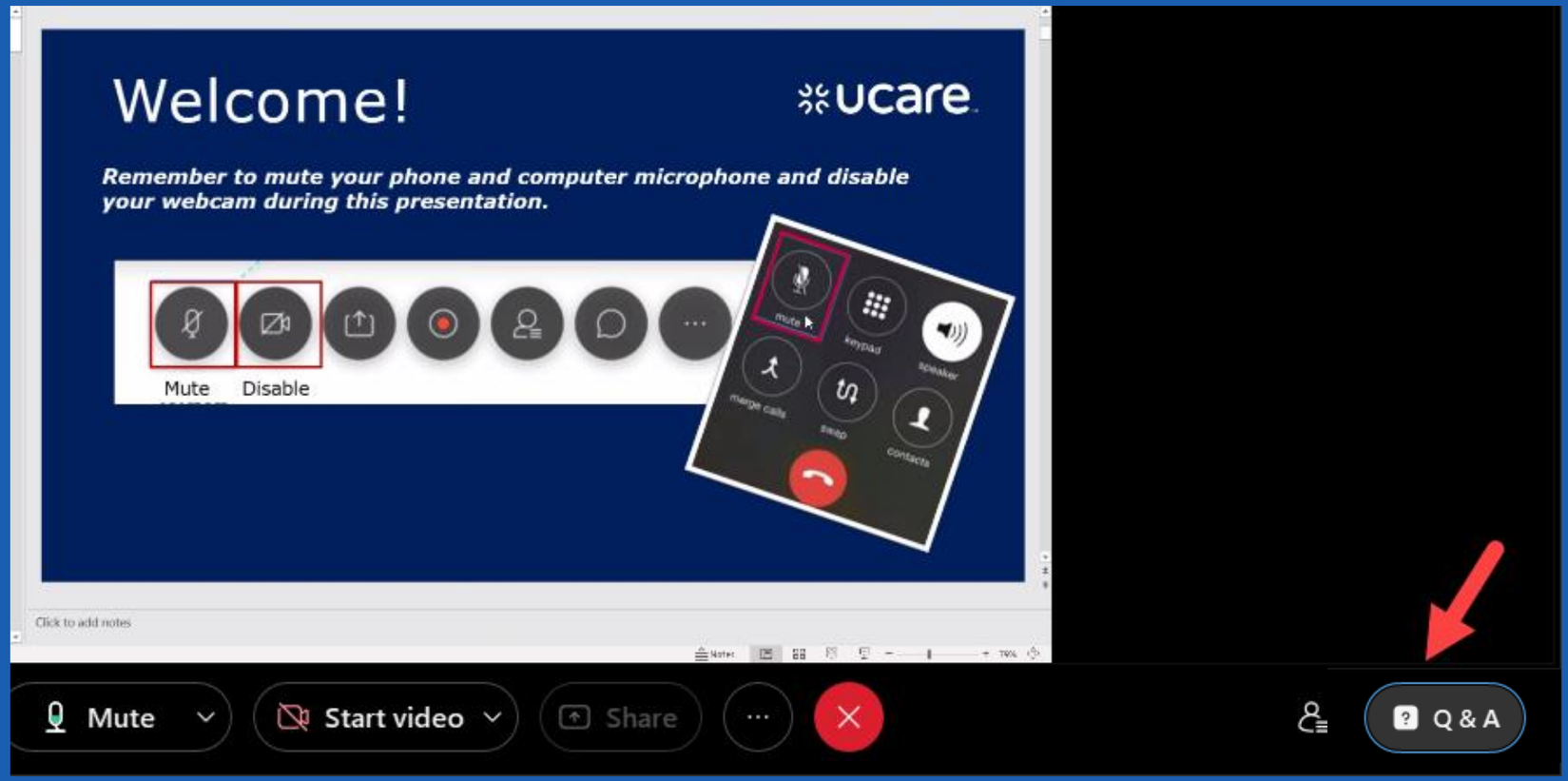

ucare®

UCare
Connect/Connect + Medicare
&
MSC+/MSHO

2nd Quarterly Meeting

June 15, 2023

Questions welcome!



Q & A

All (0)

Select a question and then type your answer here. There's a 512-character limit.

Send

Send Privately

Today’s Agenda

Time	Topic	Audience	Presenter/Team
9:00 – 9:05am	Welcome	All	Clinical Liaisons
9:05 -10:05am	Care Coordination Updates	All	Clinical Liaisons
10:05 - 10:25am	UCare SIU	All	Mena Xiong
10:25 – 11:00am	Quality Initiative Updates	All	UCare Quality Team
Connect/Connect + Medicare Optional/Feedback Survey Link Shared			
11:00 – 11:10am	PCA/CFSS and EW T2029 Updates	MSHO/MSC+ (SNBC optional)	Esther Versalles-Hester
11:10 – 11:25am	LSS Healthy Transitions	MSHO/MSC+	LSS Team

Care Coordination Updates

Presenter: Clinical Liaisons

Care Coordination Meeting Schedule

CEUs offered quarterly (optional)

Office hours (optional)

MSHO/MSC+ and SNBC will be separate & offered at different times

Registration for optional events will be in the monthly newsletter

UCare Product	Meeting Type	Date & Time (Subject to change)
MSHO/MSC+ and Connect/Connect + Medicare	Live Quarterly WebEx Meeting	June 15th, 9 am September 12th, 9 am December 12th, 9 am
MSHO/MSC+ and Connect/Connect + Medicare	CEU Event (optional)	August 22nd, Announced in July November 28th, Announced in Oct
MSHO/MSC+	Office Hours (optional)	July 25th, 10:00-11:00 Oct 24th, 10:00-11:00
Connect/Connect + Medicare	Office Hours (optional)	July 25th, 1:30-2:30 October 24th, 1:30-2:30

→SAVE THE DATE←

MnCHOICES Updates

Beta Testing:

- UCare is participating MnCHOICES Beta testing & beta testing users report it is going well.

All delegates should have UCare MnCHOICES Mentors using MnCHOICES MTZ to begin working on internal workflows/processes

- MTZ link - https://mnchoices-trn-carity.feisystemsh2env.com/#/

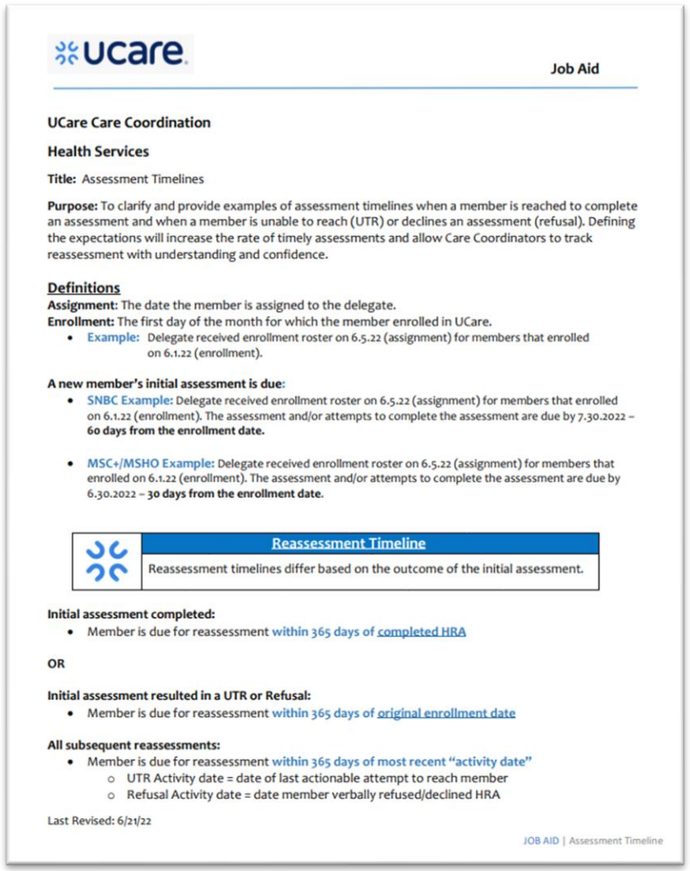
Clinical Liaisons will be sending out a final blank MnCHOICES onboarding spreadsheet

- Please add any MnCHOICES users that are new to or have left your organization since March 2023
- Onboarding spreadsheet will be due by June 30
- After June 30, please use the DHS Access Request Form to request new access or to remove access for MnCHOICES users within your agency.

It is critical that UCare MnCHOICES Mentors are viewing the MnCHOICES Launch Webinars hosted by DHS

- If a webinar is missed, a recording and the PowerPoints are available on the DSD training archive

Reminder: 365-day timeline



ucare

Job Aid

UCare Care Coordination

Health Services

Title: Assessment Timelines

Purpose: To clarify and provide examples of assessment timelines when a member is reached to complete an assessment and when a member is unable to reach (UTR) or declines an assessment (refusal). Defining the expectations will increase the rate of timely assessments and allow Care Coordinators to track reassessment with understanding and confidence.

Definitions

Assignment: The date the member is assigned to the delegate.

Enrollment: The first day of the month for which the member enrolled in UCare.

- Example: Delegate received enrollment roster on 6.5.22 (assignment) for members that enrolled on 6.1.22 (enrollment).

A new member's initial assessment is due:

- SNBC Example: Delegate received enrollment roster on 6.5.22 (assignment) for members that enrolled on 6.1.22 (enrollment). The assessment and/or attempts to complete the assessment are due by 7.30.2022 – **60 days from the enrollment date.**
- MSC+/MSHO Example: Delegate received enrollment roster on 6.5.22 (assignment) for members that enrolled on 6.1.22 (enrollment). The assessment and/or attempts to complete the assessment are due by 6.30.2022 – **30 days from the enrollment date.**

Reassessment Timeline
Reassessment timelines differ based on the outcome of the initial assessment.

Initial assessment completed:

- Member is due for reassessment within 365 days of completed HRA

OR

Initial assessment resulted in a UTR or Refusal:

- Member is due for reassessment within 365 days of original enrollment date

All subsequent reassessments:

- Member is due for reassessment within 365 days of most recent "activity date"
  - UTR Activity date = date of last actionable attempt to reach member
  - Refusal Activity date = date member verbally refused/declined HRA

Last Revised: 6/21/22

JOB AID | Assessment Timeline

Reassessment Timelines

Calculating reassessment outreach is a critical piece to meeting regulatory requirements and can be challenging due to the variables of each situation.

Reminder of Scenarios:

- All completed HRAs must have the following HRA completed prior to 365 days from the previous HRA date.
- When a new member is an unable to reach (UTR) or refusal (R), the following assessment needs to be completed prior to 365 days of the enrollment date.
- After the first reassessment is completed, if the member remains unable to reach or refusal, the following reassessments must be completed prior to 365 days of the last activity (UTR/R).

Review the Reassessment Timelines Job Aid, Member Process Flow, and reach out to the Clinical Liaisons if you are unable to determine when the next reassessment is due.

IMPORTANT: A completed assessment is always the best outcome. When members are resistant, the Member Engagement Strategies Job Aid offers talking points and tips engaging members.

- Leap Year impact! 2024
  - Keep this in mind as you set up reminders for next year!

Connect/Connect + Med MAL Update

COMING SOON!

2023 Connect/Connect + Med Monthly Activity Log

Month:		(Select from the dropdown menu)
Delegate		(Select from the dropdown menu)

email to: connectintake@ucare.org by the 15th of each month.

See Example Actvities data on rows 12, 13, 14

Drop Down Options	HS Code Key		Support Plan Updates	
Living Status	HS Code	HS Code Definition	Support Plan Update Type	Update Definition
Institutional	HP	Member assessed	6 month	Support Plan updated on 6 months assessment
Community	NR	Unable to reach	TOC Support Plan Update	Support plan updated on a transition of care
	NI	Declined/refused assessment	Other	Support Plan update for significant changes
	GH	Group Home -Bluestone only		

Member Demographics							Annual Assessment Activity			Connect + Medicare Only			Support Plan Updates			Care Coordinator/Scheduler			
Assigned Assessor Entity	Product	Last Name	First Name	UCare Member ID# (9 digits)	DOB	Living Status	2023 Activity Completion Date	HS Code (Select from the drop down menu)	If HP: Type of Activity	Unable To Reach Attempt 1	Unable To Reach Attempt 2	Unable To Reach Attempt 3	2023 Support Plan Update: 6 Mo/TOC	2023 Date of Support Plan Update	Type of Activity	Last Name of Assessor *(for Refusals or UTR list name of Scheduler)*	First Name of Assessor *(for Refusals or UTR list name of Scheduler)*	Title of Assessor	Comments
UCare	Connect+Med	Doe	Jane	423456789	1/1/1958	Institutional	7/5/2023	HP	In Person							Stallone	Sylvester	RN	
UCare	Connect	Doe	John	487654321	10/6/1964	Community	8/5/2023	NR		7/29/2023	8/2/2023	8/4/2023				Letterman	David	Case Aide	
UCare	Connect+Med	Smith	Sam	456789102	12/1/1975	Community							6 Mo	1/7/2023	Telephonic	Helpsalot	Susie	LSW	

- What's New?
  - One tab for both Connect/Connect + Med
  - Organized columns coordinating columns
  - Updated drop downs to include type of activity
  - Removed 2022 activity info
  - Updated examples.

Reminder to return the MAL with the activity completed each month to ensure the HS codes are updated timely.

Member engagement is increasing!

Improving Communication: The Master Contact List

- Our goal is to have an accurate and routinely updated staff contact information list to improve and streamline communications
  - We want to ensure the right information gets to the right people based on each agencies specified contacts
  - We want to ensure compliance with Model of Care annual training
- What it will contain:
  - All staff members names, phone numbers, email, MMIS PW (as applicable), general role/title, products affiliated with (i.e.: MSHO/SNBC), and agency preferences for Newsletter/Alerts, Reports and other communications.
- Master Contacts will be requested bi-annually to update as staffing and communication contacts change.

Medical Assistance Renewals

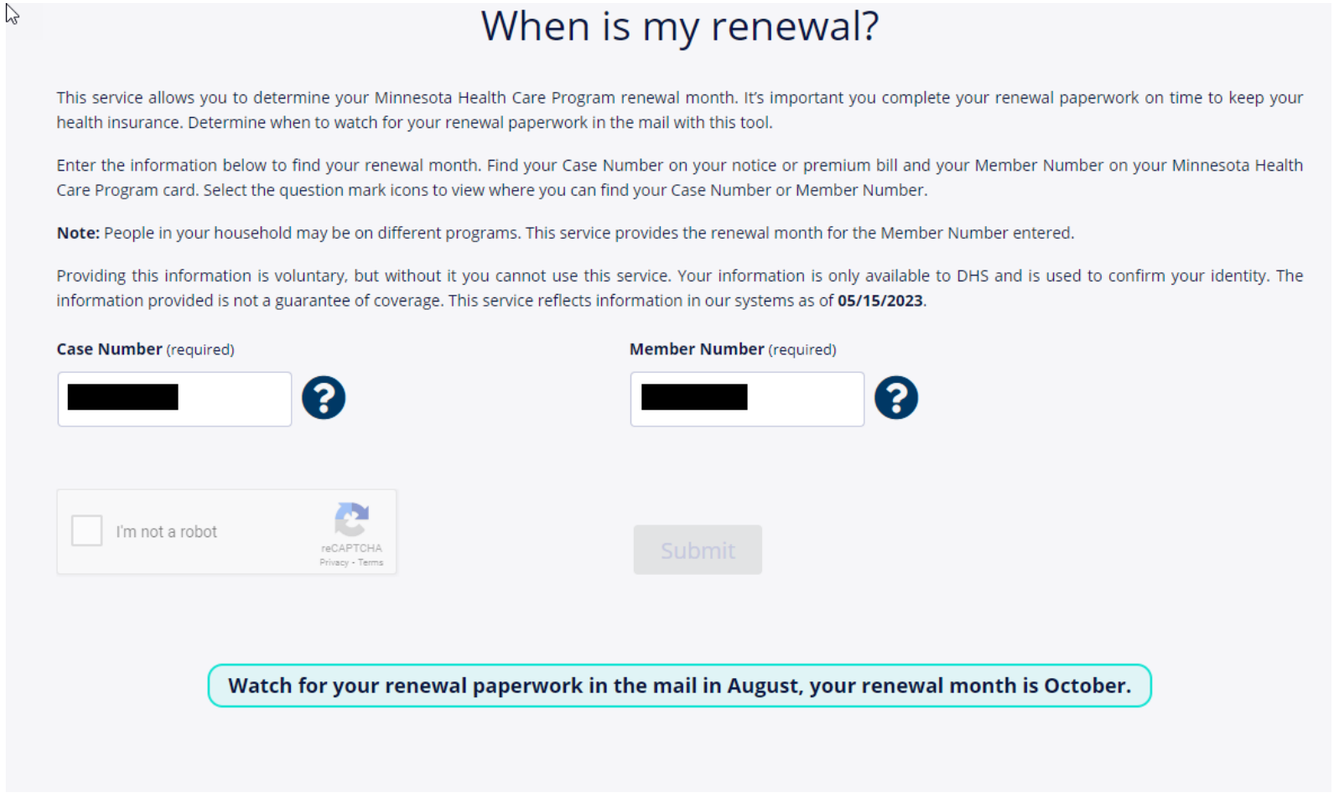
UCare’s Keep Your Coverage team actively outreaches to members by way of live calls or interactive voice messages. The team is available to receive referrals from care coordinators to assist members with their MA renewal questions and paperwork. Referrals can be sent to:

Keep Your Coverage Flyer: keepyourcoverage

Medical Assistance Renewals

UCare will begin sending a new Quarterly MA Future Renewal Date report. Report will contain month of renewal due and **MAXIS CASE NUMBER!**

- **New**: Renewal Lookup (mnrenewallookup.com) – using info from report, CC can confirm renewal information.



Medical Assistance Renewals

Care Coordination Role:

1. Review the list to be informed of members renewal. Use best judgment for additional outreach needed: Reach out to members the CC believes would be at risk of not completing MA paperwork or would benefit from support.

2. Ensure member's address is accurate and updated.

NEW: address change: [DHS-8354-ENG (MCO Member Address Change Report Form) (mn.gov)]


DEPARTMENT OF HUMAN SERVICES

DHS-8354-ENG 5-23 (1.0.8)

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

MCO Member Address Change Report Form

Person reporting change

3. Ensure they have received MA renewal paperwork. Refer to KYC if needing assistance. KeepYourCoverage@ucare.org

4. Consistently address MA renewals at 6 mo/mid-year updates and Annuals. Provide education about the importance of MA renewals at assessments and supports available.

Gaps in Care Reports – coming Summer 2023!

What is a Gap in Care? A gap in care is a missing preventative care measure identified using claims information for Connect + Medicare and MSHO members.

How are they useful? Gaps in care reports provide claims information about preventative care services like: PCP AWV, colonoscopy, mammograms, diabetic preventative visits completed over the past 12 months. If an item appears on the GAP report it means the person has not completed the preventative care measure – thus has a GAP IN CARE. When there is evidence of a claim for a preventative care measure – the gap is closed.

Why are they important? Closing a gap in a member's care helps ensure the member is receiving optimal medical care.

Early detection of disease can improve health outcomes by getting access to treatment and care early. CCs help ensure members understand what preventative care needs the member may have and help members overcome barriers they have to completing.

Knowledge is Powerful!
The more you know the better equipped you are to assist your members!

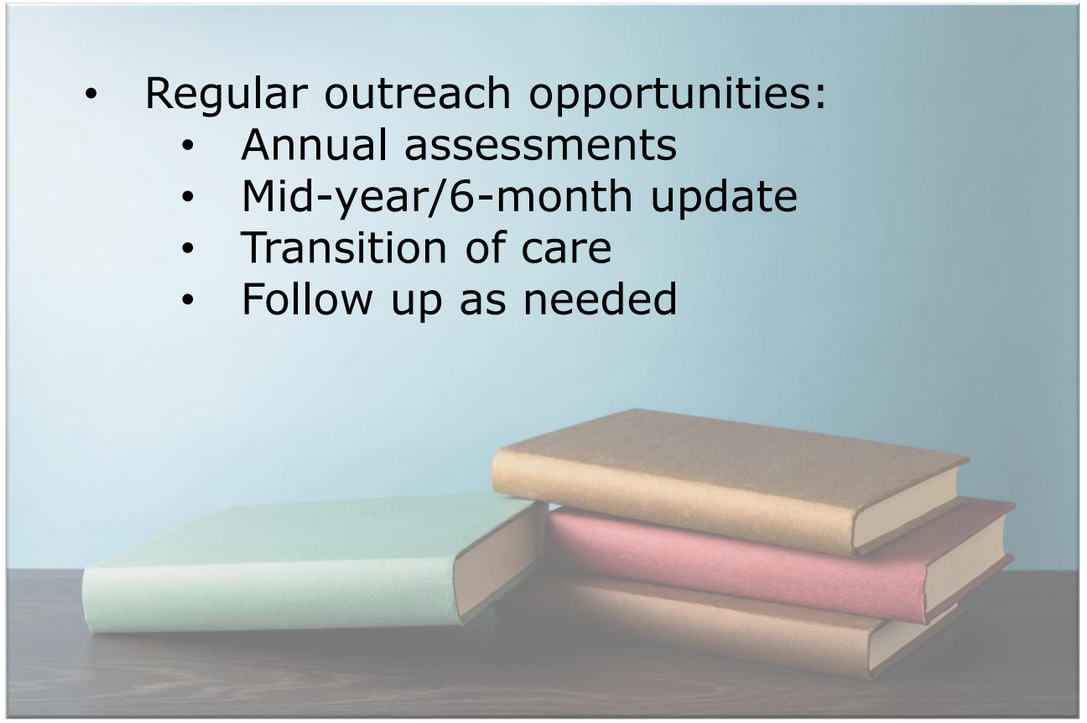
Tangible Support Using Gaps in Care Reports

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

- HRA
  - Physical Health
  - Preventative Care
  - Vision
- Care Plan/Support Plan
  - Managing and Improving My Health section
  - My Goals
  - Barriers to achieving goals

Prepare for a visit: **MSHO/Connect + Medicare**

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



Quality Reviews

UCare’s Quality Review Team conducts annual real-time reviews using the current Requirements Grids. Quality Reviews are supplemental to the annual audits conducted by UCare’s Compliance department. We aim to highlight CC's areas of strength and provide resources in areas that could be improved. Review results will help gauge trainings, job aids, and other communication across all UCare Care Coordinators.

Review period: 3-6 months, depending on enrollment roster.

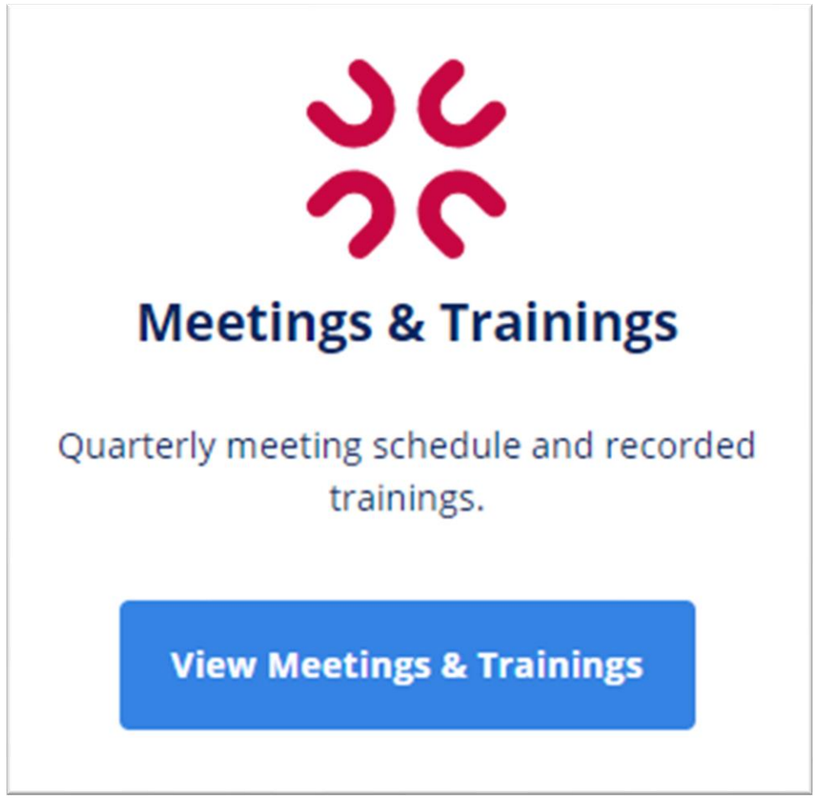
Number of charts: No more than 10-20 files per product.

Who is notified of an upcoming QR: The delegate leaders will get an email.

Other FAQs:

- QR provides real-time reviews and feedback.
- Do not alter/"scrub" charts before sending.
- QR do not result in CAPs. QR helps to have awareness of overall performance and prevent future DHS audit CAPs.
- QR Team is intended to be supportive and educational.
- A follow up meeting is scheduled with leadership to give results, feedback, and resources.

Care Coordination Recorded Trainings



Quarterly Meetings:

- Access to previous Care Coordination Quarterly Meetings with links to recordings and PowerPoint slides

Other Care Coordination Trainings:

- Navigating Your Enrollment Roster Using Excel
- UCare SNBC 101 Care Coordination Training
- SMART Goals
- Transitions of Care (TOC) Training
- Advanced Directives Training
- NEW! Fairview Caregiver Assurance Training

How to Find Answers to Common Questions

Your Clinical Liaison team is available to help you be a successful UCare care coordinator. We ask that you review any internal resources or check with leadership staff as appropriate/available ahead of reaching out to the Clinical Liaisons.

UCare Resources

Requirements Grids – source of truth for UCare care coordination expectations

Customer Service can assist with ordering member ID cards, questions about MA coverage/benefits, claims information and intake of appeals & grievances

MSC_MSHO_ClinicalLiaison@ucare.org for:

- Advise regarding EW coverage and benefits and MSC+/MSHO care coordination questions, training and education

SNBCClinicalLiaison@ucare.org for:

- Advise regarding Connect/Connect+ care coordination questions, training and education

Wellness@ucare.org for:

- Member rewards/incentive vouchers, Healthy Savings, One Pass, Member Kits (example: dental kits)

CLSIntake@ucare.org for:

- Waiver Service Authorizations and other medical prior authorizations

CMIntake@ucare.org and **ConnectIntake@ucare.org** for:

- Member bi-monthly enrollment discrepancies and/or questions

SecurityLiaison@ucare.org for:

- MMIS, MnSP, MnCHOICES access requests and password resets

Public Health Emergency and MSC+ and MSHO Care Coordination

As it relates to MSC+/MSHO unable to reach and refusal members, the April 11, 2023 AASD and DSD eList announcement states the following:

Annual reassessment instructions

Lead agencies must complete annual reassessments when due according to waiver/AC policies on CBSM – Assessment applicability and timelines. All people will have their reassessment completed based on the date of their last assessment or reassessment. Lead agencies cannot change reassessment dates simply to align with MA financial renewal dates.

For any annual reassessment completed beginning in May 2023 that has an effective date of July 1, 2023, or later, the person must meet all waiver/AC eligibility criteria in order to continue on the program. If the person no longer meets all waiver/AC eligibility criteria at reassessment, the lead agency must close the waiver/AC program no earlier than the first day after the end of their current waiver/AC span. For additional information, refer to CBSM – Temporary waiver exits and restarts: MMIS actions. Lead agencies must provide advanced notice (refer to CBSM – Notice of action) and follow all other requirements.

As it relates to retuning to face-to-face for assessments, the April 4, 2023 eList announcement states the following:

Case management face-to-face requirements resume Nov. 1, 2023

Beginning Nov. 1, 2023, lead agencies must meet minimum case management face-to-face requirements for people using:

- Alternative Care (AC) program
- Brain Injury (BI) Waiver
- Community Access for Disability Inclusion (CADI) Waiver
- Community Alternative Care (CAC) Waiver
- Developmental Disabilities (DD) Waiver
- Elderly Waiver (EW)
- Essential Community Supports (ECS) program.

This applies to people whose waiver year ends on or after Nov. 1, 2023.

Care Coordination Satisfaction Survey

Care coordination satisfaction survey will be sent out by SurveyMonkey today and will be open through July 7, 2023.

Responses are anonymous.

We review all responses and take them back to the appropriate internal teams for review.

MSHO/MSC+ Care Coordination Requirements Grids Updates

What's new or changing for Requirements Grids effective 7/1/2023:

- Welcome Letter to be used for all Product Changes
- Two attempts needed to reach members/responsible party when completing TOC tasks
  - Reduced from four
- Verbiage changed from "6 Month Review" to "Mid-Year Review"
- Tasks upon admissions over 30 days, distinguished nursing facility vs. hospital days of stay
- Institutional annual preventative care follow up activities
- New CC's tasks when a transfer does not include Care Plan Signature Page
- Added criteria of when the PCC Change should not be initiated

Significant updates are highlighted in YELLOW

Coming soon:

- MnCHOICES MSHO/MSC+ Community Requirements Grid
  - This requirements grid will outline the expectations for MSHO/MSC+ assessments and support plans completed in the MnCHOICES platform.

Connect and Connect + Medicare Care Coordination Requirements Grid Updates

What's new or changing:

- Face to Face vs Telephone HRA requirements clarified
- THRA timeline extended to 60 days from day one of month of enrollment or transfer
- THRA expanded use for other MCO to UCare SNBC transfers
- Welcome letter to be used for all product changes
- Clarification on UTR/Refusal 6-month contacts
- Two attempts needed to reach members/responsible party when completing TOC tasks (reduced from four)
- Significant updates are highlighted in YELLOW

An additional requirements grid will be ready to post for MnCHOICES launch. The existing grid will remain in effect until the soft launch is complete and all HRAs are done in MnCHOCIES.

- Completing an HRA in MnCHOICES?
  - Use the MnCHOICES requirements grid
- Completing an HRA on the 3428H edoc?
  - Us the current Connect/Connect + Medicare Requirements Grid

UCare Special Investigations Unit (SIU)

Mena Xiong, Senior Investigator and Training Specialist
Rebecca Lozano, Senior Investigator

UCare SIU – Purpose and Definitions

SIU's Mission: *The prevention, detection and investigation of potential fraud, waste or abuse (FWA) by providers or members for all lines of business.*

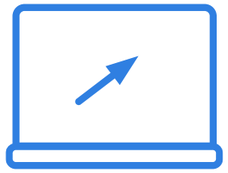
Fraud, Waste and Abuse Program | Policy Number: CCD001

- **Fraud:** An intentional deception or misrepresentation made by a person with knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes an act that constitutes fraud under applicable federal or state law.
- **Waste:** Over-utilization of services and the misuse of resources that are not caused by fraud or abuse.
- **Abuse**: A pattern of practice that is inconsistent with sound fiscal, business, or medical practices.

UCare SIU – Reporting Suspected FWA

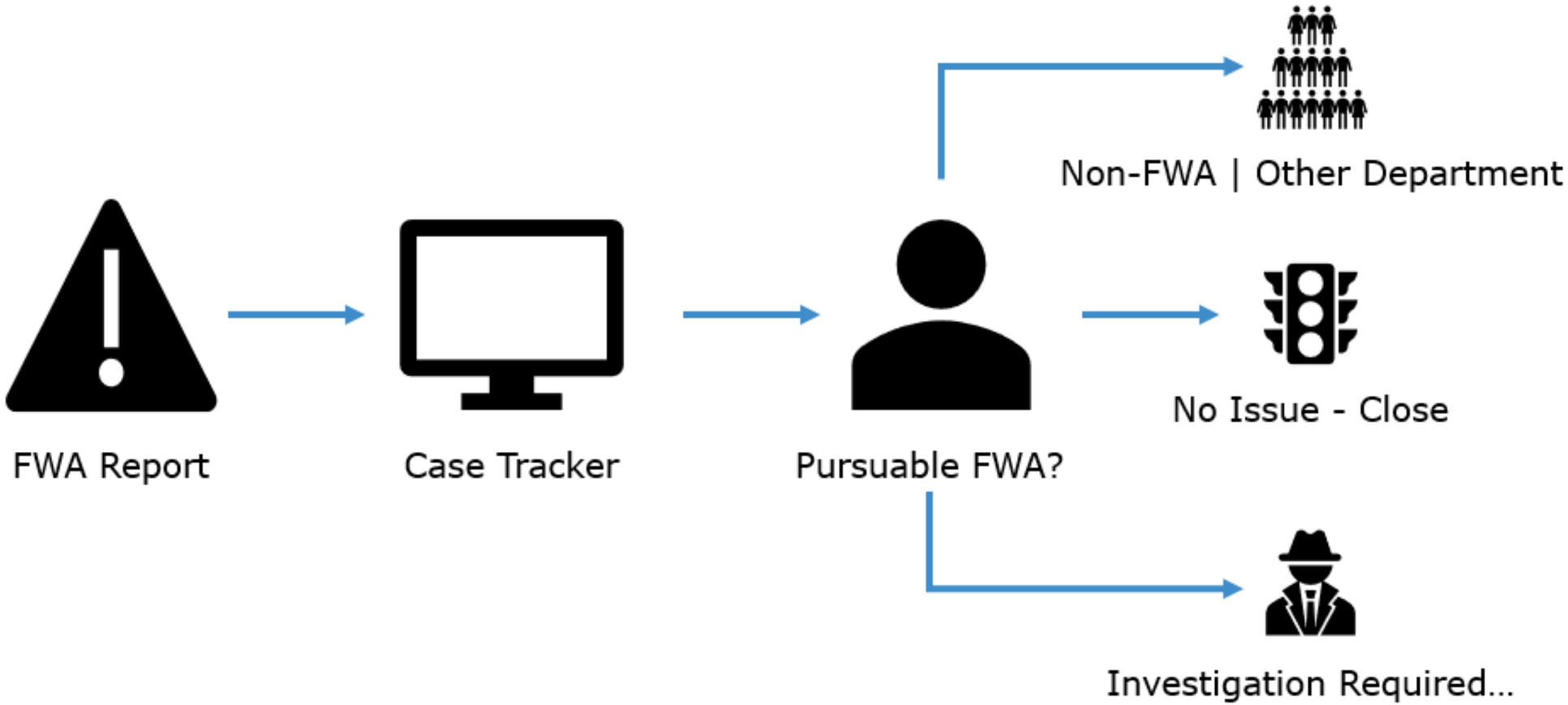
Compliance Hotline: (877) 826-6847

Compliance Email: compliance@ucare.org



UCare Hub Site (Internal Only): Tools > Report a Compliance/FWA/Privacy Incident

UCare SIU – Triage Process



UCare SIU - Investigation

10 Investigators

Backgrounds Include:

- Social Workers
- Data Analysis
- Pharmacy Techs
- Healthcare Investigators

SIU Tools

- Claims
- Internal Systems, i.e.
  - Guiding Care
- External Systems, i.e.
  - FWA Analytics
  - Search Tools
- Other Business Areas
- Record Requests/Review
- Law Enforcement
- On-Sites
- Surveillance
- Interviews

Potential Outcomes

- No Findings of FWA
- Education
- Referral to Other Department
- Corrective Actions
- Payment Suspension
- Referral to Regulator(s)
- Referral to Law Enforcement

Referrals from Care Coordination to SIU

- SIU welcomes any referrals from Care Coordination. Examples of previous referrals include:
  - Services not being rendered to members as reported
  - Possible overlapping services a member is receiving
  - Discrepancies in services shown on Explanation of Benefits mailings
  - Discrepancies in services rendered vs. authorized services

- Submitting a referral to UCare's SIU does NOT replace any necessary mandated reporting actions

When in doubt, submit!

What to Expect from SIU

- During Investigation:
  - Reporting Party may be contacted to clarify information submitted to SIU
  - Reporting Party may be contacted by SIU for member's best contact information
  - Reporting Party may be contacted for experience with member and/or provider
- Resolutions:
  - Activities and findings of an investigation are confidential
  - Clinical Services may be contacted to transition a member(s) as part of a provider no longer being able to provide services
  - Clinical Services may be contacted for outreach to member of investigation findings, if deemed necessary

QUESTIONS?

THANK YOU!

Quality Initiative Updates

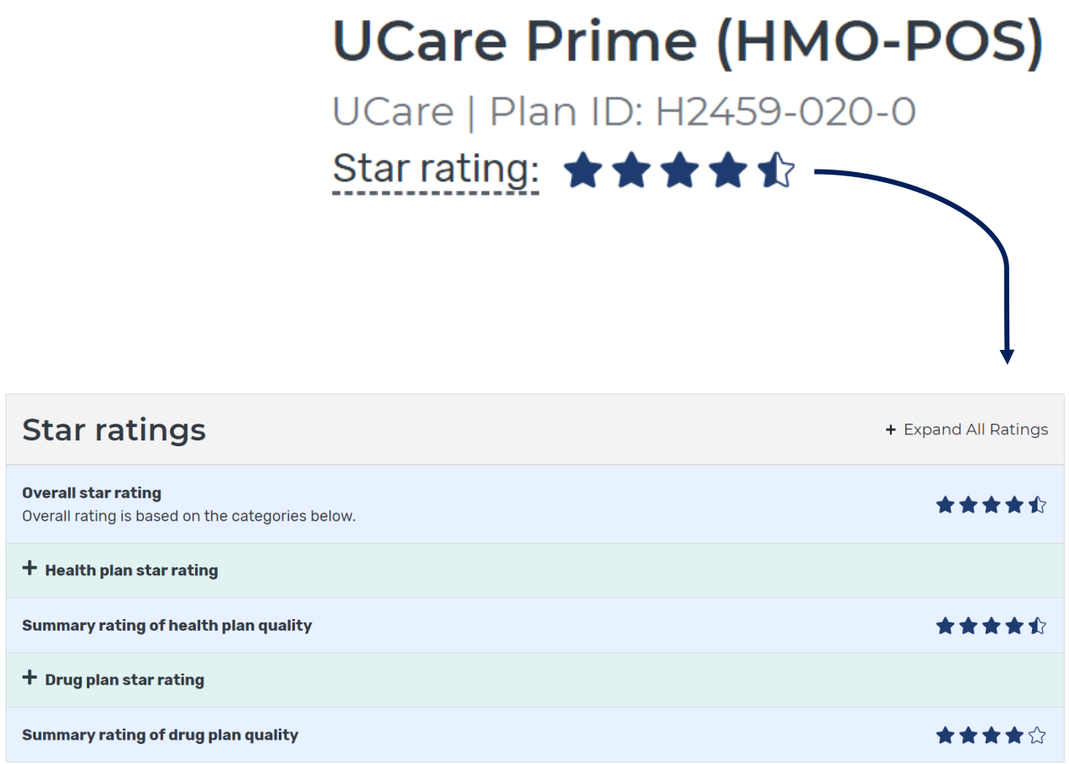
June 2023

Star Program Overview

Mai Vang

CMS Star Ratings

- 5 Star rating system that provides quality and performance information to Medicare beneficiaries to assist them in choosing a plan during fall open enrollment period.
- Issued in October annually, reflecting mostly performance from year prior.
- Currently 40 measures on clinical quality, customer satisfaction and other beneficiary experience areas.
- Measures have different weights and change and evolve.
- Quality Bonus Payments issued to plans with 4+ Stars.



Overall Ratings

Product	Prior Year Star Rating	Current Star Rating
UCare Medicare	5.0	4.5
MSHO	4.5	3.5
Connect Plus Medicare	4.0	4.0
EssentiaCare	4.0	4.0
UCare Medicare with M Health Fairview and North Memorial	No Rating / Not Enough Data	No Rating / Not Enough Data
Aspirus	No Rating / Too New	No Rating / Too New

Where Care Coordination Can Help

Utilization

- ✓ Avoiding preventable readmissions
- ✓ Follow-up after discharge
- ✓ Health Risk Assessments (HRAs)

Member Experience

- ✓ Eliminate member barriers
- ✓ Promote & refer member access to chronic disease management programs
- ✓ Promote & enroll members in benefit offerings

Preventative Care

- ✓ Help member recognize importance of routine, preventative care
- ✓ Cancer screenings
- ✓ Annual wellness visits

Health Improvement Team

Patag Xiong

Areas Health Improvement Impacts

POPULATION HEALTH

STAR RATINGS

NCQA ACCREDITATION

PERFORMANCE IMPROVEMENT PROJECTS

RFPS FOR NEW STATES AND BUSINESS

DHS WITHHOLD PERFORMANCE

STRATEGIC PLAN

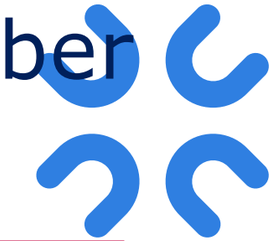
Health Improvement Webpage

Health Improvement Team

- Education on preventive care, including annual wellness visits, dental exams and immunizations (shots)
- Information on the importance of preventive care, diabetes, cancer and high blood pressure screenings
- Assistance with scheduling doctor/specialty preventive care appointments and other services
- Provide community resource and referrals to address member social needs

https://www.ucare.org/health-wellness/health-management/health-improvement-team

Data Strategies to Reduce Duplication and Member Abrasion



De-duplicate members from other outreach efforts, partnerships or value-based contracts.

Utilize language, race/ethnicity, metro or rural, SDoH risk factor.

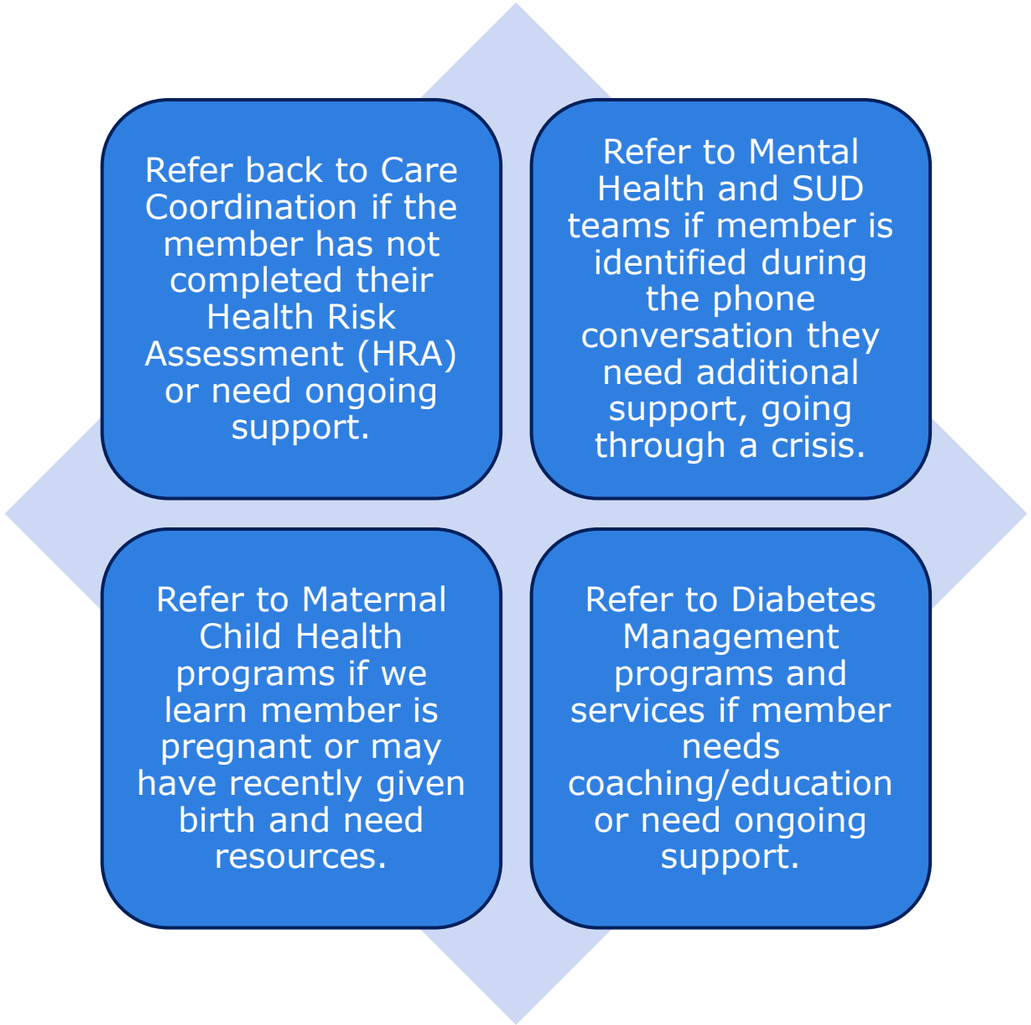
Focus on members with multiple gaps in care.

Approach by shared household/families for outreach.

Aligning outreach with member's language and/or background, if possible.

Focus areas may change for HI team as we review data trends with measures.

Examples of Internal referrals



Connecting a Member

We have a diverse team of 9 staff with backgrounds in member engagement, CHW and Nursing. Some staff are Somali, Hmong and Spanish speaking.

When to refer a member to the HI team?

- When any members need assistance – with health education, scheduling appointment needs, navigating the healthcare system, including connecting on member benefits, UCare health programs, ordering incentive forms, materials and wellness kits.
- When you need additional support with connecting members to social services – finding and making referrals for food, housing, transportation and any other community resources aligning with the member needs or cultural/ethnic background.

Where can you find the HI team?

- Doing targeted outreach and engagement calls.
- Collaborating across UCare and community partnerships to support various member-related projects and initiatives.
- In community at events to engage, provide health education, and on-site assistance for members.

Health Improvement Contact Information:

Please reach out if you have questions or would like to connect!

Call 612-676-3481 or 833-951-3185

Email directly at outreach@ucare.org

Osteoporosis Program

Cindie Kouame

Osteoporosis Screening Measure (OMW)

Percentage of women 67-85 years of age who suffered a fracture and had either a bone mineral density (BMD) test or received a prescription to treat osteoporosis within six months of the fracture

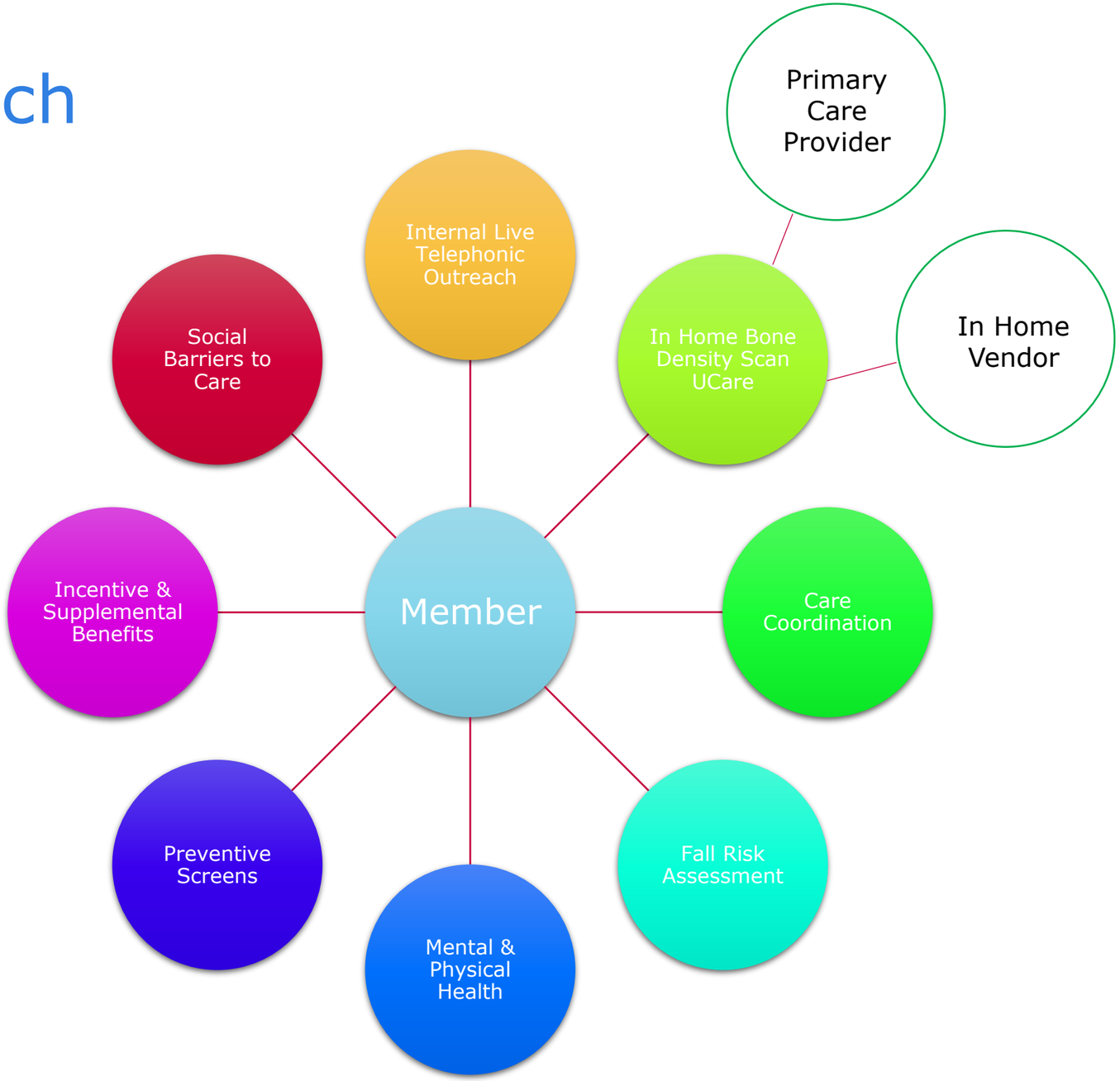
Measurement Year (MY): July – June

- 2024 Star Rating Year (SR2024)
  - Fracture: July 1, 2021 – June 30, 2022
  - Scans: July 1, 2021 – December 31, 2022
- 2025 Star Rating Year (SR2025)
  - Fracture: July 1, 2022 – June 30, 2023
  - Scans: July 1, 2022 – December 31, 2023

Strategy

- Telephonic Outreach Internally
- Connect to PCP or Vendor
- Vendor In Home Visits
- Sends Completed Scans

New Approach



Data Trends

Product	2020 Rate	2021 Rate	2022 Rate (rotation)	2023 Rate	2024 Rate
UCare Medicare – Medicare Advantage Plan 65+	37%	37%	37%	40%	38%
MSHO (D-SNP) – 65+ Special Needs Plan	33%	33%	32%	29%	29%

* SRY2024 Projections don't yet include Quest Diagnostic events as these scans appear as lab results requiring chart chases rather than Medicare claims.

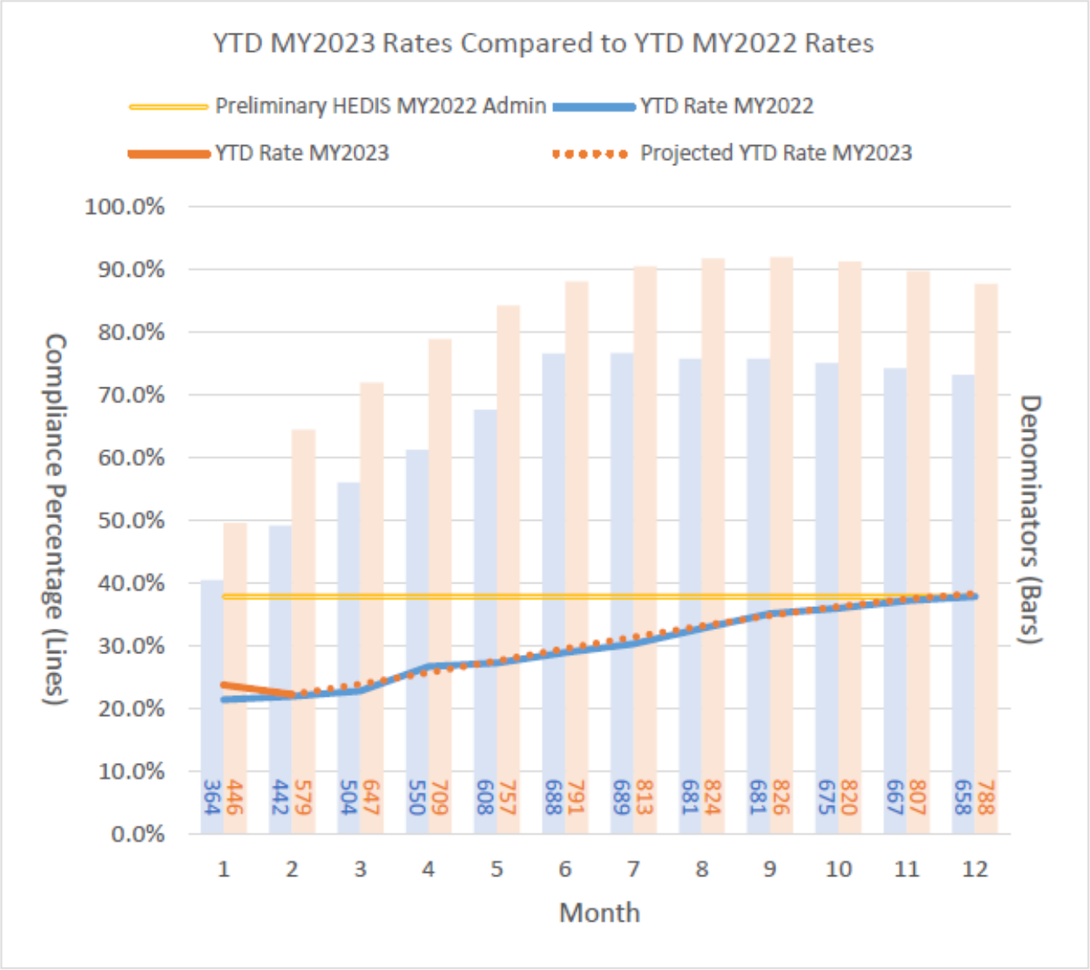
** SRY2025 projections based on Jan-Feb 2023 data and previous years' trends.

2023 Star Cut Points Key				
1 Star	2 Star	3 Star	4 Star	5 Star
Under 32	32	45	55	73

UCare Medicare OMW Trends

	Numerator	Denominator	Rate	Star Rating
Projected YTD MY2023 Closeout	299	788	38%	2
YTD MY2022 Closeout	249	658	38%	2
Preliminary HEDIS MY2022 Admin	249	658	38%	2
Projected HEDIS MY2022 Hybrid	N/A	N/A	N/A	N/A
Projected Final HEDIS MY2023 Hybrid	--	--	N/A	N/A
YTD MY2023 Month 2	129	579	22%	1
YTD MY2022 Month 2	97	442	22%	1

Not a Hybrid Measure



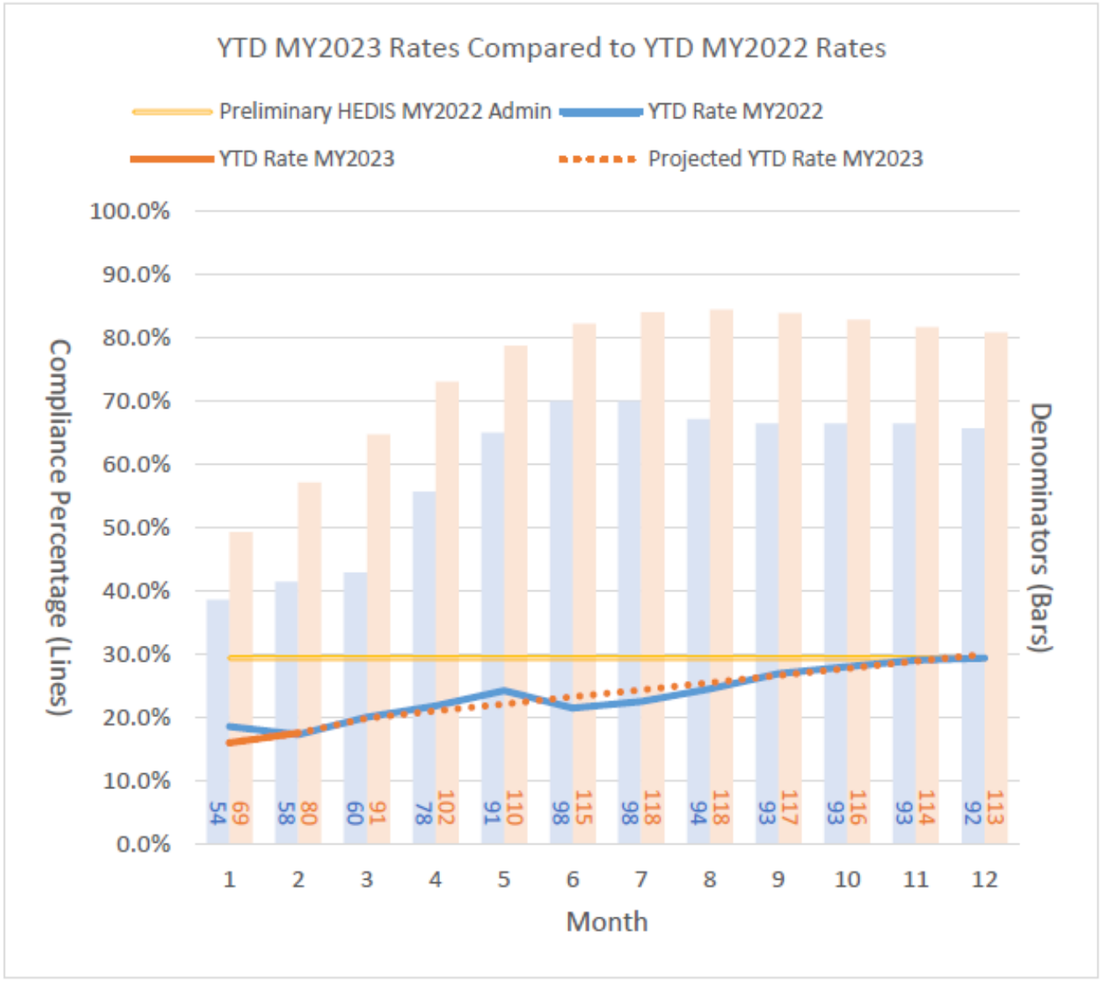
Star Ratings	Current Cutpoints	Projected Cutpoints	Projected NNT
5	73%	73%	276
4	55%	55%	134
3	45%	45%	56
2	32%	32%	-48

NNT - Number needed to treat

MSHO OMW Trends

	Numerator	Denominator	Rate	Star Rating
Projected YTD MY2023 Closeout	34	113	30%	1
YTD MY2022 Closeout	27	92	29%	1
Preliminary HEDIS MY2022 Admin	27	92	29%	1
Projected HEDIS MY2022 Hybrid	N/A	N/A	N/A	N/A
Projected Final HEDIS MY2023 Hybrid	--	--	N/A	N/A
YTD MY2023 Month 2	14	80	18%	1
YTD MY2022 Month 2	10	58	17%	1

Not a Hybrid Measure



Star Ratings	Current Cutpoints	Projected Cutpoints	Projected NNT
5	73%	73%	49
4	55%	55%	29
3	45%	45%	17
2	32%	32%	3

NNT - Number needed to treat

Cologuard Screening

Tara Nyugen and Mai Xiong

Cologuard Screening Overview

- *Cologuard is a new initiative for colorectal cancer screenings, in partnership with Exact Sciences, with anticipated roll out later this year (Summer 2023)

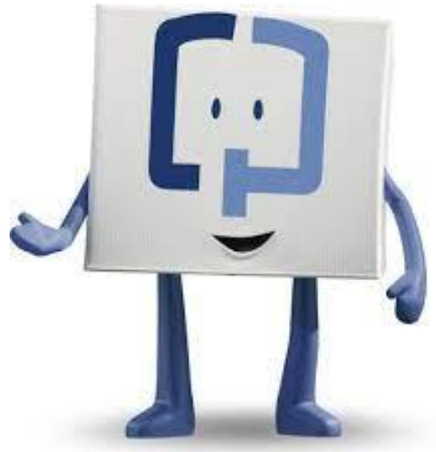
- **Benefits**

❖ Can be completed in place of a colonoscopy and in the comfort of member's home

❖ Covered as a preventative health benefit with no out-of-pocket cost to the member

❖ Repeated every 3 years as compared to annually with FIT Kit

❖ Results are provided to the member, provider (if available), and health plan



*If your member is interested in receiving a Cologuard Kit please contact UCare via this mailbox to request: Outreach@ucare.org

Cologuard Kits are not eligible for rewards and incentives

Adult Center Program

Mai Vang

2023 Program Overview

- **Goal**
  - Decrease gaps in care
    - Annual Wellness
    - Annual Dental
    - Cancer Screenings
    - Diabetes Eye, Kidney, and HBA1c
    - Medication Adherence
  - Improve member understanding of screenings and access
  - Increase member community resources

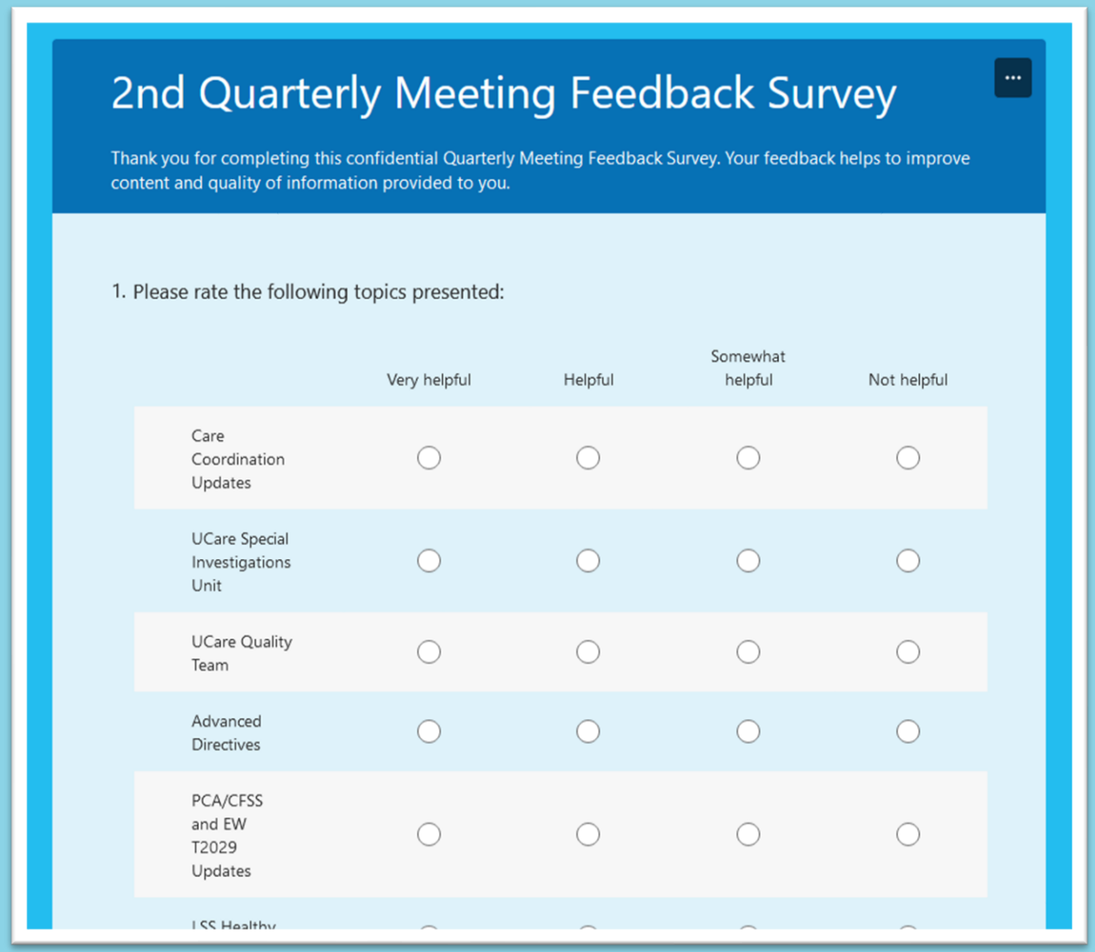
- **4 Metro Adult Day Center**
  - Member Action List
  - Onsite Support
  - Education Event

- **Products:** MSHO/MSC+

Questions!

Thank you for your feedback!

Electronic survey feedback form!



2nd Quarterly Meeting Feedback Survey

Thank you for completing this confidential Quarterly Meeting Feedback Survey. Your feedback helps to improve content and quality of information provided to you.

1. Please rate the following topics presented:

	Very helpful	Helpful	Somewhat helpful	Not helpful
Care Coordination Updates	○	○	○	○
UCare Special Investigations Unit	○	○	○	○
UCare Quality Team	○	○	○	○
Advanced Directives	○	○	○	○
PCA/CFSS and EW T2029 Updates	○	○	○	○
LSS Healthy				

PCA and EW Updates

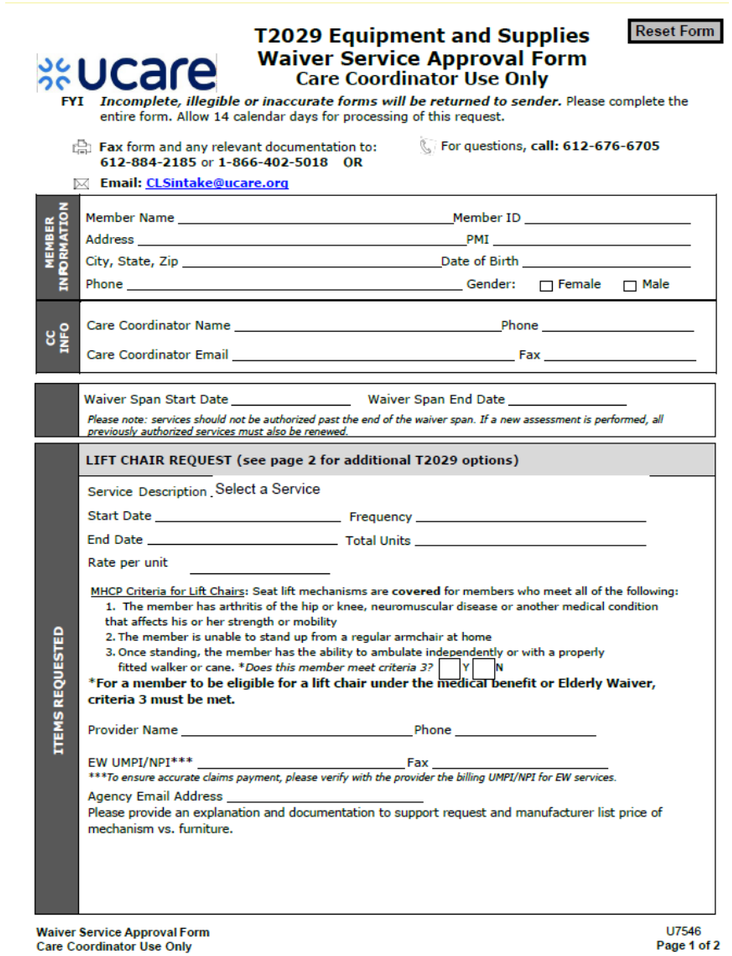
Rebecca Ormonde
Esther Versalles-Hester

PCA/CFSS Updates

- No updates at this time, CMS has not provided an approval of the CFSS program.
- UCare and its project managers continue to monitor the status and will provide updates and communication, as necessary.

- Electronic Visit Verification (EVV) for PCA has been implemented and providers are now required to report PCA visits via the HHAX system.
  - UCare will monitor provider compliance as future plans in 2024 include claims integration and potential denials due to lack of visit verification.

Changes to Elderly Waiver Approvals



T2029 Equipment and Supplies
Waiver Service Approval Form
Care Coordinator Use Only

Reset Form

ucare

FYI ***Incomplete, illegible or inaccurate forms will be returned to sender.*** Please complete the entire form. Allow 14 calendar days for processing of this request.

Fax form and any relevant documentation to: **612-884-2185** or **1-866-402-5018** **OR**
Email: CLSintake@ucare.org

For questions, **call: 612-676-6705**

MEMBER INFORMATION

Member Name _____ Member ID _____
Address _____ PMI _____
City, State, Zip _____ Date of Birth _____
Phone _____ Gender: ☐ Female ☐ Male

CC INFO

Care Coordinator Name _____ Phone _____
Care Coordinator Email _____ Fax _____

Waiver Span Start Date _____ Waiver Span End Date _____
Please note: services should not be authorized past the end of the waiver span. If a new assessment is performed, all previously authorized services must also be renewed.

ITEMS REQUESTED

LIFT CHAIR REQUEST (see page 2 for additional T2029 options)

Service Description Select a Service
Start Date _____ Frequency _____
End Date _____ Total Units _____
Rate per unit _____

MHCP Criteria for Lift Chairs: Seat lift mechanisms are **covered** for members who meet all of the following:
1. The member has arthritis of the hip or knee, neuromuscular disease or another medical condition that affects his or her strength or mobility
2. The member is unable to stand up from a regular armchair at home
3. Once standing, the member has the ability to ambulate independently or with a properly fitted walker or cane. **Does this member meet criteria 3?* ☐ Y ☐ N

***For a member to be eligible for a lift chair under the medical benefit or Elderly Waiver, criteria 3 must be met.**

Provider Name _____ Phone _____
EW UMPI/NPI*** _____ Fax _____
****To ensure accurate claims payment, please verify with the provider the billing UMPI/NPI for EW services.*
Agency Email Address _____
Please provide an explanation and documentation to support request and manufacturer list price of mechanism vs. furniture.

Waiver Service Approval Form (continued)

ITEMS REQUESTED

SERVICE AGREEMENT

Service Description Select a service
Start Date _____ Frequency _____
End Date _____ Total Units _____
Rate Per Unit _____
Item HCPCS code (if applicable): _____
Item meets coverage criteria for MA, Medicare, other payer or TPL*? ☐ Y ☐ N
**Durable medical equipment with HCPCS codes should be verified for coverage under Medicare, MA, or other insurance payer prior to submission under Elderly Waiver. If member qualifies for a DME item under DHS medical criteria, the requested item must be submitted under the medical benefit first.*
Provider Name _____ Phone _____
EW UMPI/NPI** _____ Fax _____
****To ensure accurate claims payment, please verify with the provider the billing UMPI/NPI for EW services.*
Agency Email Address _____
Please provide an explanation and documentation to support request, including qualifying diagnosis if applicable. (If adjusting authorization due to case mix change, DTR is required. For all other changes to existing authorizations, specific details required.) Members residing in Customized Living do not qualify for continence wipes.

ITEMS REQUESTED

SERVICE AGREEMENT

Service Description Select a service
Start Date _____ Frequency _____
End Date _____ Total Units _____
Rate Per Unit _____
Item HCPCS code (if applicable): _____
Item meets coverage criteria for MA, Medicare, other payer or TPL*? ☐ Y ☐ N
**Durable medical equipment with HCPCS codes should be verified for coverage under Medicare, MA, or other insurance payer prior to submission under Elderly Waiver. If member qualifies for a DME item under DHS medical criteria, the requested item must be submitted under the medical benefit first.*
Provider Name _____ Phone _____
EW UMPI/NPI** _____ Fax _____
****To ensure accurate claims payment, please verify with the provider the billing UMPI/NPI for EW services.*
Agency Email Address _____
Please provide an explanation and documentation to support request, including qualifying diagnosis if applicable. (If adjusting authorization due to case mix change, DTR is required. For all other changes to existing authorizations, specific details required.) Members residing in Customized Living do not qualify for continence wipes.

Notes: T2029 – Supplies/Equipment: Please refer to EOC.
This approval form does not guarantee payment; benefits are subject to eligibility at the time service is being rendered.

- UCare has created a new authorization form specific to Elderly Waiver (EW) equipment and supplies
- 1st page: specific to Lift Chair and the medical criteria
- 2nd page: all other T2029 items
- If item meets coverage criteria under medical, the item must be requested under medical first
- If requesting a medical device where coverage criteria not met, please provide explanation and/or documentation to support request

LSS Healthy Transitions Service

A Lutheran Social Service of Minnesota program in partnership with UCare

June 2023

Lutheran Social Service of Minnesota

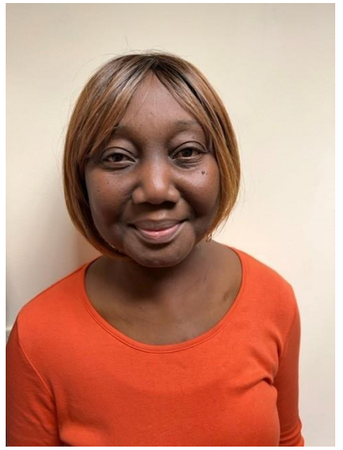
Lutheran Social Service of Minnesota

Meet Our Healthcare Team

Jenny Sannes, CHW

Katie Davis
Admin Support Specialist

Utee Moua, CHW



Oretha Nimley, CHW

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

Complementary to the Work of Care Coordinators

- This benefit supports the work of Care Coordinators and other services that are already in place for members.
- Our service does not replace the role of a Care Coordinator.
- Our goal is to reduce overall readmissions.
- This benefit is time sensitive.
- Ability to see what is going on in home within 72 hours upon notification of discharge and report back to Care Coordinator with comprehensive case notes after each visit

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

Personal Health Record (PHR)

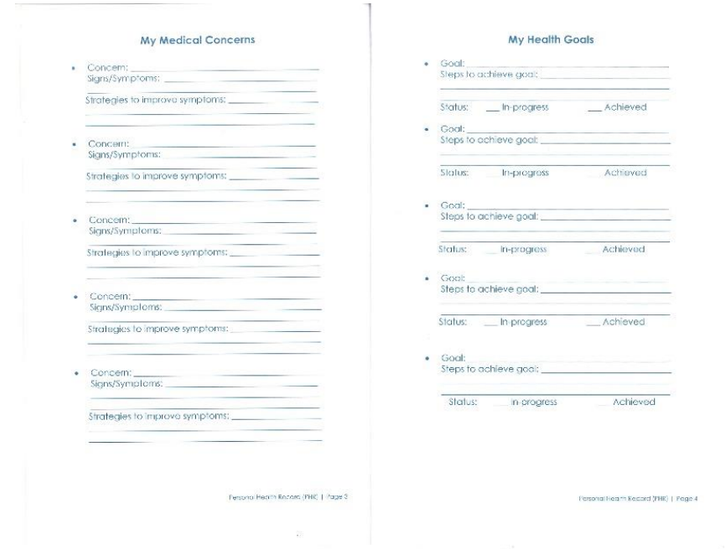
Complete Medication Review/Inventory

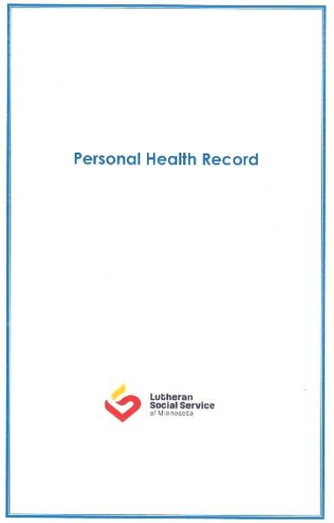
- ✓ Review discharge orders
- ✓ Medication questions

Discuss and Capture

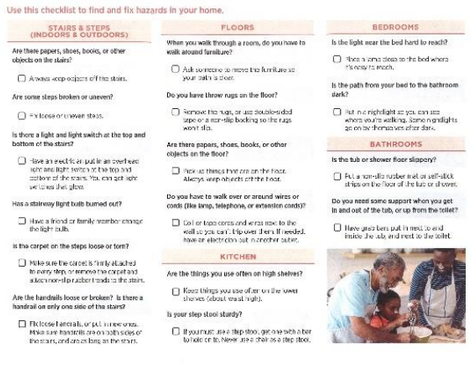
- ✓ Upcoming appointments
- ✓ transportation
- ✓ Health related goals and concerns

PHR is Left with member at end of visit





Home Safety Assessment


Use this checklist to find and fix hazards in your home.

STAIRS & STEPS (INDOORS & OUTDOORS)

Are there papers, shoes, books, or other objects on the stairs?

☐ Always keep objects off the stairs.

Are some steps broken or uneven?

☐ Fix loose or uneven steps.

Is there a light and light switch at the top and bottom of the stairs?

☐ Have an electrician put in an overhead light and light switches at the top and bottom of the stairs. You can get light switches that glow.

Has a stairway light bulb burned out?

☐ Have a friend or family member change the light bulb.

Is the carpet on the steps loose or torn?

☐ Make sure the carpet is firmly attached to every step, or remove the carpet and add non-slip rubber treads to the stairs.

Are the handrails loose or broken? Is there a handrail on only one side of the stairs?

☐ Fix loose handrails, or put in new ones. Make sure handrails are on both sides of the stairs, and are not too high or too low.

FLOORS

When you walk through a room, do you have to walk around furniture?

☐ Ask someone to move the furniture in your path to a room.

Do you have throw rugs on the floor?

☐ Remove the rugs, or use double-sided tape or a non-slip backing so the rugs won't slip.

Are there papers, shoes, books, or other objects on the floor?

☐ Pick up things that are on the floor. Always keep objects off the floor.

Do you have to walk over or around wires or cords (like lamp, telephone, or extension cords)?

☐ Coil or tape cords and wires next to the wall so you can't trip over them. If needed, have an electrician put in another outlet.

KITCHEN

Are the things you use often on high shelves?

☐ Keep things you use often on the lower shelves (about waist high).

Is your step stool sturdy?

☐ If you must use a step stool, get one with a bar to hold on to. Never use a chair as a step stool.

BEDROOMS

Is the light near the bed hard to reach?

☐ Place a lamp close to the bed where it's easy to reach.

Is the path from your bed to the bathroom dark?

☐ Put a nightlight so you can see where you're walking. Some nightlights go on by themselves after dark.

BATHROOMS

Is the tub or shower floor slippery?

☐ Put a non-slip rubber mat or self-stick strips on the floor of the tub or shower.

Do you need some support when you get in and out of the tub, or up from the toilet?

☐ Have grab bars put in next to and inside the tub, and next to the toilet.

- CDC - STEADI (Stopping Elderly Accidents, Deaths, and Injuries) Check for Safety
- Checklist to identify potential safety hazards in the home:
  - Stairs and steps, floors, kitchen, bathrooms, bedroom
- Check for Safety is left with member at end of visit

Nutrition Review

- Ensure the following:
  - Member has access to nutritional foods
  - Member is eating regularly
  - Member is satisfied with their nutritional situation
  - Connect to resources as necessary

Lutheran Social Service of Minnesota

Community Resources

- Dependent on member's location and needs
- Provide Senior Linkage Line information, UCare health ride information, United Way 211, LSS Services
- Community Health Worker will discuss potential resources with Care Coordinator

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.

Data Collection – LSS Healthy Transitions

FROM LUTHERAN SOCIAL SERVICE

Number of visits completed

Pre-service survey

Post-service survey

Satisfaction survey

Lutheran Social Service of Minnesota

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

Questions?

Connect/Connect + Medicare: SNBCClinicalLiaison@ucare.org 612.676.6625

MSHO/MSC+: MSC_MSHO_Clinicalliaison@ucare.org 612.294.5045