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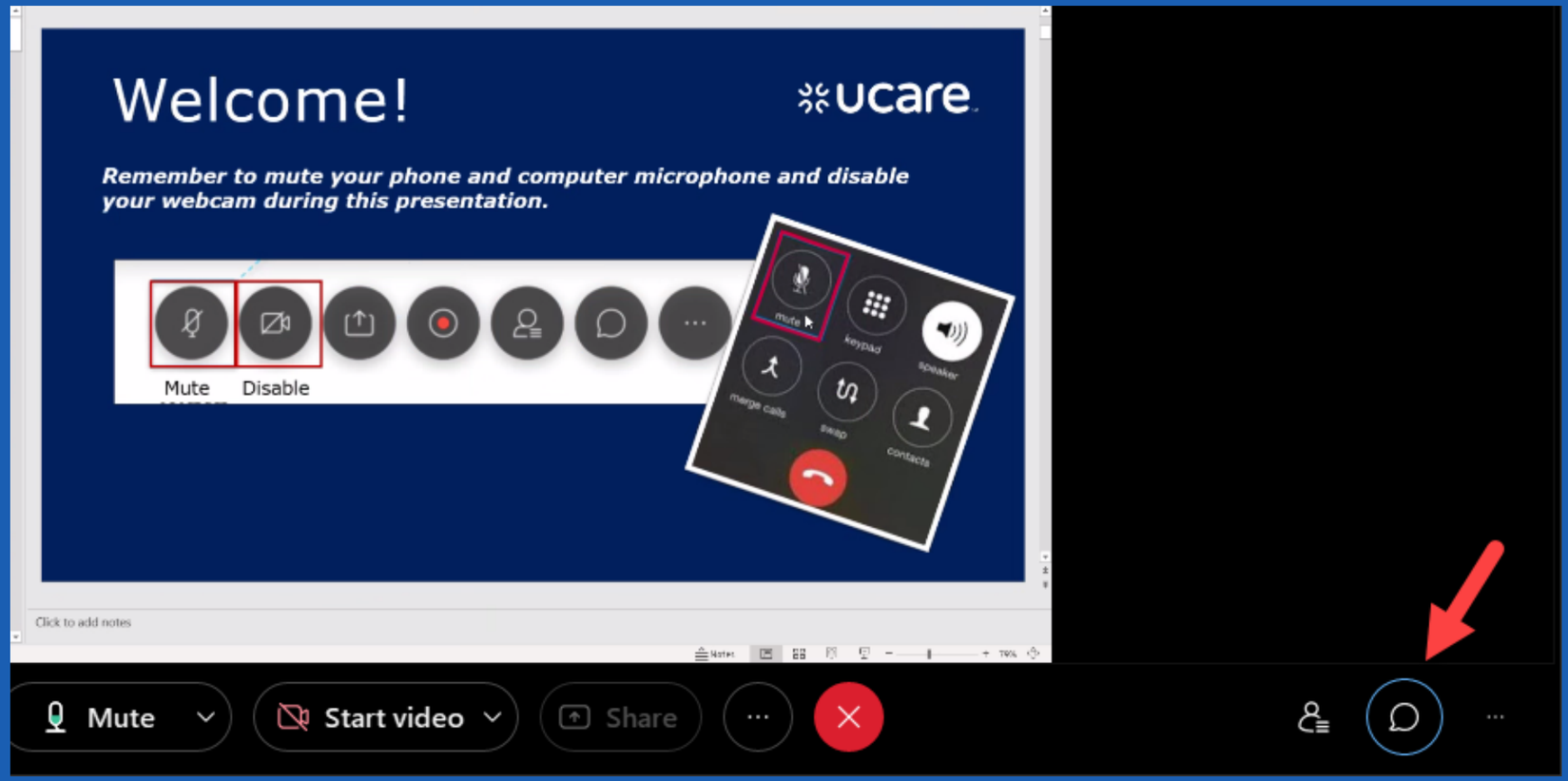
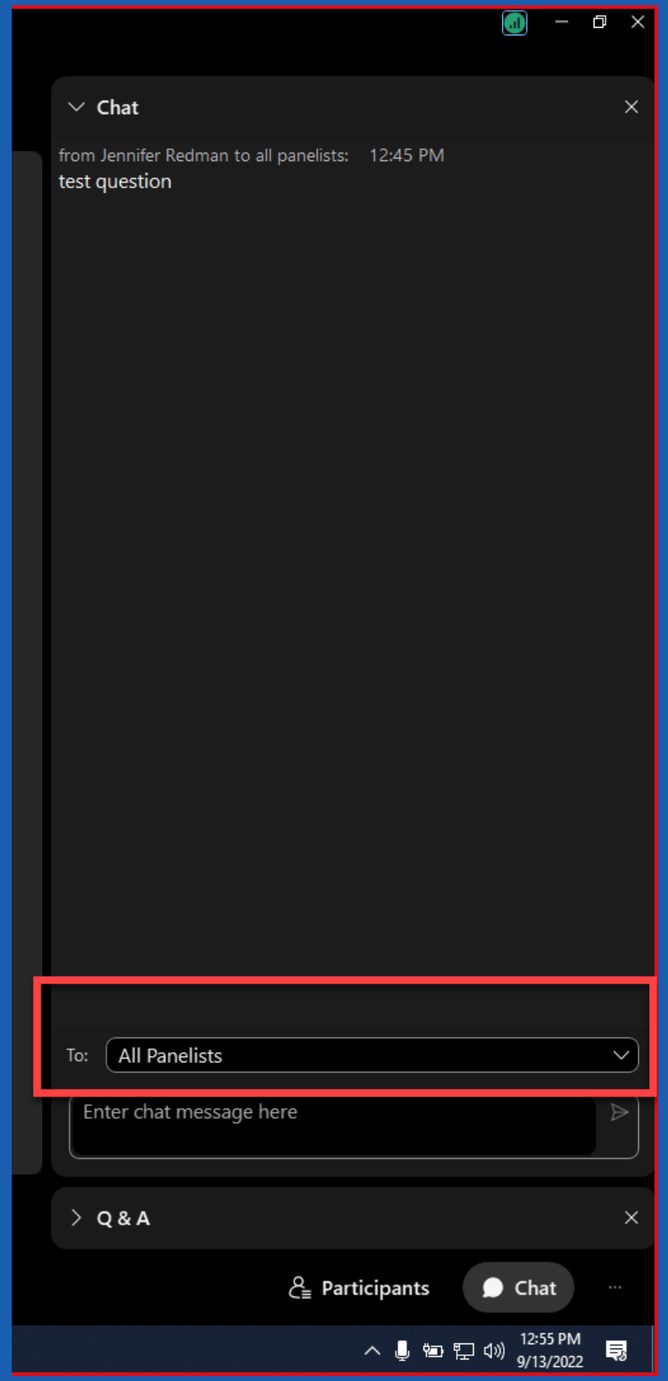
UCare
Connect/Connect + Medicare & MSC+/MSHO

1st Quarterly All Care Coordination Meeting

March 12, 2024

Questions welcome!





Today’s Agenda

Time	Topic	Audience	Presenter
9:00–9:05am	Welcome	All	Clinical Liaisons
9:05-9:55am	Care Coordination Updates	All	Clinical Liaisons
9:55-10:15am	MA Renewals and Spenddowns	All	Randie Corniea & Joan Freak
10:15-10:25am	Davita Integrated Kidney Care	All	Chris Brekke, Phil Zeller & Jennifer Whipple
10 Minute BREAK			
10:35-10:55am	Transportation	All	Trent Brier, Brent Forbord, Jonathan Enering & Jena Brown
10:55-11:15am	Healthy Benefits+ Card	All	Ashley Bruggman
11:15-11:25am	Reemo	All	Morgan Meier
MSC+/MSHO Presentations (SNBC Optional)			
11:25-11:40am	Grandpad	MSC+/MSHO	Lisa Risch
11:40-11:55am	PCA Appeals	MSC+/MSHO	Joshua Paciorek

Care Coordination Updates

Presenters: Clinical Liaisons

Care Coordination Meeting Schedule

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

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

Save the date

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

MnCHOICES Updates

UCare MnCHOICES Guidance:

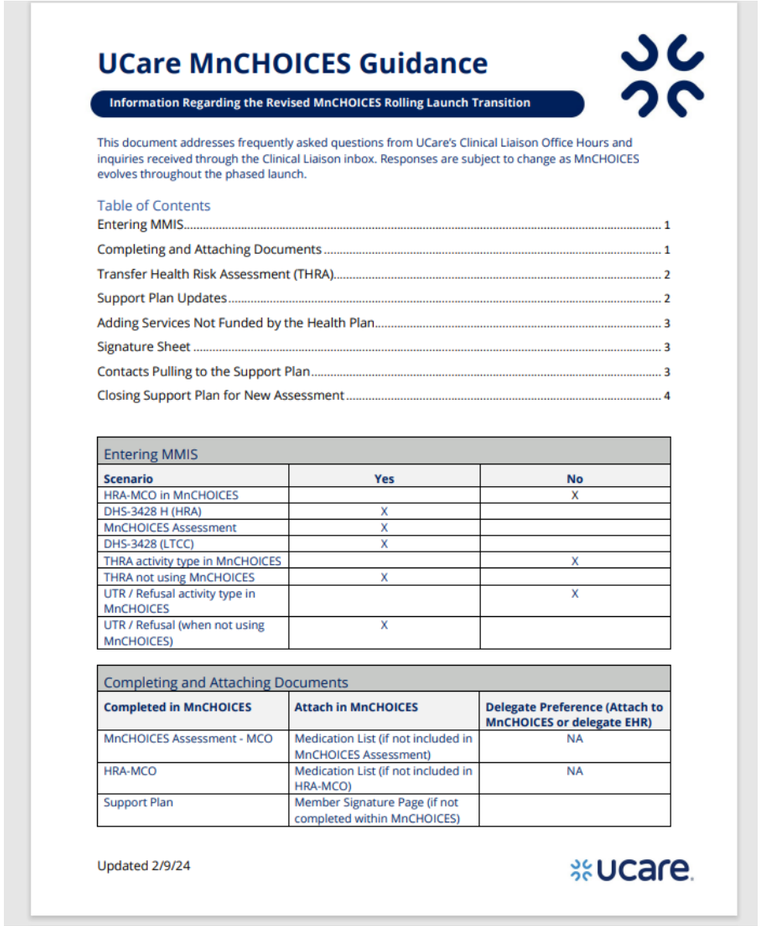
- Entering in MMIS
- Completing and Attaching Documents
- THRA Process
- Support Plan Updates
- Adding Services not Funded by the Health Plan
- Contacts Pulling to the Support Plan
- Closing Support Plan for New Assessment

DHS Rolling Launch:

April 1 – Have **100%** of staff complete all new initial health risk assessments (HRAs), assessments and support plans in MnCHOICES Revision.

July 1 – Have **100%** of staff conduct **all work** in the MnCHOICES Revision.

DHS Announcement March 8, 2024



UCare MnCHOICES Guidance

Information Regarding the Revised MnCHOICES Rolling Launch Transition

This document addresses frequently asked questions from UCare's Clinical Liaison Office Hours and inquiries received through the Clinical Liaison inbox. Responses are subject to change as MnCHOICES evolves throughout the phased launch.

Table of Contents

Entering MMIS

Scenario	Yes	No
HRA-MCO in MnCHOICES		X
DHS-3428 H (HRA)	X	
MnCHOICES Assessment	X	
DHS-3428 (LTCC)	X	
THRA activity type in MnCHOICES		X
THRA not using MnCHOICES	X	
UTR / Refusal activity type in MnCHOICES		X
UTR / Refusal (when not using MnCHOICES)	X	

Completing and Attaching Documents

Completed in MnCHOICES	Attach in MnCHOICES	Delegate Preference (Attach to MnCHOICES or delegate EHR)
MnCHOICES Assessment - MCO	Medication List (if not included in MnCHOICES Assessment)	NA
HRA-MCO	Medication List (if not included in HRA-MCO)	NA
Support Plan	Member Signature Page (if not completed within MnCHOICES)	

Updated 2/9/24

ucare

MN EAS Reminders

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

TOC Reminders

As of 1/1/24, TOC Logs are optional for **Connect** members mirroring **MSC+** current practice.

• TOC Log remains available for use as a resource.

• Continue to reach out to your member post-discharge and document in member record.

• The 4 pillars are not required, however may be useful in guiding conversations

All Products: Add Support Plan updates due to TOC on the Monthly Activity Log

•Type of Activity: TOC/Support Plan Update

UCare TOC Training & Resources Available:

•Updated: Transitions of Care (TOC) Training posted on the Care Coordination Trainings page

•**New:** TOC Scenarios Job Aid

Pharmacy Transitions of Care (TOC) Program

- **Goal:** To complete a medication review with members within 30 days of discharge in hopes of reducing hospital readmissions and to ensure the member is not experiencing any side effects or confusion from their medications.
- **Eligibility:** MSHO and Connect+ Medicare members who have been discharged from an inpatient status within the past 30 days
- **How to Refer:** Care Coordinator to complete the TOC Pharmacist Referral Form and email to: PharmacyLiaison@ucare.org. Include discharge summary if available.
- **What to expect:** Pharmacy will reach out to member within 1-2 business days to schedule a review. A 20–60-minute telephonic review will be completed with the member

UTR/Refusal Support Plan Reminders

As of 1/1/24 UTR and Refusal Support Plans are optional for Connect and MSC+ members

- The tool will remain available for use at care coordinator discretion as a resource
- Continue to document your efforts to reach members for assessment in member record
- All other UTR/Refusal tasks remain as indicated in the 1/1/24 Requirement Grids

UTR/Refusal in MnCHOICES

- **Health Risk Assessment-MCO Form: All products** require completion of the HRA-MCO Form for MMIS activity. Enter date of activity with assessment result notes of either “UTR: Person not located for HRA” or “Refusal: Person declines HRA Assessment” along with any additional pertinent information. Save as Completed.
  - **MSHO/Connect + Medicare Members:** Complete UCare UTR or Refusal Support Plan from Care Coordination website, save in member file and attach in MnCHOICES
  - **MSC+/Connect Members:** Document outreach attempts and outcomes in member record

Understanding the 90-Day Grace Period

MSC+/Connect: Members removed from the enrollment roster when MA terms.

When these members are in their 90-day grace period they appear inactive in MN-ITS.

- Claims are not paid while MA is inactive.
  - If MA is reinstated and backdated, medical providers can submit claims retroactively.
  - Care Coordinator must track MSC+/Connect termed members for 90 days.

MSHO/Connect + Medicare: Members remain on the enrollment roster because they do not term from health plan, thus do not require additional tracking. They will appear inactive in MN-ITS during their 90-day grace period.

- UCare continues to pay claims for member in the 90-day grace period.
- Medical Providers are responsible for verifying eligibility prior to providing services.
- Refer to the Care Coordination Enrollment Roster for the future term date.

EW Members: CC to send the DHS 6037 to County by the 60th day if MA is not reinstated.
All Products: Care Coordination continues during 90-day grace period. CCs monitor member's assessment schedule. UCare requirements are to provide ongoing care coordination elements during the 90-day grace period.

Website Updates

Watch the Care Coordination Newsletter for documents that are new, revised, and coming soon!

ALL CARE COORDINATION NEWS

New on the Care Coordination and Care Management Website

All products

- 2024 Benefits by Condition (New 1/10/24)

MSC+/MSHO

- Numbers to Know: MSC+ and MSHO (New 1/16/24)

Connect/Connect+ Medicare

- 2024 Monthly Activity Log (Revised 1/18/24)

Coming soon

- EW Budget Cap Tool (New)
- Assessment Checklist – MnCHOICES – MSC+/MSHO (New)
- MSC+/MSHO Care Coordination 101 Training Series (New)
- Transportation Job Aid - Medical (New)
- Website Overview Recorded Training (Revised)
- Transition of Care (TOC) Recorded Training (Updated 2/2/24)
- Waiver DHR decision
- PCA communication Form

How to find Massage Therapy providers:

1. Visit Fulcrum Health website

OR

2. Search “massage” in the UCare provider network search

Not sure where to find things on the website?

UCare Website Overview (New 2/13/2024)
Recorded Webinar

Claims: Who Pays First?

Medical Assistance Only (no Medicare):

- Enrolled in MSC+ or UCare Connect
  - Covered services/DME/Prescriptions paid by UCare (including DHS formulary prescriptions and OTC's).
  - Must use UCare network providers

Dual Eligible:

- Enrolled in MSHO or Connect + Medicare (Medicare Advantage)
  - All covered Medicare A, B & D claims submitted to UCare for payment
  - UCare formulary Part D co-payments apply
  - Must use UCare network providers

Claims: Who Pays First?

Medicare Eligible
Primary Insurance: Medicare A,B,D
Secondary Insurance: Enrolled in MSC+ or Connect

1

Medicare Primary Insurance: Pays first - A & B covered claims

- Must use Medicare eligible providers

Medicare Part D: Covers Medicare formulary prescriptions

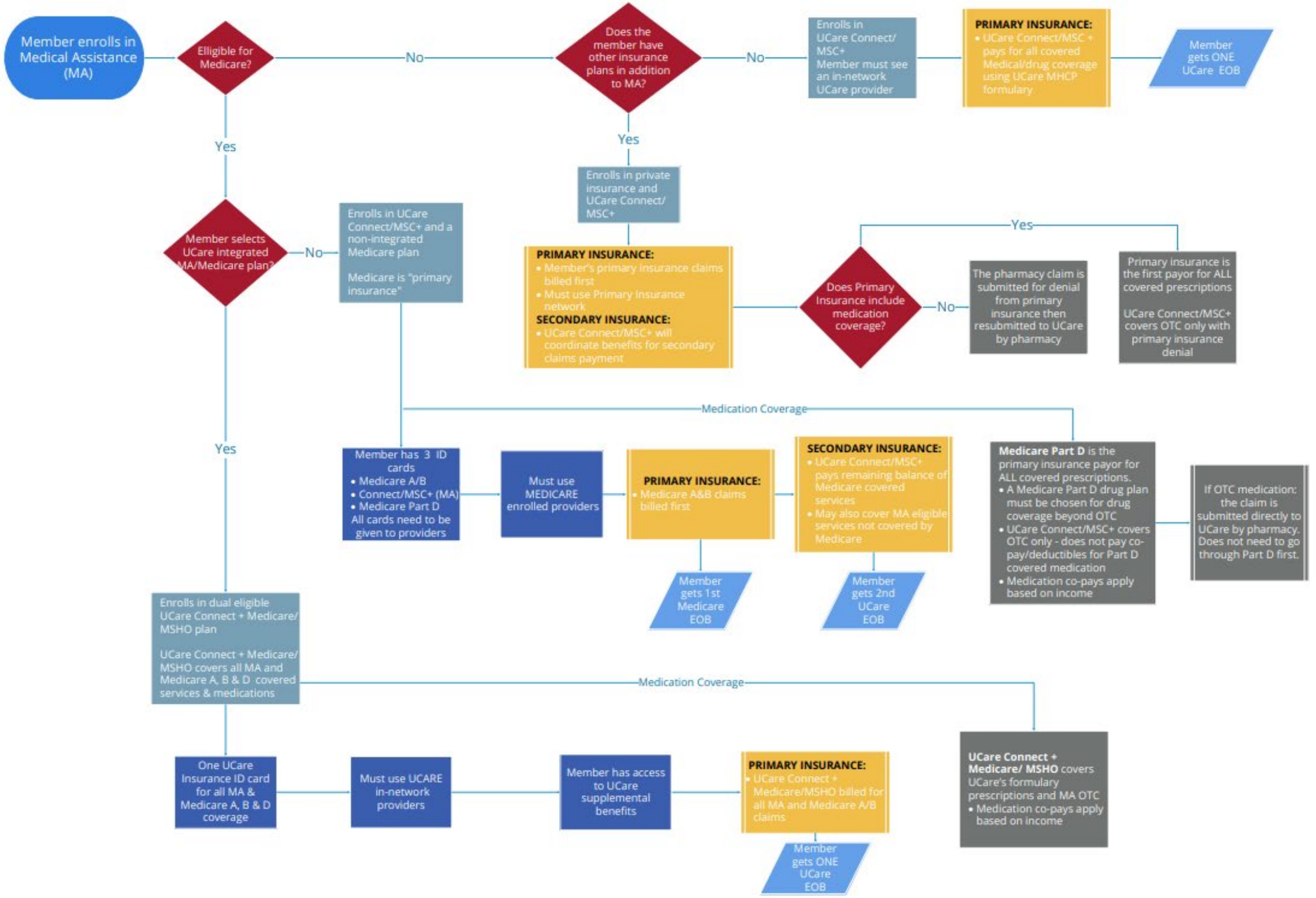
- Members continue to pay Part D co-payments
- Connect/MSC+ covers MA covered Over-the-Counter (OTC) medication

2

UCare MSC+ & Connect Secondary Insurance: UCare coordinates benefits with Medicare to provide co-payment for Medicare A & B covered services

Note: Member has 3 ID cards (Medicare, UCare, Part D)

Medicare/Medicaid: Coordination of Benefits



Housing Stabilization Services – Moving Expenses

Who is eligible?

- Members receiving Housing Stabilization Transition services *and* are transitioning out of a Medicaid-funded institution or leaving a provider-operated living arrangement and moving into their own home, which is a less restrictive living arrangement.

What is HSS – moving expenses?

- A $3,000 non-reoccurring HSS – transition benefit component a member can access when moving into their own home within an approved HSS eligibility span.

Eligible Living Situations

- Members must be currently residing in a Medicaid-funded institutional setting, currently homeless or has stayed in a shelter in the last 12 months, or leaving specific provider care requirements

What is covered?

- Essential household furnishings, costs associated with moving and durable household goods

What is not covered?

- Rent and mortgage payments, food, clothing, cell phone, recreational items such as computers, streaming devices, televisions or cable TV

When is this service available?

- April 1, 2024

UCare Housing Specialists Office Hours

Connect/Connect + Medicare
- Wednesday, April 3, 2024
- 1:00 – 2:00 PM
- Register here

MSC+/ MSHO
- Wednesday, April 17, 2024
- 1:00 – 2:00 PM
- Register here

Reminder: Elderly Waiver Spans

The **effective date** of the initial opening or reopening screening document is any day within the month. The eligibility span for the waiver is twelve months with the end date being the last day of the twelfth month

- Example: The effective date of an EW assessment is 3/12/24. The twelfth month is February 2025 and the EW span will end 2/28/25

Source: DHS-4669

Reminder: EW Remote Reassessment Policy

As of Nov. 1, 2023, care coordinators must meet minimum care coordination in-person visit requirements for people who use Elderly Waiver (EW). This applies to people whose Elderly Waiver year ends on or after Nov. 1, 2023. The Community Care Coordination Requirements Grid, MnCHOICES Community Care Coordination Requirements Grid, In-Person Assessment Methods Decision Tree, In-Person Assessments Job Aid, and In-Person Assessments Work Flow are resources to help you determine your options for how an assessment can be completed. When using those resources, please keep in mind the additional clarification provided below.

Minimum required frequencies: The Elderly Waiver care coordinator must conduct at least one in-person visit per 12-month period. This visit can be included as part of the member's annual reassessment if the assessor is also the care coordinator. If a member is unable to meet in person, a phone or virtual meeting will not meet in-person requirements unless the remote contact occurred before Nov. 1, 2023.

As outlined in the Jan. 9, 2024 eList announcement, DHS has provided more context regarding previous remote assessments. DHS counts each visit held remotely before Nov. 1, 2023, as an in-person visit. Visits on and after Nov. 1, 2023, must occur in person to meet minimum in-person requirements. The following scenarios clarify the change in requirements:

- For waiver spans that begin on or after Nov. 1, 2023, visits must occur in person to meet in-person requirements.
- For waiver spans that begin before Nov. 1, 2023, and end after Nov. 1, 2023, DHS counts each remote visit before Nov. 1, 2023, as an in-person visit that counts toward compliance requirements.

Remote Adult Day Care

A member must be eligible for and receiving in-person adult day services to receive remote adult day services. The same provider must deliver both in-person and remote adult day services to the member.

Adult day services delivered remotely must:

- Be provided within the scope of adult day services
- Meet all requirements on CBSM – Remote support
- Meet additional remote support requirements specific to adult day services, as described in the remote adult day services section of the adult day services page in the CBSM

Technology considerations

When authorizing remote adult day service, the lead agency must consider:

  - Technology available to the member, as well as any additional technology needs.
  - The member's ability to use the equipment, technology and devices required to participate in remote services.

Online training available: TrainLink course code AASD-RADS

MA Renewals, Spenddowns & Keep Your Coverage

Presenters: Randie Corniea & Joan Freak

Renewal Process

Renewal, Redetermination, Recertification

All mean the same thing. It is the annual process to determine if an individual falls under the financial eligibility guidelines. It is necessary part of being a Medicaid beneficiary.

Required to Return Forms

MN has a paper-based renewal process – the state mails members paperwork and the member must mail it back to the county, state or tribal nation.

Ex-Parte (Auto Renewal)

Renewals are being processed for certain individuals automatically.* Generally this will apply to enrollees who have SSI/RSDI as their only source of income without a spenddown, eligibility for QMB, recent renewal for other county programs (GRH, Cash, SNAP).

Eligibility Guidelines

Income Limits

Income limits apply to all Medicaid beneficiaries. Income limits vary based on the age of the beneficiary, household size, and the basis of eligibility.

DHS-3461A-ENG (state.mn.us)

Asset Limits

Asset limits apply to Individuals with Disabilities and Seniors. Limits can vary based on which program the beneficiary is enrolled in, however, most members will fall under the $3000/person* asset limit.

Income Limits for Special Needs Population

	Effective 7/1/23 – 6/30/24													
	MA Elderly, Blind, Disabled (with a spenddown)		MA Elderly, Blind, Disabled (no spenddown)		*MA Qualified Medicare Beneficiaries (QMB)		*MA Service Limited Medicare Beneficiaries (SLMB)		*MA Qualifying Individuals (QI)		*MA Qualified Working Disabled Individuals (QWD)		Minnesota Family Planning Program	
Family Size	*100% FPG*		*100% FPG*		*100% FPG*		*120% FPG*		*135% FPG*		*200% FPG*		*200% FPG*	
	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually
1	$1,215	$14,580	$1,215	$14,580	$1,235	$14,820	$1,478	$17,736	$1,661	$19,932	$2,450	$29,400	$2,430	$29,160
2	$1,644	$19,728	$1,644	$19,728	$1,664	$19,968	$1,992	$23,904	$2,240	$26,880	$3,307	$39,684	$3,287	$39,444
3	$2,073	$24,876	$2,073	$24,876	$2,093	$25,116	$2,506	$30,072	$2,819	$33,828	$4,164	$49,968	$4,144	$49,728
4	$2,502	$30,024	$2,502	$30,024	$2,522	$30,264	$3,020	$36,240	$3,398	$40,776	$5,021	$60,252	$5,001	$60,012
5	$2,931	$35,172	$2,931	$35,172	$2,951	$35,412	$3,534	$42,408	$3,977	$47,724	$5,878	$70,536	$5,858	$70,296
6	$3,360	$40,320	$3,360	$40,320	$3,380	$40,560	$4,048	$48,576	$4,556	$54,672	$6,735	$80,820	$6,715	$80,580
7	$3,789	$45,468	$3,789	$45,468	$3,809	$45,708	$4,562	$54,744	$5,135	$61,620	$7,592	$91,104	$7,572	$90,864
8	$4,218	$50,616	$4,218	$50,616	$4,238	$50,856	$5,076	$60,912	$5,714	$68,568	$8,449	$101,388	$8,429	$101,148
Add'l	$429	$5,148	$429	$5,148	$429	$5,148	$514	$6,168	$579	$6,948	$857	$10,284	$857	$10,284
Asset Test	• $3,000 for a single person • $6,000 for household of two, plus $200 for each dependent		• $3,000 for a single person • $6,000 for household of two, plus $200 for each dependent		• $10,000 for a single person • $18,000 for household of two		• $10,000 for a single person • $18,000 for household of two		• $10,000 for a single person • $18,000 for household of two		• $4,000 for a single person • $6,000 for household of two		None	

What are the responsibilities of our members?

Report Changes

Complete and return their renewal applications. Members also have the responsibility to report changes that may happen outside of their renewal period.

Cooperate

Members must comply with MHCP eligibility requirements. This includes providing accurate information and proof of changes.

Truthful

Members cannot “willfully or intentionally provide a false statements or withhold, conceal or misrepresent information to receive or attempt to receive coverage for which they are not eligible.”(MHCP EPM 1.3.2.3)

Spenddowns Minnesota Health Care Programs

How Spenddowns impact D-SNP and SNBC eligibility

Medical Assistance Basis of Eligibility

Minnesota provides Medical Assistance (MA) to certain groups of people, as allowed under law, who meet certain requirements known as “basis of eligibility.”

A person’s **basis of eligibility** determines the **non-financial** criteria and **financial methodology** (spenddown) used to determine MA eligibility.

Several groups meet non-financial basis of eligibility for Medical Assistance including victims of torture, refugees, people requiring emergency Medical Assistance, people with certain types of cancer, hospitalized incarcerated people, children requiring adoption services, and people certified blind.

The two groups we work with are:

- **People aged 65 or older**
- **People certified disabled**

What is a Spenddown?

- People with an aged, blind or disabled Basis of Eligibility, and are over the income limit may be eligible for Medicaid with a **spenddown** if they have a medical need.

- A spenddown is a cost-sharing approach that allows individuals to qualify for Medicaid if their income is greater than the income limit. Federal rules refer to this population as “medically needy.”

- Think of a spenddown as a “deductible” that must be used toward qualifying medical expenses before Medicaid kicks in.

Medicaid Cost-Sharing Approaches

Medical Spenddown

Medical Spenddowns are for enrollees that live in the community. Not all Medicaid basis of eligibility offer Medicaid with a medical spenddown.

Long-Term Care Spenddown

Some enrollees eligible for the payment of long-term care services may be obligated to contribute toward the cost of services.

Waiver Obligation

A waiver obligation is the amount a person is obligated to contribute toward the cost of home and community-based waiver services. People aged 65 and older, receiving Elderly Waiver (EW) services, with income above the Special Income Standard Elderly Waiver (SIS-EW) maintenance needs allowance pay a waiver obligation.

Types of Spenddowns

Asset Spenddown

Assets are items of value that people own like bank accounts, stocks and bonds, cars, and real estate.

Income Spenddown

Earned or unearned income is over the income standard and must be spent towards medical expenses

Six-month Spenddown

A six-month spenddown is the difference between the person's net income for a six-month period and the applicable Federal Poverty Guidelines (FPG) for a six-month period. Once the spenddown is met, one will be Medicaid eligible for the remainder of the period.

Monthly Spenddown

The monthly spenddown is used when a person cannot meet a six-month spenddown or chooses a monthly spenddown. Each month the enrollee would be responsible for medical expenses until their spenddown is satisfied before Medicaid will cover the remaining costs.

How Spenddowns Are Paid

“Potluck Processing”

Medical expenses are deducted from the spenddown amount as claims are submitted. Providers then bill the enrollee for those costs. The enrollee is responsible for paying these bills.

Client Option

Enrollees pay the spenddown amount directly to DHS each month. Enrollees whose medical expenses do not meet their spenddown obligations are refunded the excess spenddown amount after 18 months.

Designated Provider

Enrollees who receive PCA or home and community-based services through one of the waiver programs may elect a designated provider. Medical expenses incurred from the designated provider must meet spenddown obligations.

Allowable Health Care Expenses to Meet a Medical Spenddown

Health care expenses not paid for, covered by, or reimbursed by Medicaid

- Health, dental, vision and long-term care (LTC) insurance premiums
- Medicare premiums*
- Co-pays
- Deductibles
- Health care expenses for dependents or financially responsible relatives who are not eligible for Medicaid

Keep Your Coverage Program

Overview

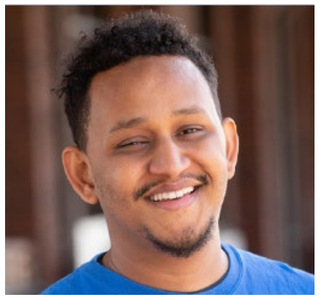
Keep Your Coverage program, UCare's retention program, started in 2013 to address high disenrollment rate

In January 2022, UCare recognized the need to expand our Keep Your Coverage program to Senior Medicaid members

We are 8 months into the COVID Unwinding. We continue to modify our approach based on DHS requirements and member feedback

Our Keep Your Coverage Team

Randie Corniea
Retention Specialist, Senior
rcorniea@ucare.org
612-294-5111



Abdi Warsame
Retention Specialist
awarsame1@ucare.org
612-294-5473

Hli Lo Xiong, LSW
Retention Specialist
hxiong@ucare.org
612-294-5332
Hmong Interpreter

Anna Sosa
Retention Specialist
asosa@ucare.org
612-294-4023

Chee Vang
Retention Specialist
cvang8@ucare.org
612-294-6695

Aiyan Mohamed
Retention Specialist
amohamed2@ucare.org
612-294-5769

UCare
Special Needs Plans

Keep Your Coverage services are offered for:

- **UCare Connect**
  Non-integrated plan
- **UCare Connect + Medicare**
  Integrated plan
- **UCare Minnesota Senior Care Plus (MSC+)**
  Non-integrated plan
- **UCare Minnesota Senior Health Options (MSHO)**
  Integrated plan

What do they do?

- Identify members at risk of losing eligibility
- Make outreach phone calls and mail outreach letters
- Operate a dedicated call center
- Collaborate with counties and care coordinators to track Medicaid eligibility
- Assist members obtain, complete, or submit renewal forms and verifications
- Clarify notices received from DHS
- Assist members with Medicaid and UCare plan reinstatement after termination
- Assist members in enrolling in alternate UCare plans if member is no longer eligible for Medicaid
- Assist members with filing Medicaid appeals or connecting with an Ombudsman

If the you are unsure of whether to reach out to us, there’s no harm in calling and explaining the situation. We’ll see what we can do!

What to expect when you make a referral

Research

A KYC Specialist will research the members history and gather information from our available sources.

Outreach

KYC Specialist will contact the member to discuss their situation

Plan for continued healthcare

KYC Specialist will work with the member to move forward

Follow up

You should receive a follow-up email or phone call within 1 business day

How to refer a member to the KYC Team

Send us an Email

Include the name and PMI of the member with updated contact information.

Briefly explain why you are referring the member.

Give us a call

We’ll ask you for all the information to get us started.

If you must leave a message, be sure to leave the members name, PMI, contact information and reason for the referral.

Also leave your contact information for follow-up or any questions we may have.

We’re Here to Help

UCare Keep Your Coverage Help Line

612-676-3438
1-855-307-6978
TTY: 1-800-688-2534

8 am to 5 pm, Monday-Friday

KeepYourCoverage@ucare.org

DaVita Integrated Kidney Care (IKC) and UCare

Program Overview

March 2024

Chris Brekke – Sr. Director, IKC Account Management

Phil Zeller – Sr. Director, IKC Operations

Jennifer Whipple – Regional Manager, IKC Operations

DaVita® Integrated Kidney Care

What is DaVita IKC, and how does work with UCare members?

- Integrated Kidney Care (IKC) helps patients manage kidney disease
- We manage patients' health care needs to keep them healthier and out of the hospital – from providing education to coordinating timely information across the broader care team
- DaVita IKC and UCare are partnering to offer this program at no additional cost to members

DaVita®
Integrated Kidney Care

ESKD: Optimal modality, transplant, and admit reduction

MODEL OF CARE

- Perform clinical, behavioral health, and SDOH assessments to identify goals of care, primary concerns, and treatment barriers
- Educate on in-home dialysis and transplant
- Educate patient to manage kidney and overall health
- Coordinate care across clinic, nephrologist, PCP, vascular surgeons, and specialists
- Identify high-risk patients through predictive algorithms and assessments; escalate for multidisciplinary team reviews
- Provide transition of care to avoid readmits
- Support end-of-life planning

CLINICAL GOALS

Patient leading kidney-friendly diet and lifestyle

Patient empowered for modality selection

Reduce hospitalizations

End of life aligned with patient wishes

Increase access to transplant

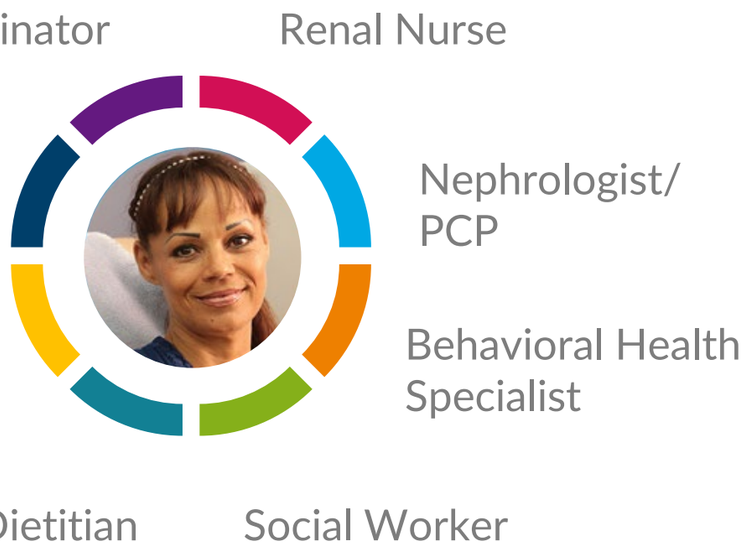
Increase home dialysis penetration

UCare specific goals for DaVita patients

- *Hospital Admit Rate Reduction*
- *Medication Reviews*
- *Depression Screenings (PHQ-9s)*
- *Advance Care Planning*
- *Influenza Vaccines*

Members are supported by a multi-disciplinary care team

Integrated kidney care team surrounds patient with support



Local support team in Minnesota

- **6** registered nurses
  5 ESKD & 1 CKD
- **7** care coordinators
  5 ESKD & 2 CKD
- **4** nurse practitioners
- **3** operations managers

Deep renal expertise across care team to provide the right care to the right patient at the right time

Collaboration with DaVita IKC for ~200 UCare ESKD Members

Reminder: who is eligible

- ESKD members at least 18 years of age
- Receive dialysis at DaVita
- Part of the following plans:
  - UCare Medicare Advantage
  - Minnesota Health Care Programs
  - Minnesota Senior Health Options (MSHO)
  - Minnesota Special Needs Basic Care, dually eligible, integrated enrollee

How to contact us

- 1-800-767-0063 (TTY 711)
  - *Available Monday – Friday, 7AM to 7PM EST*

If you'd like to connect with DaVita IKC, note that …

- We focus on patient's renal needs, to complement support that UCare is already providing
- Our care teammates have received training on UCare plans
- We welcome your collaboration – please call us to get in touch!

UCare Member Story

About Member

- ***31 year old***, ***black male***, *lives alone; heath conditions include* ***type 1 diabetes***, *hypertension, hyperkalemia, anemia, and* ***partial toe amputation***
- *Over the last couple of months, the patient experienced a* ***diabetic foot infection*** *which was* ***preventing him from getting a job***
- *When he broke his tooth in October, the soonest appointment he was able to get scheduled was 3 months away*
- *With so many health concerns, the* ***patient*** *expressed being* ***overwhelmed*** *and having* ***difficulty remembering*** *his* ***appointments***

Our Work

- *In addition to* ***tracking*** *all of the patient's* ***appointments*** *and sometimes scheduling them, the* ***IKC CC*** *consistently provides* ***reminders*** *to the patient so appointments are not missed*
- *The* ***IKC CC*** *worked with Hennepin to* ***move*** *his* ***tooth extraction*** *appointment from* ***early 2024 to Nov 8th 2023***
- ***IKC RN*** *has been* ***coaching*** *the* ***patient*** *on* ***proper wound care*** *so the foot infection does not get worse and to help him feel in control of the situation*

The Impact

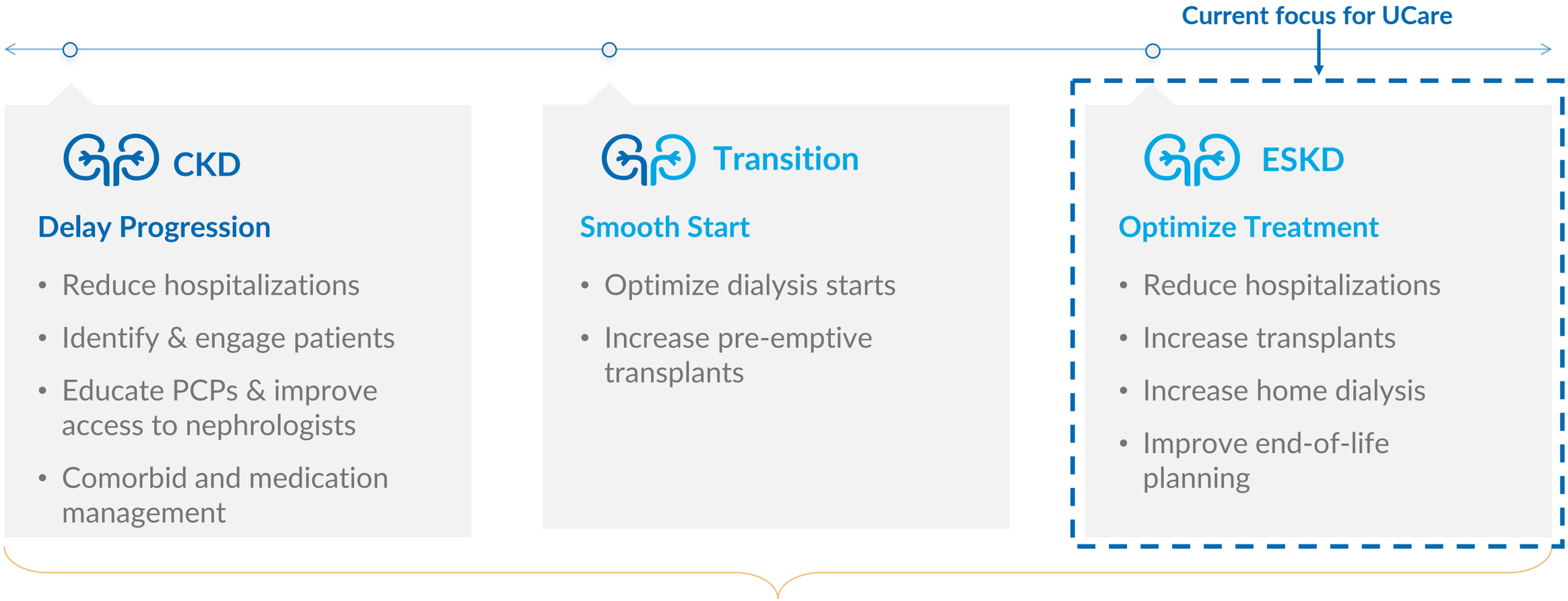
- *After getting his foot infection under control, the* ***patient started*** *his* ***new job*** *at UPS on 12/7!*
- *The patient also recently* ***expressed interest*** *in getting on the* ***transplant waitlist*** *and has* ***asked*** *for* ***support*** *in scheduling those appointments so he has everything in order when a transplant becomes available*

"Good to be working again!" - ***Patient***

DaVita IKC – UCare Program: who is eligible?

- Contract effective August 2021 – June 2024
- ~ 200 total ESKD members with UCare primary insurance coverage
- Eligibility:
  - Member is at least 18 years of age
  - Diagnosis of ESKD
  - Receive dialysis at a DaVita facility
- Plan types:
  - UCare Medicare Advantage
  - Minnesota Health Care Programs
  - Minnesota Senior Health Options (MSHO)
  - Minnesota Special Needs Basic Care, dually eligible, integrated enrollee

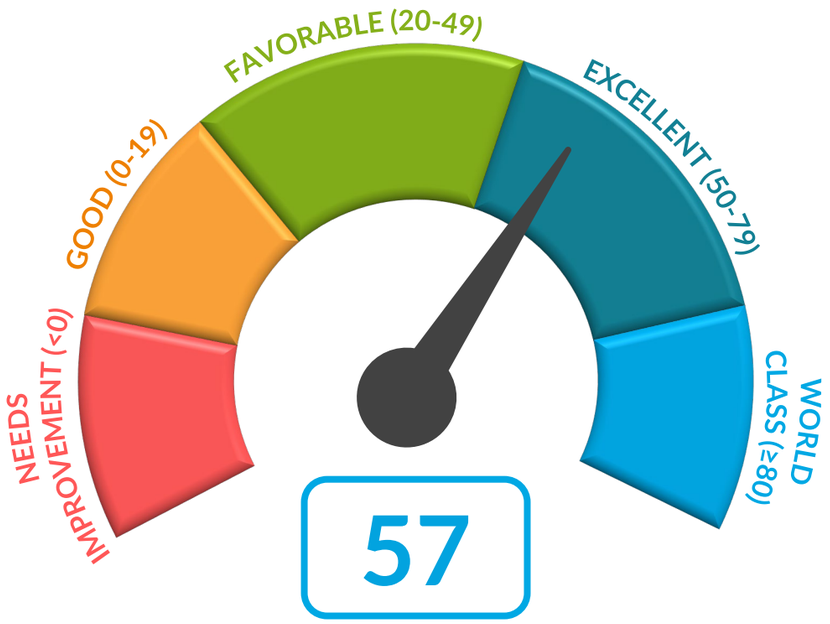
Our clinical vision for the full kidney care continuum



Improve Quality and Decrease Total Cost of Care

Excellent Net Promoter Score Results from UCare Members

Net Promoter Score (NPS)



What's Working

"Kidney team is very helpful."
"By offering to make appts w/doctors and arranging cab rides….I didn't know this was one of their duties."
"Absolutely very valuable to me and all patients. Thank you care team."

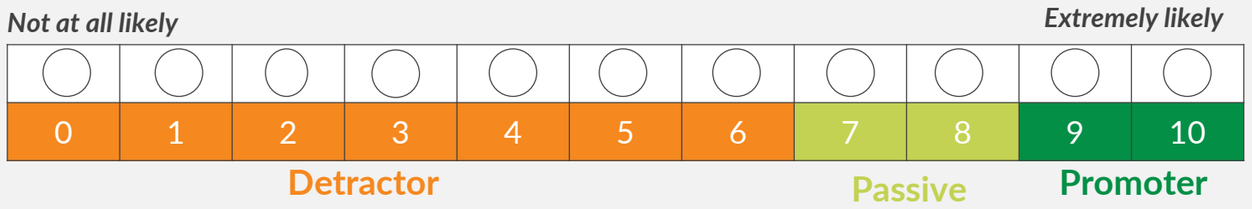
Opportunities for Improvement

"Visiting doctors do not respond right away when they say they will initiate a treatment, sometimes they forget…"

Net Promotor Score (NPS) Breakdown

% Promoters – % Detractors = NPS
Scale of -100 to 100

I would recommend DaVita Integrated Kidney Care to other patients with Chronic Kidney Disease or End Stage Kidney Disease



Patients surveyed Feb 2023; must have been active in program for ≥6 months as of 12/31/2022 and still active at time of survey; N=21 (response rate of 19%)

UCare Member Success Story

Situation

- **77 year-old** member who was **experiencing hypotensive episodes** during dialysis
- During the fall of 2021, he **struggled with depression**, and **was considering ending dialysis** because he felt like he was a burden to his wife
- After being **hospitalized for cellulitis in November and for his hypotensive episodes in December**, he received a poor prognosis of only having **two months to live**

Intervention

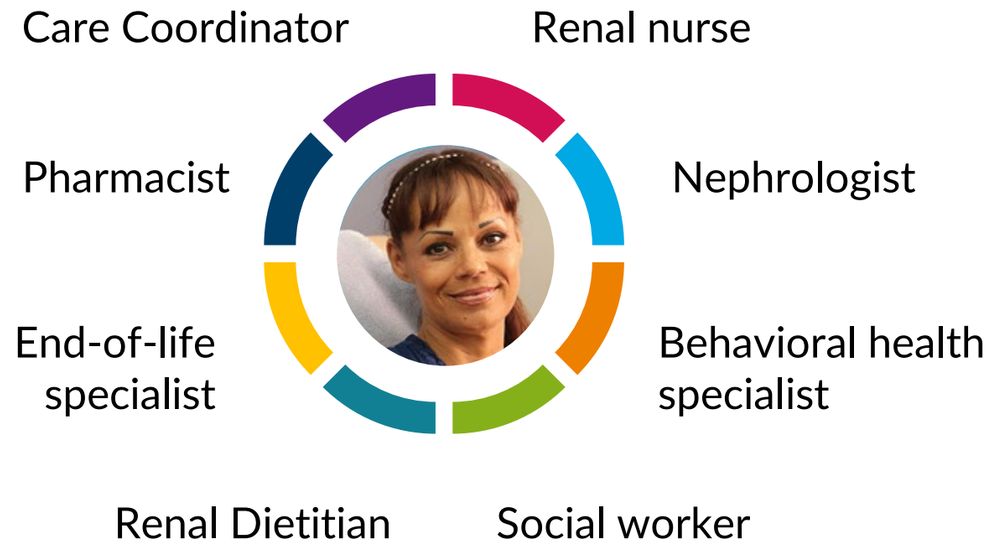
- The **member was referred to DaVita IKC's supportive care program**, which focuses on meeting the needs of patients who are nearing end of life
- DaVita IKC helped schedule a **follow-up appointment with the member's PCP,** who **prescribed Sertraline** for the member's depression
- Post-hospitalization, the **member was discharged to rehab**, and DaVita coordinated his **temporary transfer to a dialysis clinic that was closer to his rehab facility**
- The patient's **dialysis target weight was adjusted**, and he was **referred for home care**

Outcomes

- **Member became focused on improving his health**, and was **able to return home** in mid-Jan
- The member now **receives home care for assisting with showers, and has necessary DME**
- **Dialysis treatments are going well** back at the patient's home dialysis center (no more hypotensive episodes), and the patient's hemoglobin is improving
- Member's **outlook has improved overall**; he recently stated, **"I'm not dying anytime soon!"**

DaVita IKC patients are supported by a multi-disciplinary care team

Integrated kidney care team surrounds patient with support



Integrated kidney care team key activities

- Patient and caregiver engagement
- Dialysis clinic collaboration
- Nephrologist collaboration
- Customized renal care coordination
- Transitions of care
- Comorbid management
- Medication reviews
- Diet counseling
- Modality education and vascular access planning
- End of life/ACP

Deep renal expertise across care team to provide the right care to the right patient at the right time

10-minute Break

10:25-10:35

UCare Health Ride Transportation

Presenters: Trent B, SR Manager
Brent F, CSS Supervisor
Jonathan E, NOCCS Supervisor
Jena B (presenting), Booker Supervisor

Table of Contents

What is UCare Transportation

- UCare transportation provides Non-Emergency medical transportation for medical and dental needs for our members based on their UCare plan.
- Traditionally we book about 50-100k legs a month, we average about 1200-2000 calls a day.
- We are staffed for normal ride bookings Monday through Friday **7am to 8pm**, Saturday and Sunday for urgent/emergency transportation **8am to 4:30pm.**

Best Practices for Booking a Ride

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

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

Always have the member's name, member (UCare) ID number, on file address and phone number available when you call.

How to Book a Ride

The process for booking a ride is very simple. You call with the member PHI information, the location for pick up, the location for the appointment, and a phone number the provider can reach the member.

If the ride is same day/next day, STS (assisted), or out of the 7-county metro area Health Ride will have to get verbal acceptance from the transportation company before we can book the transportation.

Inside the metro for a common carrier (non-same day ride/next day) Health Ride can book without the verbal acceptance from the transportation provider.

Depending on the ride HealthRide may need to verify the appointment or the prescription ready status before booking the ride.

UCare uses a software program that our transportation providers have access to, this allows us to quickly process the ride request.

Sanctions and Restricted Recipient

If a member is found to be misusing the transportation services, Health Ride may set them up on sanctions or restrictions.

Sanctions will be initiated with a written warning. Once the warning has been issued any future misuse of the transportation services will result in either a sanction or recommendation for restricted services. A sanction is one year from date of issue. Sanctions typically sets the member for bus pass only or requires verification on all appointments and RX.

If a member is put on the restricted recipient program, they will be limited to only the approved primary, pharmacy, and ER set by the restricted recipient coordinator.

What happens if my ride doesn’t show?

Hopefully, this doesn’t happen. If this does happen the member can call UCare, and Health Ride will contact the provider. If the provider can not accommodate the ride, we will call all other providers in our network who can accommodate the ride.

If we cannot find a provider to accommodate, Health Ride will escalate the issue to our supervisor team who will also attempt to find a provider to accommodate.

In very rare cases Health Ride may not be able to get a provider we will work with the member to reschedule their appointment and if that is not an option, Health Ride will have to DTR (denial, termination, or reduction of transportation services) the ride.

What is new from last year

- Qryde application- We completed the first full year of the using the new application. It was very successful first year with no down time due to issues.
- Grocery store rides- UCare has implemented Grocery store rides for Connect + and MSHO plans for qualified members. Please see Supplemental Benefits Summary for process.
  - Care Coordinators authorize grocery store rides using this form: Healthy Benefits Grocery Ride Authorization
- Working with PRC to open the transportation provider network. We hope to have it completely open by 2nd quarter.
- Added a team and process to assist in getting member future rides booked when a provider isn't available on the initial call, this is only for rides that are not same day or next day request.
- Phase 2 of Qryde has started and that will include member portal, provider portal, and driver app/GPS.

Working to make the transportation experience better for everyone

- The UCare team is constantly looking at how we can improve the service to our members, care coordinators, partners, and providers.

- We have created teams that are dedicated to assisting Care Coordinators, Proactive ride bookings for members.
  - Routine scheduled appointments like dialysis.
  - Direct ride booking with providers for our STS (assisted) members.
  - Escalation team to handle issues in real time.

- We encourage feedback and we act on it. We believe that every idea is worth listening to and we also believe in implementing ideas that can assist us in providing a better service.

Working to make the transportation experience better for everyone

- We are looking into how we can reduce the time a member is in a cab.
  - Utilizing telehealth either at the member's home or a predetermined location.
  - Pharmaceutical deliver either by carrier or mail instead of rides to and from the Pharmacy.
- We have worked hard to decrease the members wait time to an average of under a minute.
- We added a virtual hold function.
- As with the whole of UCare we are looking at how we can implement a chat function for our member to book rides.
- The new portals will allow the members and care coordinators to request rides, cancel rides and see important ride information.

Healthy Benefits+ Visa Card

Presenter: Ashley Bruggman

Healthy Benefits+ Visa Card

- **<u>1/1/2024 all products will transition</u>** from having the UCare Rewards Benefit Mastercard and the Healthy Savings Card to having all allowances and reward dollars on one Healthy Benefits+ Visa Card
- **The card is reloadable -** to not throw the card away
- **The card can be used anywhere a Visa debit card is accepted**
  - This card can't be used for cash or any cash equivalent
  - This card will not work at liquor, firearm and tobacco/vaping retailers
  - Other limits may apply (no Target or Amazon Purchases)
  - Walmart is back in under their S3, UPC level network
- **How do members receive a card**
  - All members with an allowance will automatically be issued a card

  Members without an allowance will be issued a card upon earning a reward or by request

  2024 members with a rewards balance at the end of 2023 will receive a card with their remaining rewards balance

Healthy Benefits+ Visa Card

- Allowances
  - Food Allowance (monthly)
    - MSHO
    - C+M
  - Utility Allowance (monthly)
    - MSHO only

- Rewards
- Grocery Discount Program

How Member’s Can Use Their Card

- In store
  - Grocery discounts are in store only
  - OTC & Food allowances limited to S3 network- use location finder
  - Other allowances are limited to Visa network *restrictions apply
- Online
  - Healthybenefitsplus.com/ucare
  - Other allowances can be used on other websites where Visa is accepted *restrictions apply
- Over the phone
  - Calling the number on the back of their Healthy Benefits+ card
  - Phone orders where Visa is accepted *restrictions apply

Healthy Benefits+ Customer Service

- Members can Contact Healthy Benefits+
  - Healthybenefitsplus.com/ucare
  - Phone number on the back of their Healthy Benefits+ card
  - Healthy Benefits+ mobile app
- What they can help with (Customer Service 1-833-862-8276 (TTY 711))
  - See balances
  - See transactions
  - Use allowance/place an order
  - Request replacement card/catalog
  - Find participating locations
  - Password resets
  - Activate Card 1-855-256-4620 (TTY 711)
    - Use 17-digit S3# in the lower left-hand corner on back of card

Healthy Benefits+ Visa Card

Plan	OTC Allowance	Food Allowance	Rewards	Grocery Discount	Eyewear Allowance	Combined Flexible Benefit Allowance (D/V/H)	Utilities Allowance	Transportation Allowance
UCare Medicare	$75		X	X	$100-$200			
UCare Medicare w/MHFVNM	$75		X	X	$100			
EssentiaCare	$75		X	X	$100-$200			
Aspirus	$75-$125		X	X	$175-250			
ISNP	$75			X	$200-$225			$500
Medicare PPO	$75		X	X		$1,200-$2,000		
EC Access plan	$75		X	X		$900		
MSHO		$60*	X	X			$50*	
Connect + Medicare		$50*	X	X				
Connect			X	X				
PMAP			X	X				
MNCare			X	X				
MSC+			X	X				
IFP			X	X				

*With eligible chronic condition
Yellow= semi-annual allowance. Expires June 30 and December 31
Blue= monthly allowance. Expires at the end of each month
Red= annual allowance. Expires at the end of each calendar year

Healthy Benefits+ Visa Card Networks

Plan	OTC Allowance	Food Allowance	Rewards	Grocery Discount	Eyewear Allowance	Combined Flexible Benefit Allowance (D/V/H)	Utilities Allowance	Transportation Allowance
UCare Medicare	S3		Visa + S3	S3	Visa + S3			
UCare Medicare w/MHFVNM	S3		Visa + S3	S3	Visa + S3			
EssentiaCare	S3		Visa + S3	S3	Visa + S3			
Aspirus	S3		Visa + S3	S3	Visa + S3			
ISNP	S3			S3	Visa + S3			Visa
Medicare PPO	S3		Visa + S3	S3		Visa + S3		
EC Access plan	S3		Visa + S3	S3		Visa + S3		
MSHO		S3	Visa + S3	S3			Visa + S3	
Connect + Medicare		S3	Visa + S3	S3				
Connect			Visa + S3	S3				
PMAP			Visa + S3	S3				
MNCare			Visa + S3	S3				
MSC+			Visa + S3	S3				
IFP			Visa + S3	S3				

S3- use location finder on Healthy Benefits+ website/app to find participating locations
Visa- accepted where Visa is accepted (MCC restrictions apply)

Program & Allowance Descriptions

Food Allowance

- For MSHO & Connect +Medicare members with eligible conditions. Benefit expires at the end of each month.
  - MSHO $60 a month w/ CHF, IHD, diabetes, hypertension
  - Connect + Medicare $50 a month w/ diabetes, hypertension, lipid disorder
- Benefit can be used in store, online, over the phone
- Must be used at a participating location (S3 network)
- Eligible items include
  - Fresh fruit & vegetables
  - Canned fruit & vegetables
  - Frozen produce & meals
  - Fresh salad kits
  - Dairy products
  - Meat & Seafood
  - Beans & legumes
  - Pantry staples (flour, spices, etc.)
  - Soups
  - Healthy grains (bread, cereals, pasta, etc.)

Utility Allowance (New!)

- For MSHO members with CHF, IHD, diabetes, hypertension
- $50 monthly allowance that expires at the end of each month
- Can use to pay utility bills such as
  - Gas/electric/fuel oil
  - Water/sanitary/sewer
  - Internet & telecommunications
  - Government services/municipalities
- Ways to pay bills
  - Online at healthybenefitsplus.com/ucare through bill payer tool. There will be a $1.50 service charge for this.
  - Over the phone by calling Healthy Benefits+. There will be a $1.50 service charge for this.
  - Over the phone or online directly through their utility provider
- FAQ
  - The utility bill must be in the member's name and match their address on file at UCare
  - If the utility bill is more than $50 the payment must be a split payment. The member will need to specific to only run $50 or less for this payment using their HBP visa card.

Grocery Discounts

- Can only be used in store only at participating locations (S3)
- Similar to digital coupons
- Change weekly and are automatically loaded to the card
- Discounts can be found online or in the app
- For those with only grocery discounts (no allowance)
  - Old Healthy Savings grocery discount card will work until:
    - They earn a reward and get a new Healthy Benefits+ card
    - They request a Healthy Benefits+ card

Rewards

- Members can earn rewards for a variety of preventative visits
- Cannot be used at Target or Amazon
- Walmart is in network through S3
- If the member has allowance programs, the rewards dollars will automatically be pulled from if they spend over their allowance amount or if they purchase items that the allowance does not cover.
- Any unused 2023 rewards will be transferred to the Healthy Benefits+ card on 1/1/24 if the member is a 2024 UCare member.
- Members have access to their reward dollars until they spend them or are no longer a UCare member.

How the card operates

- The card is designed to always spend funds from an allowance wallet/program prior to spending funds from the Rewards wallet/program.
  - Example: UCare Medicare Member goes to Cub Foods and purchases Tylenol, Band-Aids, and popcorn. The card will pull funds from their OTC dollars first and then will pull funds from their Reward dollars for the popcorn.
  - If member does not want to use their Reward dollars for leftover items after purchasing allowance items, they will need to complete two separate transactions.

Appendix

Definitions

- **S3 Network:** Select network of locations provided by the vendor. Use the store finder at Healthybenefitsplus.com/ucare to find in-network locations
  - Example: Walmart is in the vendor's S3 network which will now allow are members to shop there

- **Visa Network:** Anywhere Visa debit card is accepted AND has a qualified Merchant Category Code (MCC). Some MCCs are restricted due to CMS regulations. MCCs are determined by each individual location.
  - Examples: Member's will not be able to use their HBP care at any location that their MCC falls under liquor, firearm and tobacco/vaping retailers
  - Target and Amazon are still classified as a "big-box-retailer" by CMS therefore their MCC codes have been restricted and members will not be able to make purchases at these locations

Reemo

Presenter: Morgan Meier

reemo

Deeper impact through intuitive experiences.

March 15, 2024

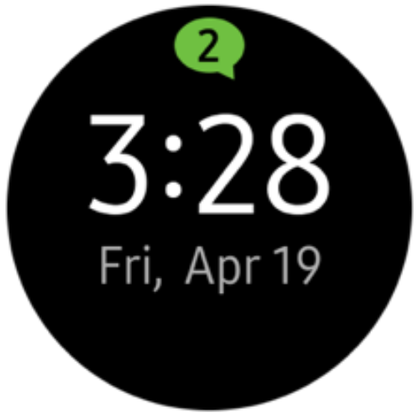
Reemo Overview

The Reemo Smartwatch and Blood Pressure Cuff are free to users if offered by their health plan.

Various Smartwatch features and functions are available, determined by the available program.

The Smartwatch allows users to track their own health at home, place Emergency Calls, communicate with their Health Plan, and more.

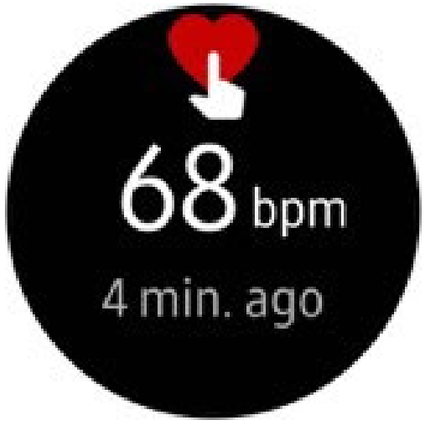
User Functions



Time & Date

Steps

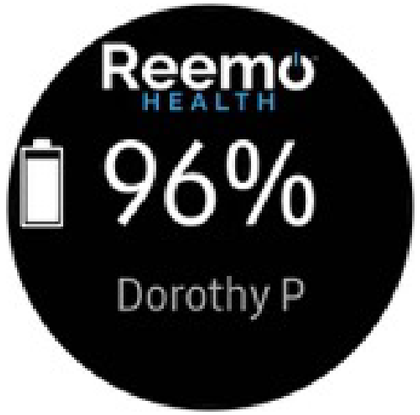
Call-for-help



Heart Rate

Messaging

Blood Pressure Cuff



Status

User Feedback

- Simplicity and ease-of-use
- No set up required/ready to turn on and use out of the box
- No internet or phone needed
- Use inside and outside the home
- Stylish – not a pendant
- More than just a PERS device

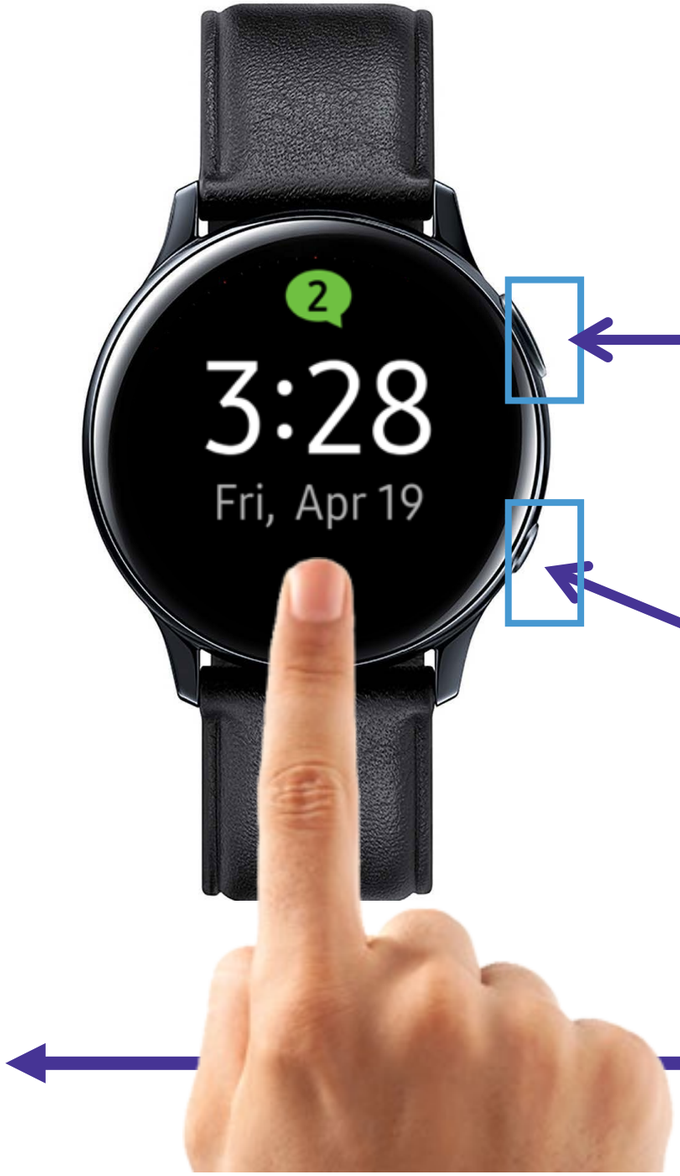
"I love my watch because of the PERS feature. My phone was out, and I have a pacemaker. I had an issue and used the PERS button to call for help."

"This watch is ideal. It's gotten me to move more and it really challenges me!"

"This is what I have been looking to find for years. Thank you for making this."

Simple User Experience

Easy to Use!
No cost
No WiFi Required
No Cell Phone Required
No Apps
No Setup
Shipped to member
Open the box and turn it on!



Wake Button
Press once to display the watch face.

Power Button
Press and hold to turn the watch on/off.

Finger Sweep
Swipe screen left or right to access features.

2023 UCare User Feedback

Do you enjoy this watch?

89%

“Yes”

Do you feel safer with this watch?

90%

“Yes”

Would you recommend this watch?

84%

“Yes”

Is this watch easy to use?

88%

“Yes”

Motivated to get more activity with this watch?

84%

“Yes”

Is this watch useful to you?

87%

“Yes”

Is watch helping you make health changes?

84%

“Yes”

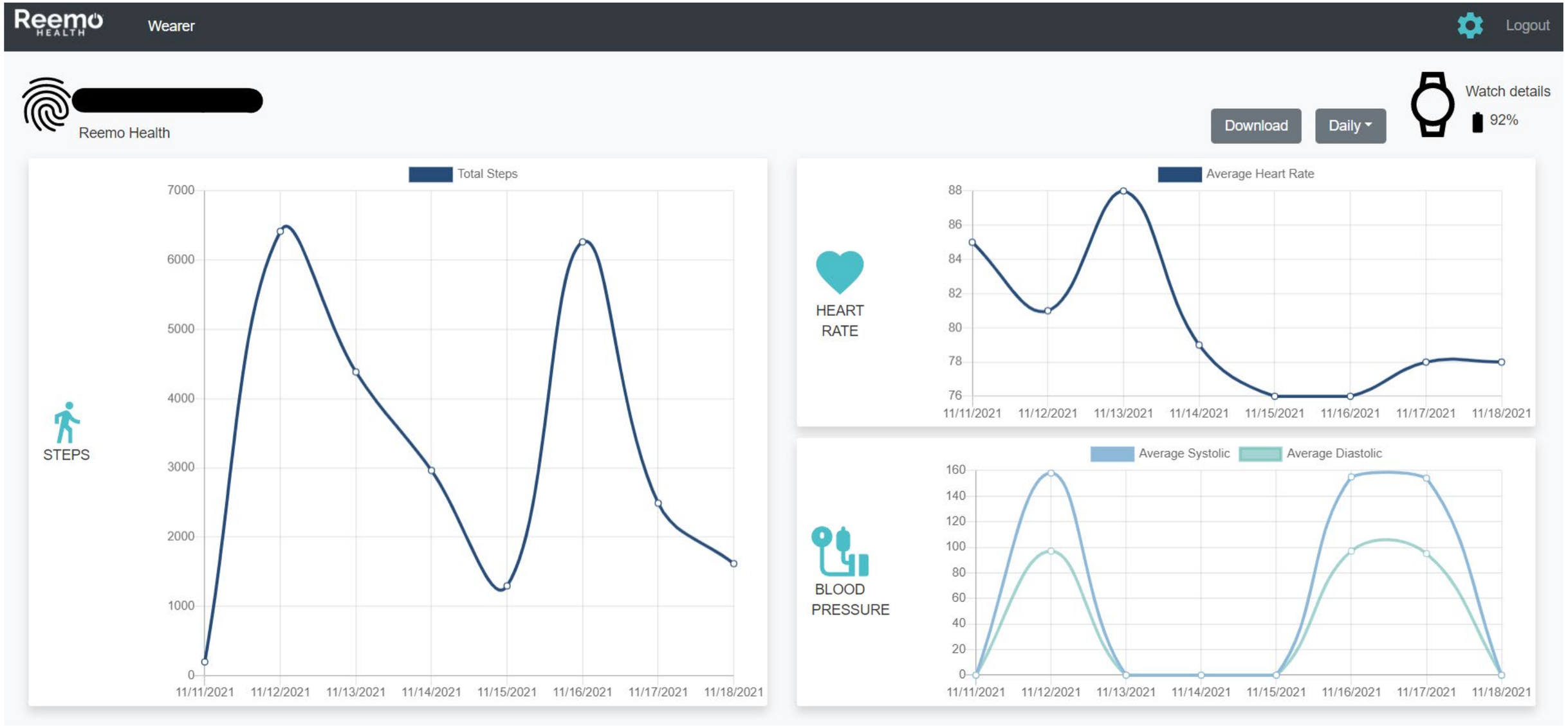
Additional Functions

Messages pushed to individuals to encourage movement, watch feature reminders and general wellness information.

Blood Pressure Cuff available on certain plans.
(automatically pairs to the watch)

User Portal

*User Email required for login creation

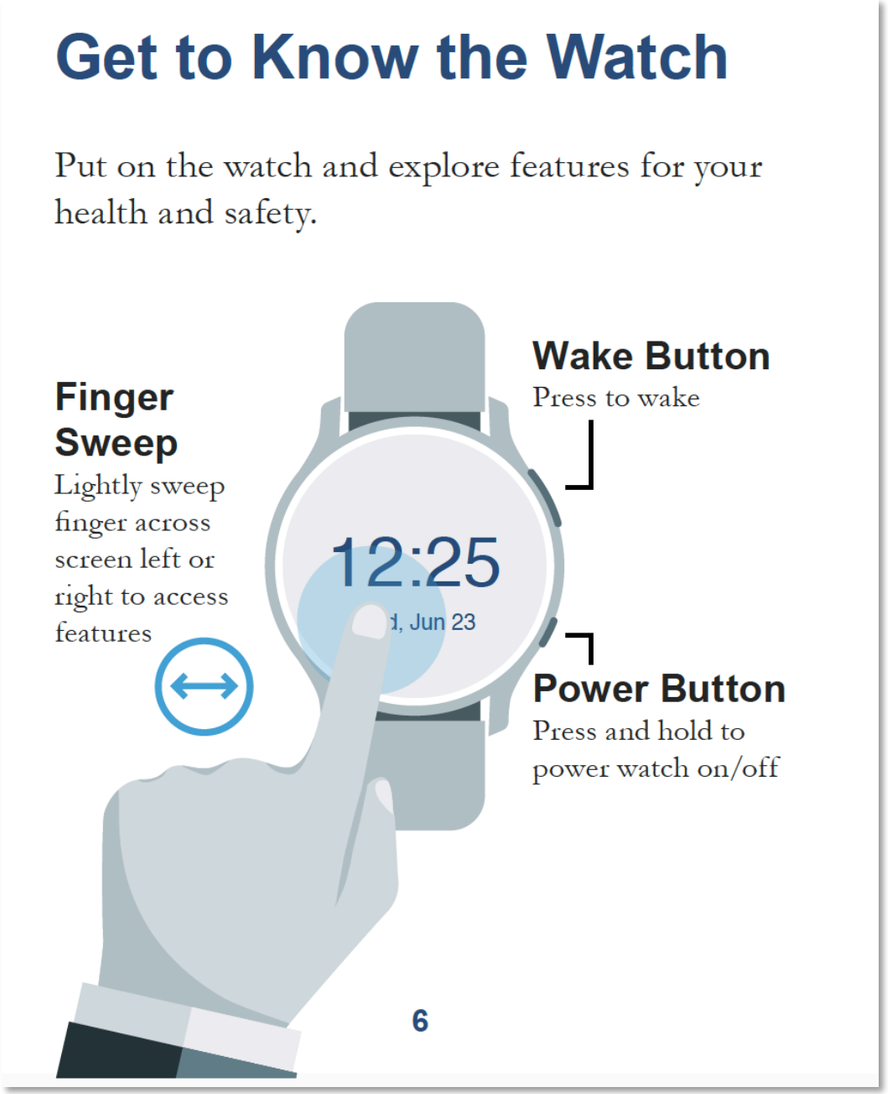


Onboarding and Support

ONBOARDING

Welcome Guide

Welcome call



SUPPORT

Helpline

Outreach

UCare Eligibility Key

	Activity Tracker	PERS	PERS	Blood Pressure Cuff	Blood Pressure Cuff
	All receive upon enrollment	All receive upon enrollment	Enrollment upon Care Coordinator request	Enrollment upon member request	Enrollment upon Care Coordinator request. Required Hypertension diagnoses on file.
MSHO	X		X		X
Connect + Medicare	X		X		X
Aspirus (Essentials RX)	X	x		x	

Email orders & questions to ucare@reemohealth.com

Order Form (1 of 2)

Email orders & questions to ucare@reemohealth.com

Connect + Medicare Supplemental Benefit: Reemo Health Smartwatch Order Form

Use this form to order the Reemo Health smartwatch for Connect + Medicare members. All Connect + Medicare members are eligible for the smartwatch. The Reemo Blood Pressure cuff is available to all Connect + Medicare members with a diagnosis of Hypertension on file with UCare. **The item/service requested under the Connect + Medicare supplemental benefit does not count towards the member's Elderly Waiver budget**. Incomplete, illegible or inaccurate forms will be returned to the Care Coordinator

- This form can only be completed by a UCare care coordinator.
- Email completed form for **new orders** to: **ucare@reemohealth.com**
- For process related questions contact: snbcclinicalliaison@ucare.org
- For order status questions contact: wellness@ucare.org

Member information

First Name: _____ Last Name: _____

UCare Member ID: _____DOB: _____Gender: _____

Phone Number: _____ Order Date:_____

Shipping Address (PO boxes not allowed): _____

City: _____ State: _____ Zip: _____ Require signature upon delivery? Yes ☐ No ☐

Emergency Contact: (First & Last Name): _____Phone: _____

Order Form (2 of 2)

Email orders & questions to ucare@reemohealth.com

Intended use of watch: ☐ Activity Tracking Only ☐ Activity Tracking and PERS ☐ Blood Pressure Cuff

Care Coordinator Information

The Care Coordinator will receive an email invitation to view the member's data in the my.reemohealth.com portal.

Care Coordinator First Name: _____ Last Name: _____

Email Address: _____ Phone: _____

Delegate Organization: _____

For device questions or service termination, contact Reemo at: support@reemohealth.com for assistance and device return instructions.

Provider Name: **REEMO Health** NPI: 1831720457 Phone: (877) 697-3366

The Reemo devices will ship within 10 business days of receipt of complete UCare/Reemo order form and will be delivered to the shipping address above. If order form has incomplete information, Reemo will send it back to the Care Coordinator within 7 business days to complete. The Reemo devices will be ready for use immediately. If you have any questions about the Reemo device functionality, please contact Reemo Health at: support@reemohealth.com

MSC+/MSHO Presentations

(SNBC Optional)

GrandPad

Presenter: Lisa Risch

GrandPad®

Live Grand®

GrandPad for UCare

Our Mission

Improve the lives of millions of seniors by reconnecting them with their families, friends, and caregivers.

Participant Engagement - Medical & Social Interaction

IDT's, Clinicians, Providers, Office

Medical Interaction

Proactive Outreach

Video / Voice Call

Wellness Surveys

Connected Devices

Not shared with family unless the Medical team releases or family admin asks for it

Senior

Social Interaction

Family & Friends / White List

Reduces Social Isolation

Cognitive data is captured along with social interaction data

No personal interactions (family pictures, emails, etc) shared with Medical Team unless family believes it's pertinent

Family & Friends

Connect the Circle of Trust

Improve their quality of life.

Family

+

Participant

+

Care Team

Simple. Safe. Secure.

GrandPad Support – Member Experience Agents

Frontline Support

- MEs provide frontline support via phone and video calls with GrandPad members, family, customers & clients.
- Intelligent Call Routing
- No “Press 1, 2, 3…”
- Unique Training - Initial & Ongoing

Flexible & Dependable

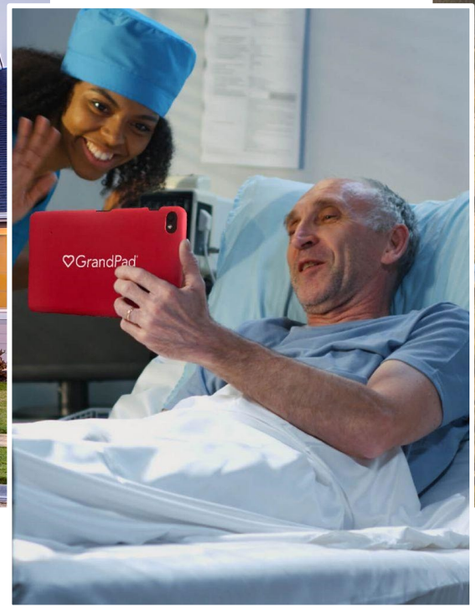
MEs are available to delight our seniors with white-glove customer care.

- 7 x 24 support
- 365 days a year

Build Relationships

MEs foster good communication and create valued friendships with our seniors by providing friendly, patient, caring and compassionate customer service.

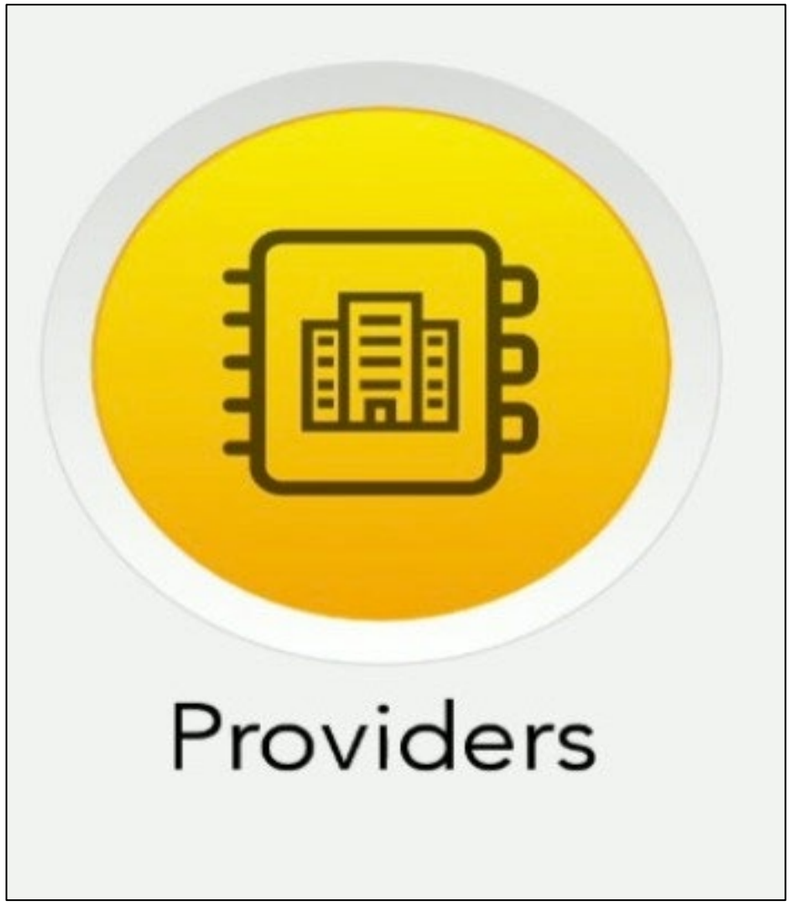
Reliable Digital Endpoint



- Virtual Care = Increased opportunities to improve quality of care
- Meeting participants where they are at and when you need them

Drives engagement, connection and participation

Providers Button



The Providers Button On the GrandPad

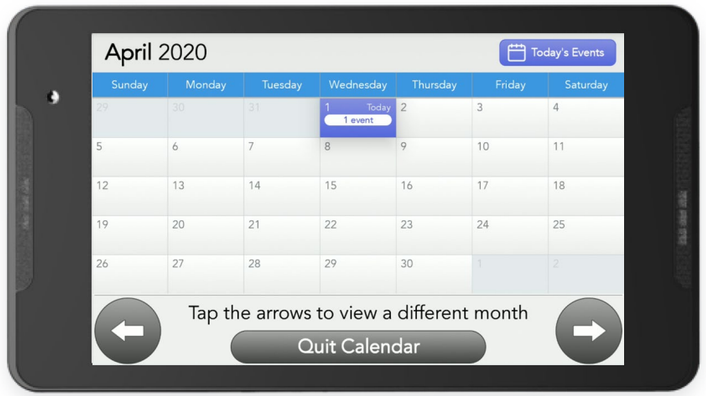
This Is The Provider Button Image For Care Coordinators.

This Is The Providers Button Image For Primary Care Providers.

Calendar / Reminders

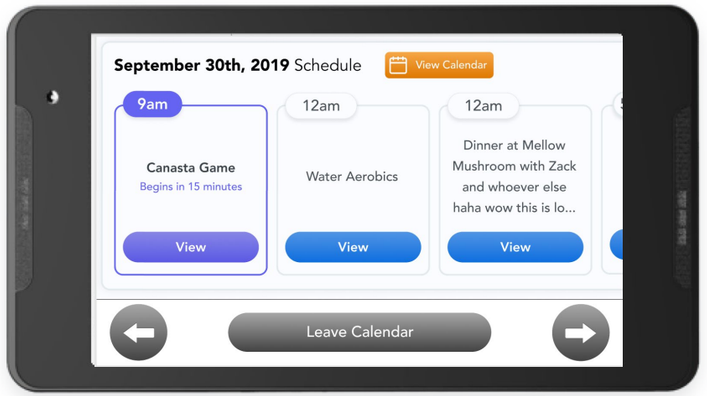
Providers can set appointments and have them automatically added to the GrandPad Calendar and each participants calendars via GrandPad Central.

Month View



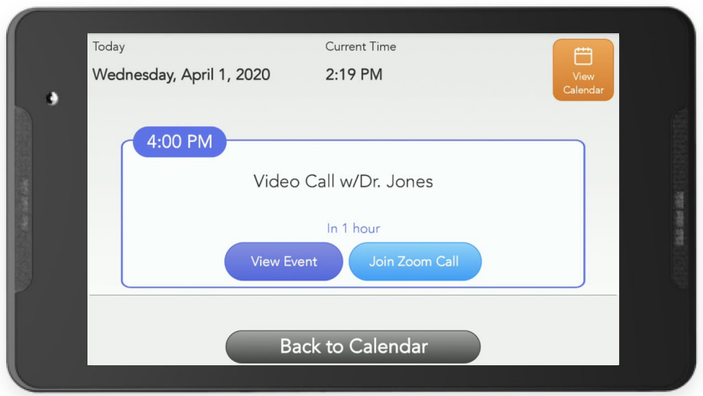
- Invitations to join a Zoom call are received via the Email app

Day View



- Caregiver can remotely add events to a patient calendar

Event Detail



- Click into event to see details and special instruction
- Tap the “Join Meeting” button to be placed into a video call

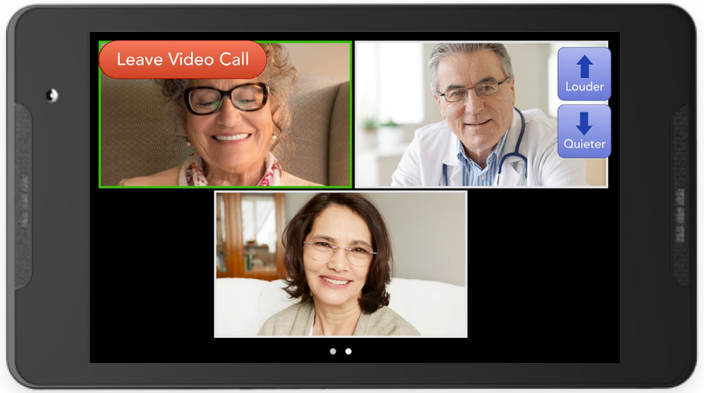
Zoom Group Calls

Joining a multi-party video call without hassle. No sign-ins, meeting numbers or hidden functionalities. It is simple and effective — just as you'd expect from GrandPad.

Clear Instruction

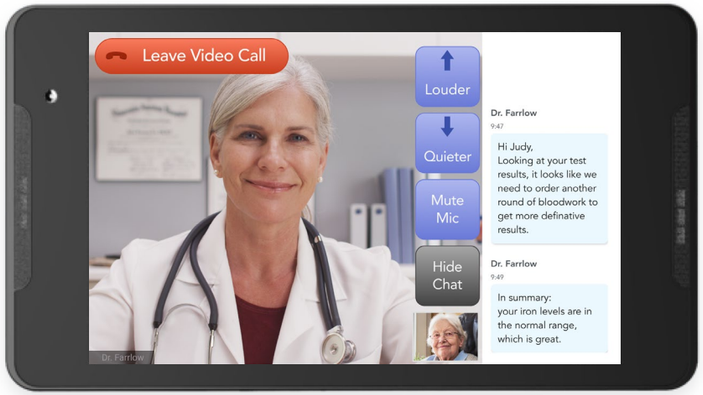
- Invitations to join a Zoom call are received via the Email app
- Tap the "Join Meeting" button to be placed into the video call

One Tap to Join the Call



- Multiple participants can join the conversation at any time
- Include family members or caretakers for assurance and clarity of information

Includes Chat Functionality

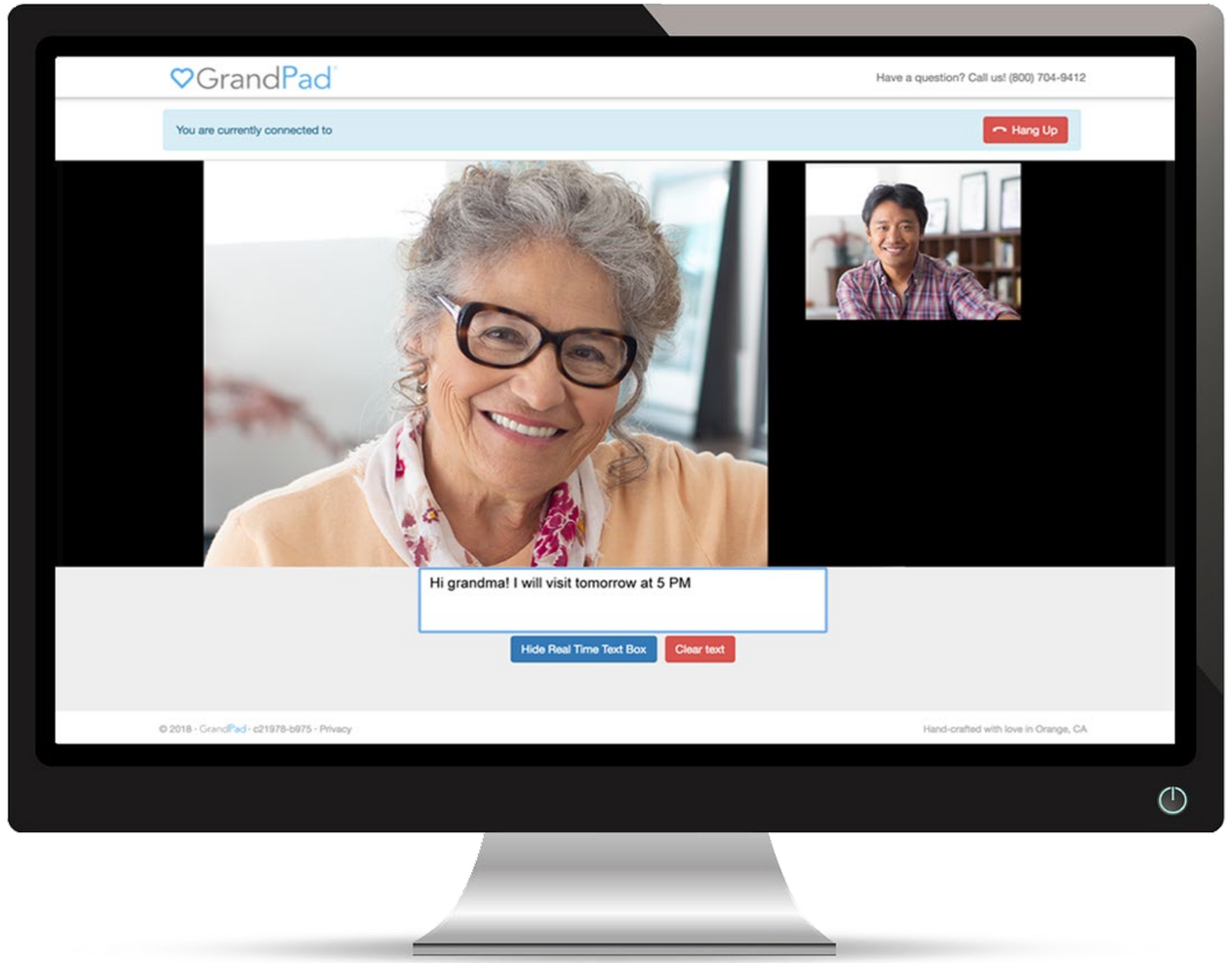


- Multiple people can be included in the conversation such a as family members or caretakers

Include the entire family so everyone can be in-the-know

Video Calling - Provider Console

- Accessible via a web browser
  – *Chrome preferred*
- Secure & HIPAA compliant
- Simple interface for making video calls
- Video calls are **not** recorded or stored
- GrandPad Member Experience support is available
- Webcam or camera and microphone is required to place a video call to the GrandPad



GrandPad Portal Demo Training

Care Coordinator

- Monitor patient status
  - Videochat to check on patient health status and state of enviroment
- Care plan development
  - Virtual visit to discuss care plan and/or answer questions about care plan
- Education
  - Videochat to discuss medical issues, care plans, best practices for positive outcomes
- Coordinate care teams and plans

Personal Care Providers/Therapists/Social Workers

- Wellness Check
  - Visual check in on participant to check physical status
  - Visual check on participant's home environment
- Virtual support
  - Videochat to help support participant
  - Make video recording for reference as needed
- Support
  - Videochat to provide support and/or encouragement for social engagement

Onboarding Survey Checks Physical and Mental Health

Questions?

Lisa Risch
Client Success Manager
GrandPad
1-800-704-9412

A&G PCA Appeals

Presenter: Joshua Paciorek

PCA Appeal Process

Health Plan Appeal Process:

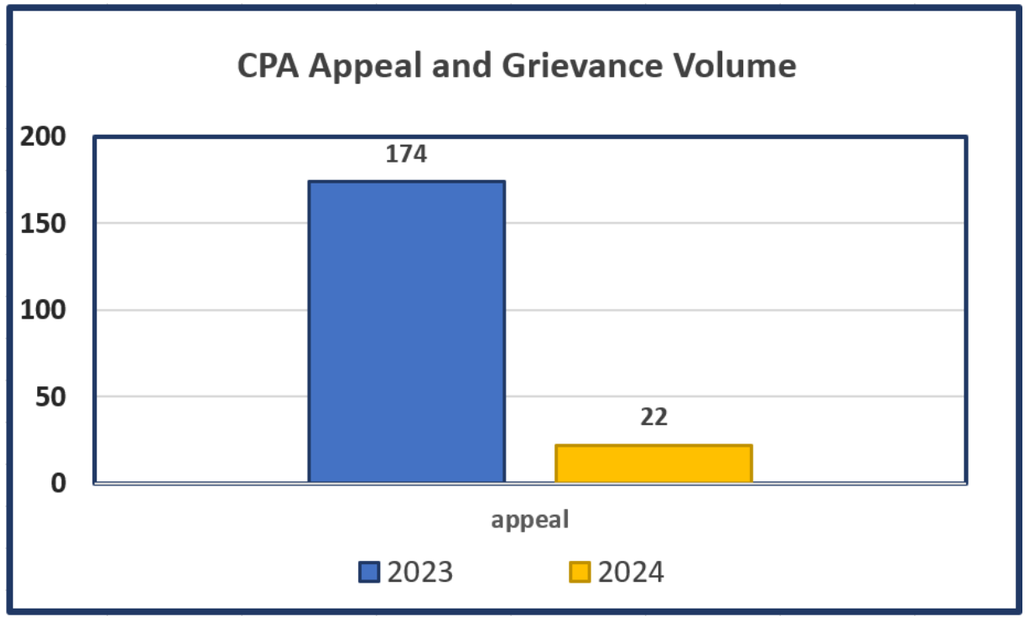
- UCare receives the appeal and confirms it is valid.
- UCare faxes cover sheet to DHS.
- A&G reviews the account for continuation of benefits (if the appeal is before the effective date of the action.
- The A&G Specialist assigned to the case conducts a comparative analysis of the current year's assessment with the prior year's assessment.
  - *A&G reviews the member's assessment determinations the year before.*
  - *A&G reviews what has changed this year.*
  - *A&G Determines if any related conditions are chronic and how health needs may have changed.*
  - *A&G reviews for any changes in the member's condition that would warrant a new assessment.*
  - *A&G Reviews claims history to determine if any services were rendered that would indicate a need for PCA services (additional hospitalizations, injuries, etc.).*
- The A&G Specialist documents their research findings and makes a recommendation to the medical director.
- The Medical Director makes a decision which is communicated to the A&G Specialist.
- A Resolution Letter is sent to the member.

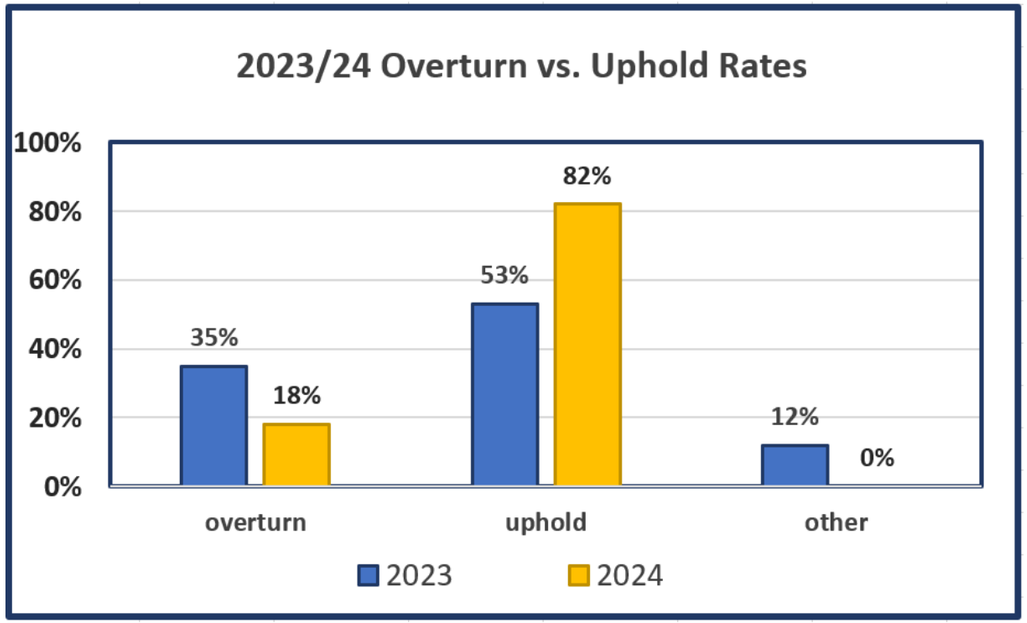
PCA Appeal Process

State Fair Hearing (next-level appeal) Process:

- If a member disagrees with the Health Plan appeal decision, they may pursue a next-level appeal by requesting a State Fair Hearing through DHS.
- Members must exhaust the health plan appeal process to request a State Fair Hearing. These requests must be submitted within 120 days of UCare's appeals decision.
- UCare receives a State Fair Hearing request and validates that a health plan appeal has been setup and processed.
- A review of the original health plan appeal is conducted by A&G.
- A State Fair Hearing packet is sent to the State Fair Hearing judge at least 3 days prior to the hearing.
- The State Fair Hearing judge renders a decision on the case. This case take up to 90 days from the date of the hearing.
- A&G receives the judge's decision by fax and appealing members receive the same letter.

PCA Appeal Volumes





- In 2023, UCare received and completed 174 PCA appeals. 53% of appeals were upheld, 35% were overturned, and 12% were withdrawn or dismissed.
- In 2024, UCare has completed 22 appeals (20 in process). 82% of appeals have been upheld and 18% have been overturned.

Notable Item:	Context:
Uphold rates have increased significantly in 2024 when compared to 2023.	In 2023, phone assessments still contributed to higher overturn rates as the absence of in-person observations make it harder to substantiate not honoring member appeal requests.

How you can help A&G:

- Provide detailed documentation on PCA assessments. Clear statements about why a member is not meeting an ADL are helpful.

- Provide specific information upon request: Sometimes, A&G may reach out for details to help us render an appeal decision. Providing targeting answers that address our specific questions is very helpful.

- Provide requested information timely. A&G works cases on strict timelines determined by our regulators.

Questions?

Connect/Connect + Medicare

SNBCClinicalLiaison@ucare.org

612-676-6625

MSC+/MSHO

MSC_MSHO_Clinicalliaison@ucare.org

612-294-5045