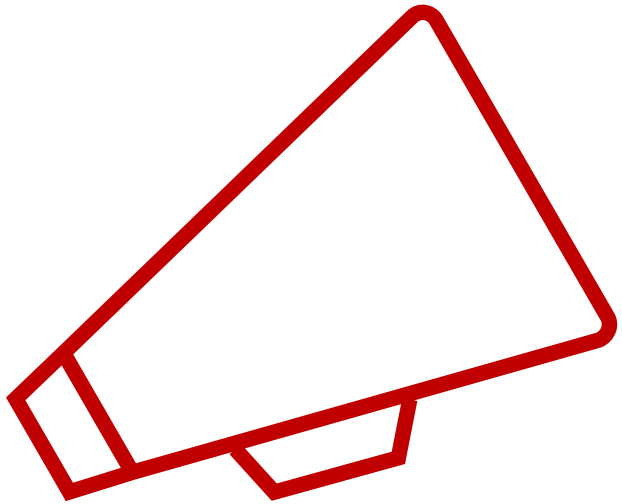
Other Services:

- Digital Campaigns
- Tele-dentistry Options
- Mobile Dentistry
- Enhanced Service Model

MN EAS / PointClickCare (PCC)

Jennie Paradeis

MN EAS / Point Click Care



- Updates regarding the continued transition from MN EAS to PCC
- This transition has created a delay in some of our timelines
- Full DAR to discontinue at the end of 2024

The Why

MN DHS agreement with Audacious Inquiry

DHS and Audacious Inquiry roll out and continued operation of the Encounter Alert System (EAS).

Audacious Inquiry acquisition by PointClickCare

In 2022 Audacious Inquiry was acquired by PointClickCare.

PointClickCare decision to transition to Ambulatory Solution

After acquisitions of multiple organizations, PointClickCare, with the help of providers, determined that the move from the current EAS solution to PointClickCare Ambulatory solutions was the best path forward.

What Does it Mean for EAS Users

1. All Medicaid Care Coordination Delegates will receive access to PCC at no cost

2. All Care Coordination delegates will be required to onboard with PointClickCare by 12/1/2024

3. New platform added features:
   - Visibility into patient encounters across nationwide network
   - Enhanced customization or notifications and reports
   - A more user-friendly portal

Next Steps / Call to Action

1. PCC working on initial delegate onboarding to start enrollment into PCC. Care Systems have already been engaged and PointClickCare will be hosting a subsequent webinar for county delegates 9/26

2. Following contract completion, a PointClickCare Project Manager will be assigned to each organization to begin implementation and training of the new solution and tailor to each delegates needs

3. Delegates not currently in MNEAS will be prioritized. All transitions are to be completed by December 1st, 2024

MN EAS / Point Click Care

- Continue to upload your panel into EAS at least monthly
- Check EAS on business days for admission/discharge notifications

- UCare will continue to send the full DAR through the end of 2024
  - 2025 will start sending a “skinny” DAR to include any authorizations that will not be found in PointClickCare

We appreciate your feedback!

Please take some time to complete the 3rd Quarterly CC Meeting Feedback Survey

Electronic Visit Verification (EVV) Updates

Esther Versalles-Hester

EVV

Electronic visit verification compliance is in effect as of Sept. 1, 2024.

- The Minnesota Department of Human Services (DHS) issued a notice that it will enforce electronic visit verification (EVV) compliance starting Sept. 1, 2024. EVV is required for in-home or community-based services where people receive support with ADLs and/or IADLs.
- For a list of services that must be verified using EVV, refer to the affected services tab of DHS – EVV.
- Impacted UCare providers must be compliant with this direction provided by DHS.

The Minnesota EVV system will verify:

- Type of service performed
- Who received the service
- Date of service
- Location of service delivery
- Who provided the service
- When the service begins and ends.

HHAX (DHS Vendor for EVV) is preparing for CFSS implementation and visit verification under the new personal support model, and final phase of EVV will include visit validation for claims payment purposes.

To learn More: DHS CBSM: Electronic Visit Verification (EVV)

CFSS

Esther Versalles-Hester & Samantha Rue

CFSS Implementation

On October 1, 2024, Personal Care Assistance (PCA) services will begin to transition to Community First Services and Supports (CFSS).

Transition plan: Phase II (15 months, starting Oct. 1, 2024)

During the transition year, people will transition to CFSS at the time of their yearly reassessment to ensure there is no disruption of services.

In phase II, DHS will:

- Update MMIS with CFSS codes in the months before rollout.
- Instruct MCOs to update their authorization systems**.**
- Send communication to all interested parties.
- Update MMIS to allow the entry of CFSS service agreements.
- Update all forms not already updated.
- Continue to have all training materials available.
- Provide ongoing support to those who need it.
- Develop further training and communications based on feedback from those who find existing content confusing or difficult.
- Continue to meet with the CFSS Implementation Council.

To Learn More: DHS CFSS Policy Manual: Transition from PCA to CFSS

CFSS Manual

DHS has posted the CFSS Policy Manual with the following categories:

- Home page
- Covered personal care services
- Eligibility

  Person's rights and responsibilities
- Consultation services
- Service delivery plan (care plan)
- Personal care workers
- Service options
- Provider agencies
- Financial management services (FMS)

  Qualified professionals
- Service changes
- Resources

CFSS Implementation Project

UCare has developed a cross-departmental implementation workgroup to ensure compliance with timelines and MCO requirements related to:

- Authorization and claim system configuration
- Provider enrollment
- Provider Manual Updates
- PCA/CFSS related provider request forms (i.e. communication form, change in provider, health plan transfer forms)
- Electronic Visit Verification
- Care coordination CFSS guidance document
- Participation in weekly DHS/Lead Agency Office Hours

CFSS & Care Coordination Requirements

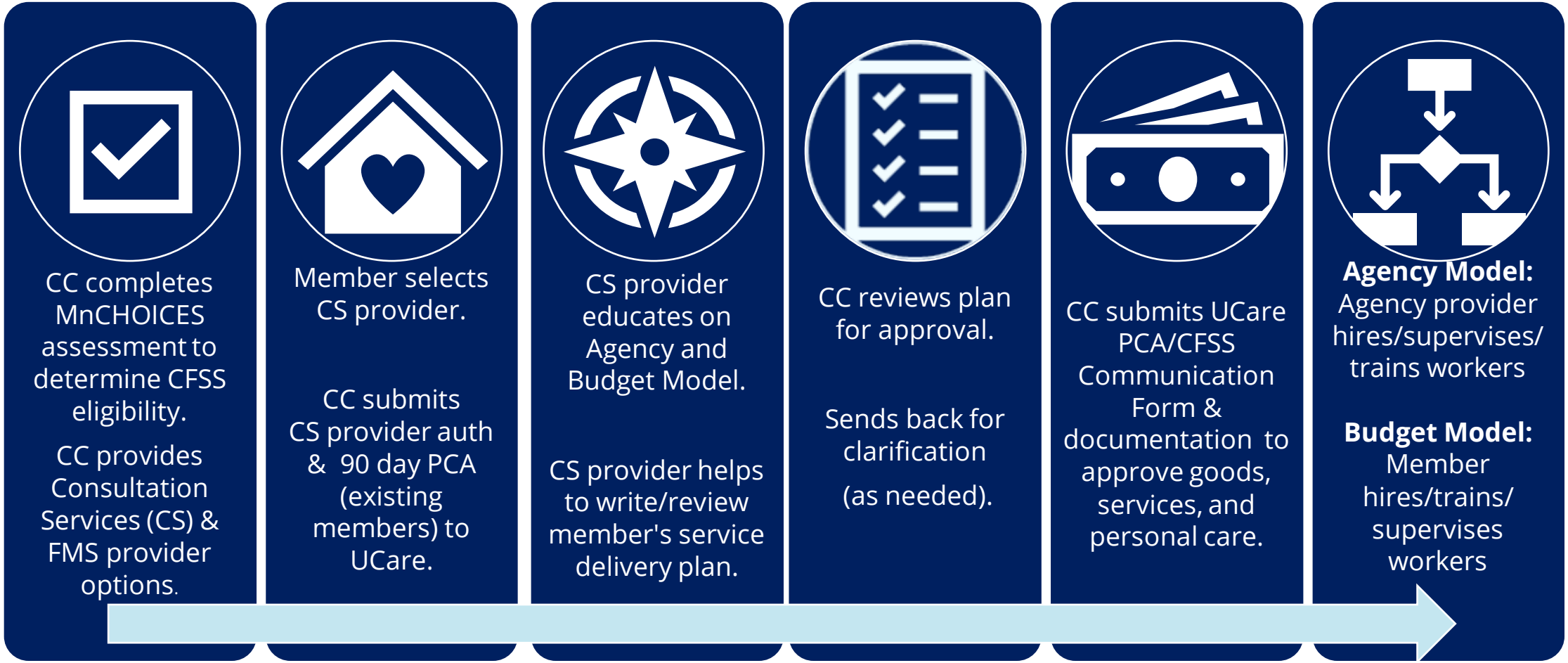
CC Expectations Prior to 10/1 Launch:

- Must complete Community First Services and Supports (CFSS) for lead agencies training in TrainLink (course code_CFSS_LA)
- Review the CFSS Policy Manual to learn more about policies, requirements, service options and more.

Coming Soon- UCare CFSS Updated/New Documents:

- UCare Care Coordination CFSS Guidelines
- Community Requirements Grid updates
- PCA/CFSS Communication Form
  - Updated email: pca_cfss@ucare.org
- PCA/CFSS Transfer Form & all other provider PCA/CFSS requests forms

CFSS Process Flow



PCA to CFSS: Timeline

MnCHOICES assessment completed **prior** to 10/1/24

1. Follow current PCA process & authorization.
2. Member continues with PCA and is not eligible for CFSS until next reassessment.

MnCHOICES assessment completed **on or after** 10/1/24

1. Follow the new PCA/CFSS process & authorization.
2. Authorize Consultation Services (CS) for all members and 3 months of PCA for existing members.
3. Once CFSS Service Delivery Plan is approved, authorize CFSS goods, services and/or personal care.

CFSS Resources & Training

- TrainLink CFSS for Lead Agencies Care Coordinator Training (Course Code: CFSS_LA)
- TrainLink CFSS Policy Training for New Lead Agency Staff (Course Code: CFSS_PO)
- DHS CFSS Program Information
- CFSS Policy Manual
- Transition from PCA and CSG to CFSS
- CFSS Frequently Asked Questions (FAQ)
- CFSS Consultation Service Providers
- Financial Management Service (FMS) providers
- CFSS Service Agreement Calculators & How to Guides
- CFSS Home Care Rating/Units Reference Tool
- CFSS Training Videos for people who use CFSS and their families (Training Tab)

In Lieu of Services (ILOS)

Dawn Sulland

In Lieu of Services (ILOS)

DHS approved UCare to provide a specific roster of waiver benefits to MSC+ and MSHO members; if this coverage will avoid a more expensive covered benefit, such as inpatient admit or SNF stay.

Specific EW services may be covered using ILOS for up to 45-day approval spans. ILOS should be considered following a member's hospitalization, an outpatient procedure, anesthesia or when a member may be at risk of hospitalization without the service(s). To be eligible for chore services, the member must have a frail health condition, and neither the member nor others in the household can perform the chore.

Services UCare includes in ILOS are:

- Homemaking
- Respite out of home or hospital
- ICLS
- Chore Service
- Specialized Equipment & Supplies (one-time purchase)

ILOS Service Request Process

1. Complete or review current MnCHOICES Assessment to determine EW eligibility
2. Member may qualify for ILOS when:
    1. Member does not meet nursing facility level of care **or**
    2. Member qualifies for EW and has an urgent need for services.
3. Care coordinator identifies a DHS enrolled waiver provider using MinnesotaHelp.info
4. Complete In Lieu of Services Request Form

Ending In Lieu of Services

After 45 days

If services are needed beyond 45 days, the CC should determine if EW services can start. If the member continues to meet ILOS eligibility, a subsequent ILOS request may be submitted.

Denial/Termination/Reduction

Upon completion of the requested ILOS service span, a DTR is not required.

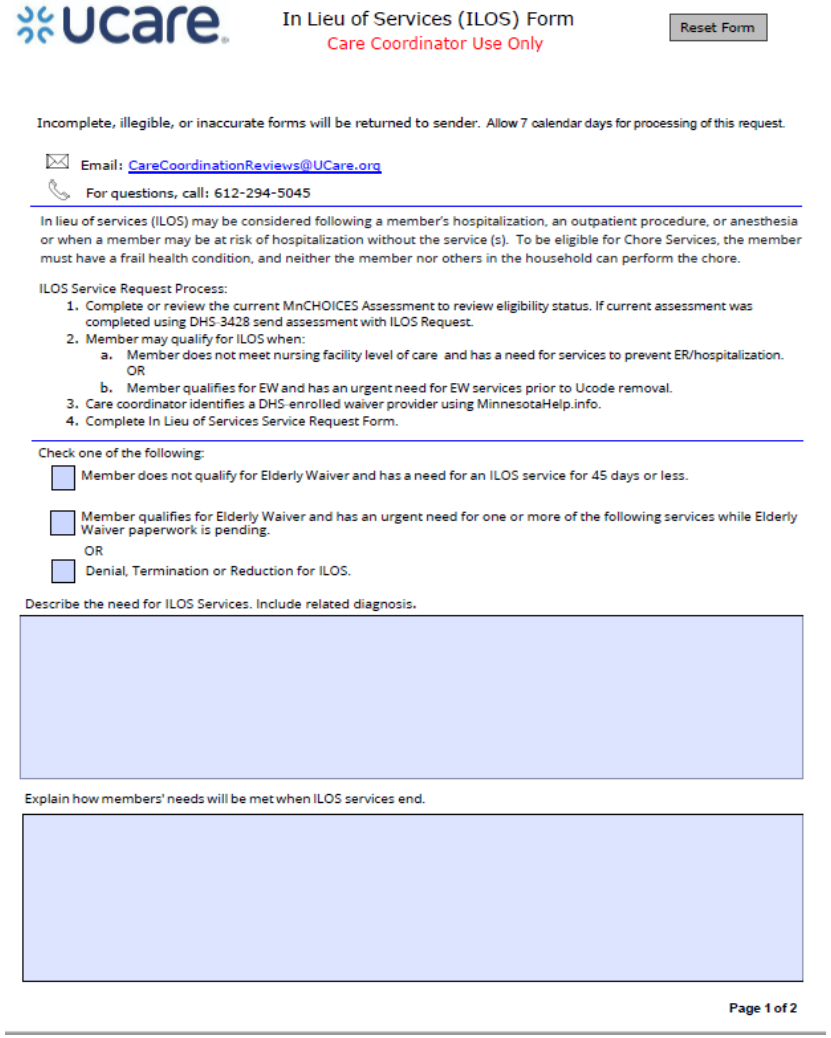
If a member requests to decrease or stop ILOS before the requested ILOS service span, the CC submits the ILOS Request Form indicating a DTR is needed.

- Select Reason Code: 1602; services are being terminated at the member's request

Upon admission to a nursing facility, the CC submits the ILOS Request Form to terminate.

- Select Reason Code: 1106; services are not covered in your benefit set

In Lieu of Services



ucare

In Lieu of Services (ILOS) Form

Care Coordinator Use Only

Reset Form

Incomplete, illegible, or inaccurate forms will be returned to sender. Allow 7 calendar days for processing of this request.

Email: CareCoordinationReviews@UCare.org

For questions, call: 612-294-5045

In lieu of services (ILOS) may be considered following a member's hospitalization, an outpatient procedure, or anesthesia or when a member may be at risk of hospitalization without the service (s). To be eligible for Chore Services, the member must have a frail health condition, and neither the member nor others in the household can perform the chore.

ILOS Service Request Process:

1. Complete or review the current MnCHOICES Assessment to review eligibility status. If current assessment was completed using DHS-3428 send assessment with ILOS Request.
2. Member may qualify for ILOS when:
   a. Member does not meet nursing facility level of care and has a need for services to prevent ER/hospitalization.
   OR
   b. Member qualifies for EW and has an urgent need for EW services prior to Ucode removal.
3. Care coordinator identifies a DHS-enrolled waiver provider using MinnesotaHelp.info.
4. Complete In Lieu of Services Service Request Form.

Check one of the following:

☐ Member does not qualify for Elderly Waiver and has a need for an ILOS service for 45 days or less.

☐ Member qualifies for Elderly Waiver and has an urgent need for one or more of the following services while Elderly Waiver paperwork is pending.

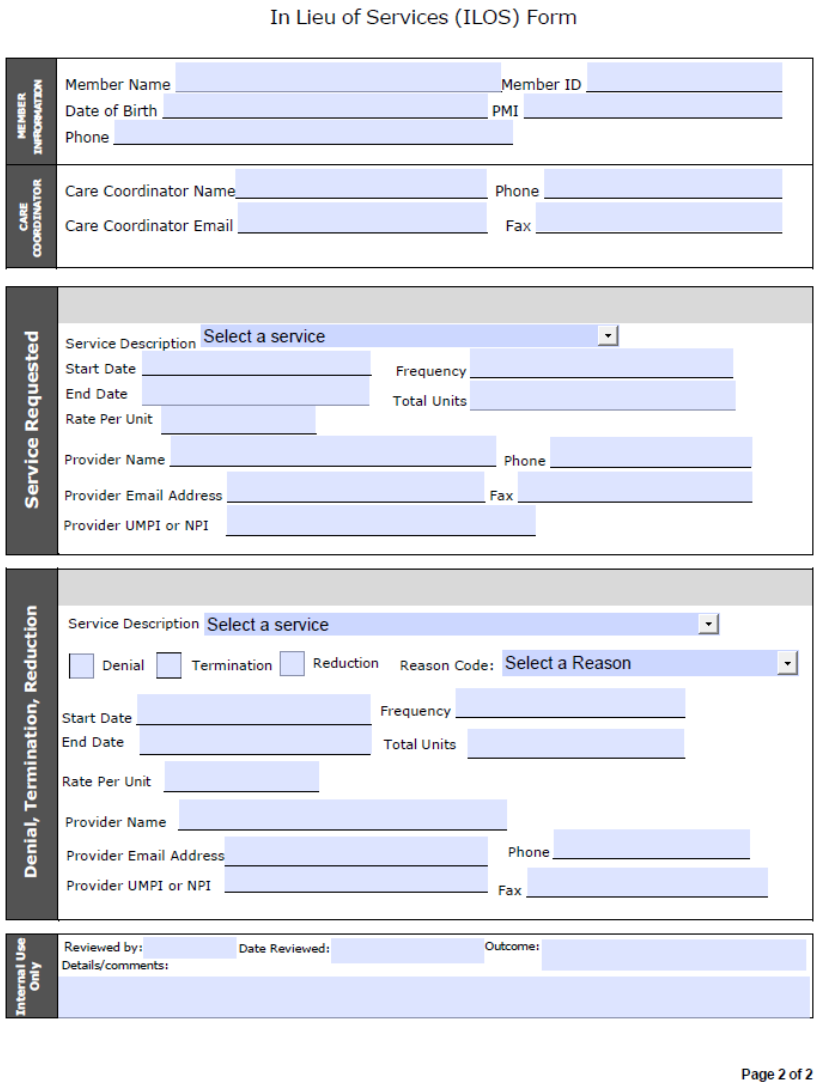
OR

☐ Denial, Termination or Reduction for ILOS.

Describe the need for ILOS Services. Include related diagnosis.

Explain how members' needs will be met when ILOS services end.

Page 1 of 2



In Lieu of Services (ILOS) Form

MEMBER INFORMATION

Member Name _____ Member ID _____

Date of Birth _____ PMI _____

Phone _____

CARE COORDINATOR

Care Coordinator Name _____ Phone _____

Care Coordinator Email _____ Fax _____

Service Requested

Service Description Select a service

Start Date _____ Frequency _____

End Date _____ Total Units _____

Rate Per Unit _____

Provider Name _____ Phone _____

Provider Email Address _____ Fax _____

Provider UMPI or NPI _____

Denial, Termination, Reduction

Service Description Select a service

☐ Denial ☐ Termination ☐ Reduction Reason Code: Select a Reason

Start Date _____ Frequency _____

End Date _____ Total Units _____

Rate Per Unit _____

Provider Name _____

Provider Email Address _____ Phone _____

Provider UMPI or NPI _____ Fax _____

Internal Use Only

Reviewed by: _____ Date Reviewed: _____ Outcome: _____

Details/comments: _____

Page 2 of 2

ILOS Form will be available in the Forms drawer on the [MSC+ and MSHO Care Coordination Resources page.]

Reminders:

- 1 service request per form
- Ensure accuracy & completion of form
- Provide detailed information to review team
- Note new email address for this form
- Allow 7 days for processing

Questions: Reach out to the Clinical Liaisons


Questions?

Clinical Liaison Contacts

MSC+/MSHO

MSC_MSHO_Clinicalliaison@ucare.org

612-294-5045

Connect/Connect + Medicare

SNBCClinicalLiaison@ucare.org

612-676-6625