UCare MSHO/MSC+
Care Coordination 4th Quarterly

December 12th and 13th 2018
Agenda

• Welcome
• 2019 Benefit Changes-Robert Burkhardt
• STARS-Cindy Radke
• Disease Management-Liz Sperr/Marie Sherwood
• Model of Care-Bobbi Jo Glood
• Care Coordination Survey-Bobbi Jo Glood
• MSHO/MSC+ Member Satisfaction Survey-Bobbi Jo Glood
• Care Coordination Updates-Dawn Sulland
• HEDIS-Chelsey Doepner
• Q & A
2019 MSHO
Supplemental Benefit Changes

Dec 2018 Care Coordination Training
MSHO Supplemental Benefits

- Continuing Supplemental Benefits:
  - Silver Sneakers health club benefit, fitness kits, FLEX classes
  - Strong & Stable falls prevention kits
  - Preventive service incentives (colon cancer, mammogram)
  - Community Education discount ($15)
  - Whole Health Living discounts
2019 MSHO Dental Benefits

- **Scaling and root planning (D4341 and D4342)**
  - Once every two years and allowing it in an office setting.

- **Additional dental exam (D0120)**
  - 1 additional per calendar year.

- **Full mouth series (x-ray) (D0210)**
  - Once per five years (MHCP only covers panoramic)
- **Periodontal maintenance (D4910)**
  - Up to 4/year
- **Molar root canal (D3330)**
  - Once per tooth per lifetime.
- **Root canal re-treatment (D3346, D3347, D3348)**
  - One re-treat per lifetime per tooth. Only covered if billed 24 months after original root canal.
- **Crown (D2750)**
  - **One** Porcelain Fused to High Noble Metal (PFM) crown per year
- **Electric Toothbrush**, 2 replacement heads
2019 MSHO Supplemental Benefits

- **Transportation to health club** (3x / wk) – bus encouraged, but other modes allowed

- **Readmission prevention:**
  - Post-discharge medication reconciliation
  - Limited meals (non-EW) up to 4 weeks (authorization)

- **Routine foot care** (1/mo) – podiatrist
2019 MSHO Supplemental Benefits

- **Personal Emergency Response System** (PERS) (non-EW) –
  - authorization required
  - history / risk of falls dx

- **Nutrition Counseling** (5/yr) –
  - Dietitian / nutritionist
  - No condition requirement
  - No provider referral required
2019 MSHO Supplemental Benefit for Non-EW Members

Additional detail for limited meals and PERS coverage for members who do not meet nursing home level of care / qualify for EW:

Care Coordinators should:

• Discuss these new benefits with MSHO members at the annual LTCC assessments.

• If approved an authorization is required via the “MSHO Supplemental Benefit Authorization Request” form for claims payment purposes.
  – The form is located on the UCare website.

• As a reminder, these services are for MSHO members who do not meet level of care for EW services but can benefit from these supplemental services.

Care Coordinators are to continue to assess and open members up to EW as appropriate.
Pharmacy Benefit Changes

• MSHO and Connect Plus Medicare will utilize the same formulary as other UCare Medicare plans in 2019
  – Uses 1 tier format instead of 5 tier format
  – Same formulary status for Part D drugs
• MSHO will keep same OTC formulary and benefit for 2019 – have added over 1400 OTCs
• MSHO and Connect+ will maintain the same open pharmacy network that is in place in 2018
Stars Update

December, 2018
And drumroll please………. 

• MSHO is a 4 Star plan!!!!

• UFS remains 4.5 Star plan!!!!

• Connect + Medicare 3 Star plan

• This is our 2019 ratings!
Where are we at?

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>MSHO</td>
<td>3.268 3.5 Stars</td>
<td>3.578 3.5 Stars</td>
<td>3.778 4 Stars</td>
<td>4.25 4.5 Stars</td>
</tr>
<tr>
<td>C + M</td>
<td>NA</td>
<td>NA</td>
<td>3.230 3 Stars</td>
<td>3.75 4 Stars</td>
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</table>

- **MSHO**: Improved by .2 for an overall score of **3.778**, rounding up to **4 Stars**

- **UFS**: Improved .06 for an overall score of **4.605**, rounding up to **4.5 Stars**. This is .15 away from our 2020 5 Star goal.

- **Connect + Medicare**: Opportunity for improvement overall score **3.230**, rounding to **3 Stars** and 0.02 away from 3.5 Stars
## MSHO 2017 – 2018 YTD Comparison

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<tbody>
<tr>
<td></td>
<td></td>
<td>2 Star</td>
<td>3 Star</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>64% (2 Star)</td>
<td>2 Star</td>
<td>-51</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>68% (3 Star)</td>
<td>3 Star</td>
<td>-722</td>
</tr>
<tr>
<td>Adult BMI Assessment</td>
<td>96% (4 Star)</td>
<td>5 Star</td>
<td>-1,153</td>
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<tr>
<td>Osteoporosis Management in Women Who Had a Fracture</td>
<td>33% (2 Star)</td>
<td>2 Star</td>
<td>-8</td>
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<tr>
<td>Care for Older Adults: Medication Review</td>
<td>91% (4 Star)</td>
<td>3 Star</td>
<td>-5,107</td>
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<td>Care for Older Adults: Functional Status Assessment</td>
<td>92% (5 Star)</td>
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<tr>
<td>Care for Older Adults: Pain Assessment</td>
<td>96% (4 Star)</td>
<td>5 Star</td>
<td>-3,775</td>
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<tr>
<td>CDC - Eye Exam (Retinal) Performed</td>
<td>81% (5 Star)</td>
<td>4 Star</td>
<td>-666</td>
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<tr>
<td>CDC - Medical Attention for Nephropathy</td>
<td>93% (3 Star)</td>
<td>3 Star</td>
<td>-44</td>
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<tr>
<td>Controlling High Blood Pressure</td>
<td>71% (3 Star)</td>
<td>3 Star</td>
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<td>Medication Reconciliation Post-Discharge</td>
<td>38% (2 Star)</td>
<td>3 Star</td>
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<td>CDC – Blood Sugar Controlled</td>
<td>81% (4 Star)</td>
<td>N/A</td>
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<td>Plan All Cause Readmissions</td>
<td>11% (1 Star)</td>
<td>N/A</td>
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<tr>
<td>Care Management</td>
<td>84% (4 Star)</td>
<td>N/A</td>
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## UFS 2017 – 2018 YTD Comparison

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<tr>
<td></td>
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<td>2 Star</td>
<td>3 Star</td>
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<tr>
<td>Breast Cancer Screening</td>
<td>78% (4 Star)</td>
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<tr>
<td>Colorectal Cancer Screening</td>
<td>79% (5 Star)</td>
<td>4 Star</td>
<td></td>
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<tr>
<td>Adult BMI Assessment</td>
<td>95% (4 Star)</td>
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<td>Osteoporosis Management in Women Who Had a Fracture</td>
<td>36% (2 Star)</td>
<td>3 Star</td>
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<td>CDC - Eye Exam (Retinal) Performed</td>
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<td>3 Star</td>
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<tr>
<td>Controlling High Blood Pressure</td>
<td>79% (4 Star)</td>
<td>4 Star</td>
<td></td>
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<tr>
<td>Medication Reconciliation Post-Discharge</td>
<td>55% (3 Star)</td>
<td>4 Star</td>
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<tr>
<td>CDC – Blood Sugar Controlled</td>
<td>79% (4 Star)</td>
<td>N/A</td>
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<tr>
<td>Plan All Cause Readmissions</td>
<td>10% (3 Star)</td>
<td>N/A</td>
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</tbody>
</table>

**Breast Cancer Screening**

- 2019 Star Rating: 78% (4 Star)
- Projected Star Rating 2020: 4 Star
- Projected Number Needed to Treat: 645

**Colorectal Cancer Screening**

- 2019 Star Rating: 79% (5 Star)
- Projected Star Rating 2020: 4 Star
- Projected Number Needed to Treat: 358

**Adult BMI Assessment**

- 2019 Star Rating: 95% (4 Star)
- Projected Star Rating 2020: 4 Star
- Projected Number Needed to Treat: 612

**Osteoporosis Management in Women Who Had a Fracture**

- 2019 Star Rating: 36% (2 Star)
- Projected Star Rating 2020: 3 Star
- Projected Number Needed to Treat: 210

**CDC - Eye Exam (Retinal) Performed**

- 2019 Star Rating: 79% (4 Star)
- Projected Star Rating 2020: 4 Star
- Projected Number Needed to Treat: 293

**CDC - Medical Attention for Nephropathy**

- 2019 Star Rating: 95% (3 Star)
- Projected Star Rating 2020: 3 Star
- Projected Number Needed to Treat: 293

**Controlling High Blood Pressure**

- 2019 Star Rating: 79% (4 Star)
- Projected Star Rating 2020: 4 Star
- Projected Number Needed to Treat: 1,395

**Medication Reconciliation Post-Discharge**

- 2019 Star Rating: 55% (3 Star)
- Projected Star Rating 2020: 4 Star
- Projected Number Needed to Treat: 381

**CDC – Blood Sugar Controlled**

- 2019 Star Rating: 79% (4 Star)
- Projected Star Rating 2020: N/A
- Projected Number Needed to Treat: N/A

**Plan All Cause Readmissions**

- 2019 Star Rating: 10% (3 Star)
- Projected Star Rating 2020: N/A
- Projected Number Needed to Treat: N/A
Part C assessment reporting

- Common issues with reports in 2018:
  - Putting 2018 dates in the 2017 column.
    - For 2019 logs, only indicate the last 2018 assessment in the appropriate column.
    - If multiple assessments in one year, we will capture on the respective logs for that month.
  - Not indicating assessment type
  - Not providing your delegate name
  - Work being done, not being entered on the logs

- Ensure December logs are turned in by **January 10th**

- Requests for clarifications will be in January.
- File requests will come in April for CMS data validation audit.
Assessment log changes for 2019

In effort to streamline logs:

- Removing drop down choice of Termination

- Removing CCDB and Health Plan change-
  - THRA and 3428H option available.

- Removing the column regarding MMIS entry.
Some of what UCare did this year!
What is being worked on in 4\textsuperscript{th} quarter?

- Have a member engagement vendor Welltok
  - Live agent calls to MSHO and CTM members going on now!
  - Making appointments-so far outreached to over 7,000 members and have made over 700 appointments for various measures!
  - Will be utilizing for various call campaigns-live and auto calls in 2019.
  - November 27\textsuperscript{th} IVR calls to start for Flu reminders – will also collect contact preferences.

- Outreach to members who were mailed in-home test kits end of July for colon cancer screening.

- Outreach to members who are in need of osteoporosis testing – live calls to get remaining members in before end of year.

- Assessment reporting data for SNP Assessment reporting measure
Some of the work coming in 2019

• Continued work with Vendor Med XM to target members in need of osteoporosis testing and in-home fit kit mailings.
  – Incentives in place
  – Continued outreach
• Welltok vendor for outreach calls scheduled throughout 2019.
• MDH work to start with targeted clinics for outreach on BCS, Diabetes, CRC, and Annual Wellness visits to start. Targeting immigrant populations.
• Continued work with Clinic and County partners for innovative strategies.
• Med Rec post discharge
• Continued efforts from our Care Coordination partners to improve our preventive care rates with our members!
Disease Management

MSHO 2018 Meetings
Member Engagement Specialist
Stephanie Carlson
Supports asthma, diabetes and heart failure

Health Coaching
Health Coach: Diabetes and Heart Failure
Marie Sherwood: Diabetes and Migraine
Melissa Horning: Integrated Coaching and Migraine

Asthma Educators
Linda Bell: Telephonic asthma case management
Asthma Educator: In home asthma assessments and telephonic case management
Disease Management Programs

- Diabetes
- Heart Failure
Disease Management Program Identification

- **Program identification**
  - **Daily:**
    - Emergency department/hospitalization admission notification
    - Referrals: self, provider, case manager, other caregiver
  - **Monthly:**
    - Claims and pharmacy utilization
    - HRA completer letters
  - **Quarterly:**
    - Predictive modeling report
Diabetes
Diabetes Program Eligibility

- **At-risk Diabetes program (Warm Health):**
  - Members 18-75 diagnosed with diabetes & enrolled in UCare for at least 11 mos
  - Dispensed insulin or oral medication in the last 12-25 months and/or
  - Two office visits with a diagnosis of diabetes in the last 12-24 months and/or
  - One ED/IP for diabetes within the last 12-24 months
  - Products: all products
  - Exclusions: Members in Long Term Care Facilities, on hospice or have ESRD

- **High-risk Diabetes program (Health Journey):**
  - Members 18-75 diagnosed with diabetes & enrolled in UCare for at least 11 mos
  - Recent ED/IP for diabetes
  - Trigger an alert from IVR indicating need for more in-depth diabetes support
  - Products: all products
  - Exclusions: Members in Long Term Care Facilities, on hospice or have ESRD
Program offerings
- Scheduled IVR education calls OR
- New! Text Messaging education messages
- Two diabetes care related questions per call/text (yes/no response)
  - Condition monitoring and medical testing
  - Members “alert” if response indicates they require follow-up by a HC

Target Population
- Adults

Program Overview
- Full program: 1 call/text a week
- Maintenance program: 1 call/text every 60 days
Diabetes: High-Risk (Health Journey)

- Program offerings
  - Regularly scheduled health coaching calls with a UCare Health Coach
- Target Population
  - Adults
- Program Overview
  - Partner with member to discover barriers, vision for future, establish short & long-term behavior change goals, empower to achieve goals.
  - Utilize active listening, motivational interviewing, behavior change techniques
  - PCP notified when member enrolls
  - Program tools:
    - **Health Journey book covering:**
      - Clinic visit planning form, medication lists
      - Topics: living well, nutrition, cholesterol, healthy heart, diabetes, kidney care, COPD
    - **Behavior change tools:** pedometer, diabetic bracelets, cookbooks
  - Exclusions: members in Long Term Care facilities, on hospice or have a diagnosis of ESRD or on dialysis
Diabetes: Referral Triggers

- Referral Triggers:
  - Not compliant with medications or diabetic testing
  - Unsure of medications (purpose, names, etc.)
  - Does not identify with a PCP
  - ER use for any kind of medical assistance
  - Discusses failures to make health modifications in the past
Success Story

- Female; smoker; grief stricken due to unexpected death in family; depressed; homeless, living in shelter; emotional/stress eater; pain issues with knee and hip; morbidly obese; sleep apnea, not using c-pap; not following up with doctor for preventive visits/other medical needs

- **3 month goals:**
  - Bariatric surgery within 3 months to get back on weight loss plan
  - Calling physician to get back on track with plan
  - Calling to get new sleep study to get back on track with c-pap
  - Quit smoking
  - Will have seen physicians, dieticians and counselors
1. Member quit smoking by following plan to reduce tobacco use/nicotine gradually
2. Member reports greater energy, endurance and lung stamina now
3. Member lost 20 lbs by choosing to eat vegetables and fruits and by cutting out junk food
4. Member walks halls, stairs & outside. Can go up stairs without stopping, walks 2-3 blocks without getting overly winded. Intentionally moves more in her day to stay active daily.
6. Eating smaller portions daily now.
7. Blood sugars are in the 90s with metformin only verses insulin.
8. Member has seen her physician in follow-up for A1c and to restart her bariatric plan.
9. Member enrolled in classes at shelter to help her with transition to new housing.
10. Member attends cooking classes at the shelter.
11. Member is no longer in state of grief and depression has improved through coaching process, counseling and group support.
12. Greater self-reported self-confidence, self-efficacy, improved mood & depression has lessened.
13. Restarted counseling required for bariatric plan. Attends group work at shelter for support.
Heart Failure
# Heart Failure: At-Risk (Healthy Hearts)

At-Risk Heart Failure program (Healthy Hearts):

- Weight bearing members
- Ages 18-89 years old
- Less than 2 heart failure ED/IP events in the past 15 months
- Current HF symptoms cause:
  - No limitation of physical activity
  - Slight limitation of physical activity
- Products: all products
- Exclusions: members in Long Term Care facilities, on hospice or have a diagnosis of ESRD or on dialysis
Heart Failure: At-Risk (Healthy Hearts)

- **Program offerings**
  - Telephonic health coaching with a UCare health coach

- **Program Overview**
  - Partner
  - Set personal health behavior goals (i.e. to lower sodium, weight tracking, fluid retention plan)
  - PCP receives notification when member enrolls in the program
  - Program tools:
    - Health Journey book covering:
      - Clinic visit planning form, medication lists
      - Topics: living well, nutrition, cholesterol, heart attack, stroke, healthy heart, diabetes, kidney care, COPD
    - Behavior change tools: bathroom scale, wrist blood pressure cuff
Heart Failure: High-Risk (Medtronic)

High-risk Heart Failure program (Medtronic):
- Members regardless of weight bearing status.
- Age 18 and older
- MSHO members, regardless of utilization
- More than 2 heart failure ED/IP events in the past 15 months
- Current HF symptoms cause:
  - Marked limitation of physical activity
  - Severe limitation of physical activity
- Products: all products
- Exclusions: members in Long Term Care facilities, on hospice or have a diagnosis of ESRD or on dialysis
Heart Failure: High-Risk (Medtronic)

- **Program Overview**
  - A talking scale to assess daily weight and HF symptoms via Q & A
    - Available in English, Hmong, Spanish
  - Member data transmitted to Medtronic RN for triage, assessment and follow up
    - If member data suggests a flare up of HF PCP is contacted
  - Monthly RN calls
    - Education on HF, co-morbid condition(s) and lifestyle management
    - Stars preventive measure reminders
  - PCP notified when member enrolls in the program
  - Additional info: DM team has Medtronic dashboard access to view member activity
Heart Failure: Referral Triggers

- Referral Triggers:
  - Not compliant with medications or daily weight check ins
  - Unsure of medications (purpose, names, etc.)
  - Frequent pneumonia and respiratory infections
  - Excessive salt and fluid intake
  - Does not identify with a PCP
  - ER use for any kind of medical assistance
Success Story

- Female, 76
- Diagnoses: CHF, HTN, CAD, Afib, heart attack, high cholesterol, arthritis, sleep apnea
- Enrolled after ER/IP event
- Member goals: To learn about HF, low salt diet and how to safely incorporate exercise.
- Main concerns: devastated/shocked/disbelief with new diagnosis of CHF; initially didn’t want to use HF terminology; wants to feel better to do things she enjoys; wants to reduce anxiety of feeling like her heart may not hold out; overwhelmed with shopping for low salt foods and realized she needed to make changes.
- At graduation: confident with shopping for groceries, preparing meals and exercising routinely (joined SilverSneakers, has friend to exercise with)
Program Referrals
Program Referral Process

- Members can self refer by calling DM phone line

- Email
  - Member name
  - Member number
  - Program topic (asthma, diabetes or heart failure)
  - In Outlook we are disease_mgmt

- Referral Form
  - https://ucare.org/providers/Resources-Training/Pages/DiseaseManagement.aspx
DM Contact Information

- **Phone Line**
  - 612.676.6539
  - 1.866.863.8303

- **Email**
  - [DM_educ@ucare.org](mailto:DM_educ@ucare.org)

- **Fax**
  - 612.884.2467
Care Coordination Satisfaction Survey

Thank you all for taking the time to complete the survey.

- 309 responses to:
  - Questions regarding care coordination, training, notifications, audits, enrollment, authorizations
Please rate your satisfaction with day-to-day responses to your questions/concerns in the following areas within Clinical Services.
How would you rate the following resources to MSHO, MSC+ and UCare Connect products?
How satisfied are you with the content and clarity of the following?
What we are doing!

- Evaluating the phone numbers, recorded messages, and prompts within the Clinical Services Department.

- Provided feedback for the new website:
  - Dates are being added to identify when a document is updated
  - Too many “clicks” to get somewhere
  - Enhance search function

- 2019 Supplemental benefits will be shared at the 4th Quarterly.

- Process improvement discussions on Care Coordination Enrollment Rosters will begin 1st quarter of 2019.
MSHO and MSC+ Member Satisfaction Survey

DECEMBER 2018
Survey Overview

Objective:
- Assess member satisfaction with care coordination
- Improve care coordination based on member feedback

Topic areas:
- Satisfaction with Care Coordinator
- Satisfaction with Care Plan
- Satisfaction with Care Coordination in General
Distribution

- Random distribution of surveys
  - Community members surveyed
  - Members in care coordination at least a year
  - 28% response rate for MSHO
  - 14% response rate for MSC+
## Overall Results

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<thead>
<tr>
<th>Most member coordinator</th>
<th>MSHO</th>
<th>MSC+</th>
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<tbody>
<tr>
<td>I know who my care coordinator is and how to contact them</td>
<td>86%</td>
<td>85%</td>
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<tr>
<td>My CC is respectful</td>
<td>91%</td>
<td>84%</td>
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<tr>
<td>Overall satisfaction with CC</td>
<td>93%</td>
<td>93%</td>
</tr>
<tr>
<td>CC makes it easier to stay in home – yes or sometimes</td>
<td>76%</td>
<td>85%</td>
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<tr>
<td>My CC asks for input into care plan</td>
<td>83%</td>
<td>70%</td>
</tr>
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Summary

- Response rates improved from 2017
- Most response rates to individual questions similar to 2017 or slightly improved
- Most members satisfied with care coordinator and care plan development
- Majority of members indicate CC works with them to improve health
Opportunities for Improvement

- Continued focus on member input into care plan
- Person centered focus
- Keep up the good work!
Questions/Comments
UCare Model of Care
Minnesota Senior Health Options (MSHO)
&
UCare Connect + Medicare
2018
UCare’s Model of Care (MOC)

- Overall goal of the MOC:
  - 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.
UCare Special Needs Plans (SNP)

- Minnesota Senior Health Options (MSHO):
  - The MSHO program serves elderly members who are dually eligible for Medicare and Medical Assistance and are 65 years or older.

- Special Needs Basis Care (UCare Connect + Medicare):
  - The UCare Connect + Medicare Program serves members with disabilities who are dually eligible for Medicare and Medical Assistance under the age of 65.
Ucare Special Needs Plans

- Integrated products combining Medicaid & Medicare
  - Parts A, B & D (pharmacy)
  - Members have one ID card
  - One phone number to call for health plan questions

- Over 14,000 members currently enrolled
  - 12,250 with MSHO
  - 1,780 with UCare Connect + Medicare
Why does UCare have a MOC?

- Required by CMS & DHS & has four components:
  - Population description & characteristics
  - Care Coordination details
  - Provider Network to ensure adequate access
  - Quality Measures & Process Improvement goals

- It helps provide:
  - Appropriate access to primary & specialty care providers
  - Integrates care coordination based on a member’s Health Risk Assessment
  - Ensures members receive individualized care plans
  - Encourages and provides care transition support to members & families
Care Coordination

- The care coordinator (CC) coordinates care and services for the member which includes:
  - Face-to-face Health Risk Assessment (HRA) annually which is used to evaluate members’ health risks, gaps in care and quality of life.
  - An individualized, person centered care plan.
  - Facilitating access to affordable care such as: medical, preventive, mental health and social services.
  - Communicating with the Interdisciplinary Care Team (ICT), a team of professionals involved with the member to coordinate and provide health care services.
- Care Coordinators are Qualified Professionals
  - Registered Nurses, Nurse Practitioners and Social Workers
Care Transition Protocols

- The care coordinator assists 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 nursing facility
  - Goal is improved transitions to reduce fragmented care and avoid re-hospitalizations.
Provider Network

- UCare’s provider network meets a wide range of needs.
- The network includes, but is not limited to:
  - Primary care providers
  - Specialists
  - Primary and specialty clinics
  - Dental providers
- The member may receive care from any contracted provider without referral.
- Model of Care training is offered annually to all providers, delegates and UCare employees.
Clinical Practice Guidelines (CPGs)

- UCare adopts clinical practice guidelines to support good decision-making by patients and clinicians to improve health care outcomes, and meet state and federal regulatory requirements.

- CPGs are available on our provider website.
UCare collects and analyzes data and reports from a variety of sources to:

- Annually evaluate the Model of Care.
- Identify improvements to be made for our members.
Summary

- Care Coordination is one component of our care model.
- UCare has two products with care coordination services – MSHO & UCare Connect + Medicare which currently serves around 14,000 members.
- Care coordinators work with members, families and providers on transitions of care with a goal of reducing re-admissions.
- UCare uses data and reports to evaluate the Model of Care annually.
UCare Contacts

- Provider Assistance Center
  - Phone: 612-676-3300

- Clinical Liaison
  - 612-294-5045
  - clinicalliaison@ucare.org
Care Coordination Updates
When to Call Customer Service

- Care Coordinators or Members should call Customer Service when there are questions about their plan or coverage.
  - Customer Service has the ability to look at the member’s individual coverage and provide accurate information on their plan and what could possibly be covered.
- Phone: 612-676-3395
Delta Dental Update

• Delta Dental of Minnesota is changing the names of its dental networks. Effective January 1, 2019.

• CivicSmiles is becoming Minnesota Select Dental.
  – This network is used by UCare Minnesota Health Care Programs members. It is also used by UCare Individual & Family Plan members.

• CivicSmiles Senior is becoming Delta Dental Medicare Advantage.
  – This network is used by UCare Medicare Plan members.

• Please visit dentalcareforu.org for additional information on UCare dental benefits.
Elderly Waiver Service Provider Change Requests

In the event that a provider, e.g. an adult day care provider, reaches out to a care coordinator requesting an increase in services or stating that they are the new provider for the member, the care coordinator is required to reach out to the member to discuss changes to their services. If there is an addition or increase in services there should be documentation indicating the need for the additional services or increase in services.

- Any changes to elderly waiver providers or need for a change to the level of services should be initiated by the member and discussed with the care coordinator.
Transferring members from one delegate to another delegate

Before transferring a member, think – “what would I want in a transfer scenario?” To ensure continuity of care the following documents MUST be provided to the receiving delegate:

- Completed:
  - DHS-6037: Case Management Transfer and Communication Form
  - LTCC, MnCHOICES assessment, or DHS-3428H
  - Collaborative Care Plan, UCare Connect Care Plan, CSSP or CSP.

- Signed signature page of the Collaborative Care Plan, UCare Connect Care Plan, CSSP, or CSP

- OBRA Level 1, if applicable

- Waiver Service Approval Forms (WSAF), if applicable

- Additional documents as appropriate: Residential Services Tool/Workbook; PCA Assessment with signed signature page; DHS-3428Q: Person’s Evaluation of Foster Care, Customized Living, or Adult Day Service

- Please refer to the requirement grids for all transfer information.
Elderly Waiver Care Coordination
Monthly Rate

• For members on Elderly Waiver the Collaborative care Plan Home and Community Based Service and Support Plan/Budget Worksheet should always include Care Coordination/Case Management as a service with $180 total cost per month.
CDCS Rate Change Process

DHS implemented a 8.89% rate increase for CDCS for Elderly Waiver members effective January 1, 2019. The DHS-6633A Community Support Plan Addendum should be used to notify EW CDCS participants of the 8.89% increase in their CDCS budgets.

• The Care Coordinator will need to identify members who are receiving CDCS services and complete the following prior to January 1, 2019.
  - Complete the DHS-6633A following all directions in the form – including signatures
  - Review and update the POC
  - Complete a new Waiver Service Approval form and send to UCare at CLSIntake@ucare.org or by fax at 612-884-2185
  - Update member record and attach DHS-6633A

For more information refer to Bulletin 18-25-06 MN Legislature authorizes rate and budget increases for Elderly Waiver, Alternative Care, and Essential Community Supports.
2019 MSHO/MSC+ Care Coordination Requirements Grids

- The MSHO/MSC+ Community and Institutional Requirements grids will be updated and effective 1.1.19.
- All changes are highlighted in yellow.
- We will be sending out the grids in December to provide you time to review and ask clarification question.
WebEx’s Available

- Advanced Directives
- Care Coordination Enrollment, Daily Authorization and Reports
- Smart Goals
- Transitions of Care

These are located on the UCare website in “Care Coordination Trainings” in the “Care Coordination Topics” drawer.
Clinical Liaisons

- 612.294.5045
- clinicalliaison@ucare.org
HEDIS 2019 Care Coordinator Request

December 13th and 14th, 2018

Chelsey Doepner, UCare HEDIS Manager
What is HEDIS

- Healthcare Effectiveness Data and Information Set
- 90% of American Health plans use HEDIS data to benchmark plan performance against national and state quality levels.
- Standard apples to apples measurements
- All populations report HEDIS: Medicare, Medicaid and Commercial
- UCare uses HEDIS internally to focus improvement efforts
- Annual data collection is January to May for the year that just ended.
- HEDIS 2019 is measuring 2018 patient care.
HEDIS Measures from Care Coordination – MSHO Only

1. **Advanced Care Planning** Evidence of a document or discussions in the measurement year (2018). Obtained from the Comprehensive Care Plan.

2. Evidence of a **Pain Assessment** in the measure year (2018). Obtained from the Comprehensive Care Plan.


4. A Physician, Nurse Practitioner, or PharmD signed **Medication List** from any time during the measure year (2018.)
How can you help?

• Requests will be sent to counties/delegates for information that supporting measures in approx. early February.

• Provide the following information:
  – LTCC/HRA completed during 2018
  – Care plan including completed signature page and date summary sent to PCP.
  – Provide all documents in separate format.
  – Refusal/unable to reach members you can just notify by email.
  – If institutional member provide:
    • ICCD
    • MDS Assessment
    • Signed Medication review
    • LTCC or POC as above if resided in community at any point during the year.
Timeline for Request

- Initial Request Letter will be sent no later than:
  
  *February 2\textsuperscript{nd}, 2019*

- We need complete documentation or notification of refusal by:
  
  *February 15\textsuperscript{th}, 2019*

- We know it’s a tight turnaround, but your support is critical to scoring well on this Stars HEDIS measure! Every piece of information can help!

- How many members? Some may have none, some may have 2 and some may have 20. The sampling is random and UCare will not know until late January, early February.
Commonly Asked Questions

- Do you need the refusal care plan? No
- Do you need to replace refused members with another member? No
- What if I get a member who is not mine? Please just let the HEDIS Manager (Chelsey) know. If you do have 2018 data though, please send it even if the member is not yours.
- What if my member is institutional? If you receive a request for an institutional member and can provide us any of the document please do.
Questions?

Chelsey Doepner, HEDIS Manager

Cdoepner@ucare.org or qualityrecords@ucare.org

Phone and Secure Voicemail: 612-294-5674
Secure Fax: 612-884-2275
Questions?